MENTAL HEALTH

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON

LABOR AND PUBLIC WELFARE

UNITED STATES SENATE

EIGHTY-FOURTH CONGRESS

FIRST SESSION

ON

S. J. Res. 46

A JOINT RESOLUTION PROVIDING FOR AN OBJECTIVE, THOROUGH, AND NATIONWIDE ANALYSIS AND REEVALUATION OF THE HUMAN AND ECONOMIC PROBLEMS OF MENTAL ILLNESS, AND FOR OTHER PURPOSES

S. 724

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MARCH 30 AND APRIL 13, 1955

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MENTAL HEALTH

WEDNESDAY, MARCH 30, 1955

UNITED STATES SENATE,
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D. C.

The committee met, pursuant to call, at 10 a.m. in the old Supreme Court chamber, United States Capitol Building, Senator Lister Hill (chairman) presiding.

Present: Senators Hill (chairman), Lehman, McNamara, Purtell, and Bender.

Also present: Stewart E. McClure, staff director; Roy E. James, minority staff director; William G. Reidy, and John S. Forsythe, professional staff members.

Chairman HILL. The subcommittee will come to order.

This morning the Subcommittee on Health of the Senate Committee on Labor and Public Welfare is to consider a joint resolution and three bills. They all deal with the one subject which in its cost, both in dollars and in human misery, seems to be far outstripping every other problem in the field of health. I refer to the problem of mental illness.

One of these bills is Senate Joint Resolution 46, which was sponsored initially by 30 Senators and which 2 more Senators have asked to cosponsor since the measure was introduced. Senate Joint Resolution 46 represents a rather unusual legislative device. It is a joint resolution rather than a bill. It was drafted in that form inasmuch as approximately four-fifths of its contents consists of whereases and only one-fifth of substantive legislation. That in turn is because the whereas clauses set forth, I believe, in most dramatic and alarming form, the multiplicity of most demanding reasons which force us to take prompt action to correct the situation they describe. The action they require, while not simple, can be simply stated.

Among other things, the whereas clauses in the bill point out that each and every day of the year some 750,000 individuals afflicted with mental ailments are in hospitals or mental institutions in the United States. They point out that 46 out of every 100 hospital beds in the United States is occupied by a victim of mental illness, and they point out that in addition to the heartbreak and suffering that lies behind these figures, the cost of mental illness alone to the taxpayers of the Nation is now over one billion dollars a year and is increasing at a rate of $100 million each and every year. These and other unchallenged facts set forth in the whereas clauses of Senate Joint Resolution 46 can lead but to one conclusion—that we must undertake a thoroughgoing reevaluation of everything we are doing, of everything

we know, of every possible new way of utilizing knowledge, funds, and personnel in the field of mental health so as to develop radically new departures as regards the treatment, care, and rehabilitation of the mentally ill, and the substitution of mental health for incipient mental illness wherever possible. Senate Joint Resolution 46 would accomplish this by providing, over a 3-year period, a million and a quarter dollars to be used for grants to such a group of nongovernmental professional organizations active in the field of mental illness as will undertake to conduct the kind of thoroughgoing analysis and reevaluation as is needed. The amount of money authorized by the resolution will, it is hoped, be matched by contributions from private funds.

In closing this brief description of the reasoning behind Senate Joint Resolution 46, let me point out, so as to clear up some confusion which apparently exists in the minds of people who have written in to us, that a joint resolution is handled under the same legislative procedure as any bill and, if enacted, has the same force of law as would a bill.

(The bills and the reports of the Department of Health, Education, and Welfare and the Bureau of the Budget are as follows:)

[S. J. Res. 46, 84th Cong., 1st sess.]

JOINT RESOLUTION Providing for an objective, thorough, and nationwide analysis and reevaluation of the human and economic problems of mental illness, and for other purposes

Whereas some seven hundred and fifty thousand mentally ill and retarded patients are now being hospitalized on any given day; and

Whereas forty-seven per centum of the hospital beds in the Nation are occupied by mental patients; and

Whereas the direct economic cost of mental illness to the taxpayers of the Nation, including pensions to veterans with psychiatric disabilities, is over $1,000,000,000 a year and has been increasing at a rate of $100,000,000 a year; and

Whereas the emotional impact and distress suffered by millions of our people anxiously and justifiably concerned about the welfare, treatment, and prospects of mentally afflicted relatives is incalculable; and

Whereas the governors of the several States, through national and regional governors conferences and through the publications of the Council of State Governments, have shown great initiative in their cooperative attempts to develop beter methods of meeting the problem of mental illness in their States; and

Whereas there is strong justification for believing that this constantly growing burden may well be due primarily to an outmoded reliance on simple custodial care in mental hospitals as the chief method of dealing with mental illness; and

Whereas there is strong reason to believe that a lack of early intensive treatment facilities has contributed materially to the creation of such a backlog of mentally deteriorated patients that it is virtually impossible for the States to meet the need for mental hospital facilities; and

Whereas there is strong reason to believe that one of the greatest impediments to more rapid progress in the field of mental health is a definite shortage of professional personnel in all categories; and

Whereas there seems to be a discouraging lag between the discovery of new knowledge and skills in treating mental illness and their widespread application, as is evidenced by the fact that only one-third of newly admitted mental patients are on the average discharged from State hospitals in the course of a year, whereas in a few outstanding institutions the recovery rate is 75 per centum or more; and

Whereas experience with certain community outpatient clinics and rehabilitation centers would seem to indicate that many mental patients could be better treated on an outpatient basis at much lower cost than by a hospital; and

Whereas there is strong reason to believe that a substantial proportion of public mental hospital facilities are being utilized for the care of elderly persons

who could be better cared for and provided better treatment in modified facilities at lower cost; and

Whereas there is reason to believe that many emotionally disturbed children are being placed in mental hospitals which have no proper facilities to administer to their needs; and

Whereas mental illness is frequently a component of such nationwide problems as alcoholism, drug addiction, juvenile delinquency, broken homes, school failures, absenteeism and job maladjustment in industry, suicide, and similar problems; and

Whereas there is no overall integrated body of knowledge concerning all aspects of the present status of our resources, methods, and practices for diagnosing, treating, caring for and rehabilitating the mentally ill, although only through the development of such a body of knowledge can the people of the United States ascertain the true nature of this staggering problem and develop more effective plans to meet it: Therefore be it

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That this joint resolution may be cited as the "Mental Health Study Act of 1955".

STATEMENT OF PURPOSES AND POLICY

SEC. 2. (a) It is the sense of the Congress that there exists a critical need for such an objective, thorough, and nationwide analysis and reevaluation of the human and economic problems of mental illness and of the resources, methods, and practices currently utilized in diagnosing, treating, caring for, and rehabilitating the mentally ill, both within and outside of institutions, as may lead to the development of comprehensive and realistic recommendations for such better utilization of those resources or such improvements on and new developments in methods of diagnosis, treatment, care, and rehabilitation as give promise of resulting in a marked reduction in the incidence or duration of mental illness and, in consequence, a lessening of the appalling emotional and financial drain on the families of those afflicted or on the economic resources of the States and of the Nation.

(b) It is declared to be the policy of the Congress to promote mental health and to help solve the complex and the interelated problems posed by mental illness by encouraging the undertaking of nongovernmental, multidisciplinary research into and reevaluation of all aspects of our resources, methods, and practices for diagnosing, treating, caring for, and rehabilitating the mentally ill, including research aimed at the prevention of mental illness. It is the purpose of this joint resolution to implement that policy.

SPECIAL PROJECT GRANTS FOR COMPREHENSIVE MENTAL HEALTH STUDY

SEC. 3. Part A of title III of the Public Health Service Act is amended by adding after section 303 the following new section:

"GRANTS FOR SPECIAL PROJECTS IN MENTAL HEALTH

"SEC. 304. (a) The Surgeon General is authorized, upon the recommendation of the National Advisory Mental Health Council, to make a grant or grants to such qualified nongovernmental agencies, organizations, or commissions, composed of representatives of leading national medical and other professional associations, organizations, or agencies active in the field of mental health, as may agree to undertake and conduct research into and study of all aspects of our resources, methods, and practices for diagnosing, treating, caring for, and rehabilitating the mentally ill, on a scale commensurate with the problem.

"(b) For such purpose there is hereby authorized to be appropriated for the fiscal year ending June 30, 1956, the sum of $250,000 to be used for a grant or grants to help initiate the research and study provided for in this section; and the sum of $500,000 for each of the two succeeding fiscal years for the making of such grants as may be needed to carry the research and study to completion. The terms of any such grant shall provide that the research and study shall be completed not later than three years from the date it is inaugurated; that the grantee shall file annual reports with the Congress, the Surgeon General, and the governors of the several States, among others that the grantee may select; and that the final report shall be similarly filed.

"(c) Nothing in this section shall in any way affect the availability of amounts otherwise appropriated for work in the field of mental health; nor be construed

to interfere with or diminish the more limited and specific programs of research and study being carried on through or under the auspices of the National Institute of Mental Health.

"(d) Any grantee agency, organization, or commission is authorized to accept additional financial support from private or other public sources to assist in carrying on the project authorized by this section."

[S. 724, 84th Cong., 1st sess.]

A BILL To establish a Commission on Mental Health, and to provide for a study of the problems of mental illness and for the development of a national mental health program

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That there is hereby established a commission to be known as the "President's Commission on Mental Health" to be composed of a Chairman and seventeen other members appointed by the President. Members of the Commission shall be eminent representatives of the fields of psychiatry, mental hospital administration, medical education, physical medicine and rehabilitation, and allied mental health fields, and of representatives of the Council of State Governments. Such members shall be appointed for terms of three years except that any member appointed to fill a vacancy occuring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and the terms of office of the members first taking office shall expire, as designated by the President at the time of appointment, six at the end of the first year, six at the end of the second year, and six at the end of the third year, after the date of enactment of this Act.

SEC. 2. (a) The Commission is authorized and directed to conduct a thorough inquiry into the problem of mental illness, including the status, progress, and problems incident to (1) the provision of hospital and related facilities necessary to the furnishing of care and treatment for the mentally ill, (2) the improvement of mental health services and treatment both in and outside mental hospitals, (3) the availability and training of psychiatrists and allied mental health personnel, and (4) the development of research into the causes, treatment, and prevention of mental illness.

(b) The Commission is further authorized and directed to develop and recommend a comprehensive national mental health program, including long-range plans for coping with both existing and anticipated problems incident to mental illness, as well as recommendations as to methods of financing the costs of such a program and the proper role of the local, State, and Federal Governments, and of nongovernment organizations and facilities in such a national program.

(c) The Commission shall transmit a report of its findings pursuant to the inquiry authorized under subsection (a), together with its recommendations under subsection (b), to the President and the Congress not later than thirty months following the enactment of this Act. In addition to such report and recommendations, the Commission may transmit from time to time such interim reports as it deems appropriate.

SEC. 3. Upon completion of its inquiry and transmittal of its recommendations in accordance with section 2, it shall be the duty of the Commission to conduct a continuing review and evaluation of the status, progress, and problems incident to the provision of care and treatment for the mentally ill, and to report annually to the President and the Congress the results of its review and evaluation, together with such recommendations as it deems desirable, and from the sums made available therefor for any fiscal year, the Commission is authorized to (1) develop, coordinate, and initiate broad public educational programs in mental hygiene, and (2) develop and participate with State and local mental health authorities and agencies and with nongovernmental mental health organizations, upon request, in the initiation of special demonstration projects, which, in the judgment of the Commission, hold promise of making substantial contributions to the solution of problems incident to the improvement of care and treatment for the mentally ill.

SEC. 4. (a) In connection with its inquiry under the provisions of section 2 (a) the Commission is authorized to sit and act at such times and in such places; to hold such public hearings; and to take such testimony, as it deems advisable.

(b) All executive departments and agencies of the Federal Government are authorized and directed to cooperate with the Commission in its work and to furnish the Commission such information and assistance, not inconsistent with law, as it may require in the performance of its functions and duties.

(c) Members of the Commission shall receive compensation at the rate of $50 per diem while serving on business of the Commission, shall be reimbursed for actual and necessary travel expenses, and shall be entitled to an allowance of $10 per diem in lieu of reimbursement for subsistence expenses, while so serving away from their places of residence.

(d) The Commission is authorized to appoint, without regard to the civil-service laws and regulations, and to fix the compensation without regard to the Classification Act of 1949, as amended, of an executive secretary and such other employees as may be necessary to enable it to carry out its functions and duties.

(e) To enable the Commission to carry out its functions and duties, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1956, the sum of $1,000,000, for the fiscal year ending June 30, 1957, the sum of $1,500,000, and for each fiscal year thereafter such sums as Congress may determine to be necessary for the purposes of this Act. The Commission is also authorized to accept (1) funds; (2) the services of voluntary and uncompensated personnel (and to provide transportation and subsistence as authorized by section 5 of the Act of August 2, 1946 (5 U. S. C. 73b–2), for persons performing such services); (3) equipment; and (4) facilities, donated for purposes of the Commission, and to use the same in accordance with such purposes.

SEC. 5. The Commission shall cease to exist ten years after the enactment of this Act.

[S. 848, 84th Cong., 1st sess.]

A BILL To amend the Public Health Service Act, as amended

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE

SECTION 1. This Act may be cited as the "National Mental Health Act Amendments of 1955".

STATEMENT OF PURPOSES

SEC. 2. It is the purpose of this Act to provide for surveys of mental illness and to develop more effective methods of measuring the extent of the mental health problem in the United States; to improve and assist in the coordination of public and private programs and activities for the prevention, control, and treatment of mental illness; and to stimulate the development of more effective public health services in the field of mental health, and improvements in the direction and administration of institutions for the mentally ill and in the treatment of the mentally ill.

SURVEYS, STUDIES, AND COORDINATION OF MENTAL HEALTH PROGRAMS

SEC. 3. Section 303 of the Public Health Service Act, as amended, is amended by adding at the end thereof the following:

"(c) (1) To make surveys and special studies of the population of the United States to determine the amount, distribution, economic impact, and other effects of mental illness, (2) to collect periodically data of national scope on the incidence, prevalence, and duration of disability for the major types of mental illness and psychiatric disorders, and (3) to study, through sample surveys and other appropriate means, and develop improved methods of measuring the extent of the problem of mental illness in the United States.

"(d) To promote and assist in the better coordination and integration of regional, interstate, State, and community mental health services and programs, and to participate in the planning and development of regional and interstate collaboration and cooperative projects and arrangements in the field of mental health, including joint planning for the joint use of highly trained or specialized personnel and interstate or regional use of highly trained or specialized personnel and interstate or regional use of physical facilities, including facilities for research and training.

"(e) To collect and maintain a central pool of information concerning the scientific, technical, organizational, operational, and other aspects and problems of public, private, regional, and interstate programs for the control, prevention, and treatment of mental illness, to disseminate such information (including the results of special projects supported by grants under section 314 (1)) by publi-

cation and other appropriate means, and to provide to responsible authorities and officers of public agencies and nonprofit private organizations technical advice and assistance in its practical application through consultation services, short-term loans of specialized personnel, and otherwise as appropriate."

APPROPRIATIONS FOR MENTAL PUBLIC HEALTH SERVICES

SEC. 4. Section 314 of such Act, as amended, is amended by adding at the end of subsection (c) thereof a new sentence as follows: "For the five-year period beginning with the fiscal year ending June 30, 1956, appropriations authorized by this subsection shall specify an amount to be determined by the Congress for the support of mental public health services, the total sum so specified to be available for allotment among the States in accordance with the provisions of subsection (d)."

SPECIAL GRANTS FOR MENTAL HEALTH PROJECTS

SEC. 5. (a) Section 314 of such Act is further amended by adding at the end thereof a new subsection as follows:

"SPECIAL GRANTS FOR MENTAL HEALTH PROJECTS

"(1) There is authorized to be appropriated for the fiscal year ending June 30, 1956, and for each of the four succeeding fiscal years such sums as may be necessary to enable the Surgeon General to make grants to States and, with the approval of the State mental health authority, to interstate agencies or to political subdivisions of States for paying part of the cost of—

"(1) public health services in the field of mental health which are of importance for (A) the development of new techniques and better methods for the improvement of mental hygiene and the prevention of mental illness, (B) public education with respect to the causes of mental illness and methods of control and prevention, (C) the development of counseling and referral services to obtain full and effective use of community resources in the field of mental health, and (D) the development of prevention and control programs on an organized community-wide basis; and

"(2) demonstrations and experimental projects for (A) developing improved methods of care and treatment of the mentally ill, including grants to State agencies responsible for administration of State institutions for care, or for care, treatment and rehabilitation, of the mentally ill, (B) developing improved methods of operation and administration of such institutions, (C) reducing the length of institutional stay by improving or developing new methods for ambulatory care and for preparation for the return of the institutionalized patient to the life of the community, and (D) developing improvements in the design and equipment of physical facilities for institutional and ambulatory treatment of the mentally ill."

(b) Subsection (j) of such section is amended by inserting after "subsection (c)" wherever it appears the following: "or subsection (1)".

[S. 886 (title VI)]

A BILL To improve the health of the people by encouraging the extension of voluntary prepayment health services plans, facilitating the financing of construction of needed health facilities, assisting in increasing the number of adequately trained nurses and other health personnel, improving and expanding programs of mental health and public health, and for other purposes

* * * * * * *

TITLE VI—MENTAL HEALTH

DECLARATION OF PURPOSE

SEC. 600. The purpose of this title is to improve the mental health of the Nation by strengthening State and community programs in the field of mental health through a five-year program of special grants to the States for preventive and other community health services in this field, and for the development of improved methods relating to the care, treatment, and rehabilitation of patients in mental institutions.

AMENDMENTS RELATING TO GRANTS TO STATES FOR MENTAL HEALTH SERVICES

SEC. 601. Part A of title III of the Public Health Service Act is amended by redesignating section 315 as section 316 and inserting after section 314 the following new section:

"GRANTS TO STATES FOR MENTAL HEALTH SERVICES

"SEC. 315. (a) There are hereby authorized to be appropriated for the fiscal year ending June 30, 1956, and for each of the four succeeding fiscal years, in addition to the sums authorized to be appropriated pursuant to section 314, such sums as the Congress may determine, for grants to States to assist them in meeting the costs of maintaining, and of extending and improving, their public health services in the field of mental health.

"(b) From the sums appropriated pursuant to subsection (a) the Surgeon General, in accordance with regulations, shall from time to time make allotments to the several States on the basis of (A) the population, (B) the extent of the mental health problem, and (C) the financial need of the respective States.

"(c) From each State's allotment under subsection (b) for any fiscal year, the Surgeon General shall pay to such State an amount equal to its Federal share (as determined under section 314 (h)) of the cost of public health services in the field of mental health under the plan of such State approved under section 314 (d), including the cost of training personnel for State and local mental health work and including the cost of administration of so much of the State plan as relates to work in the field of mental health.

"(d) Nothing in this section shall in any way affect the availability of amounts paid to the States under section 314 for work in the field of mental health.

"(e) (1) The provisions of section 314 (e) shall be applicable to regulations and amendments thereto under this section to the same extent as they are applicable to regulations and amendments thereto under section 314 relating to work in the field of mental health.

"(2) Paragraphs (1), (2), and (3) of section 314 (j) shall be applicable to payments under this section, and section 314 (l) shall be applicable to allotments under this section, to the same extent as they are applicable to payments and allotments, respectively, under section 314."

SPECIAL PROJECT GRANTS IN MENTAL HEALTH

SEC. 602. Part A of title III of the Public Health Service Act is amended by adding after section 303 the following new section:

"GRANTS FOR SPECIAL PROJECTS IN MENTAL HEALTH

"SEC. 304. (a) There are hereby authorized to be appropriated for the fiscal year ending June 30, 1956, and for each of the four succeeding fiscal years, such sums as the Congress may determine, to enable the Surgeon General to carry out the provisions of clause (2) of section 303 (a) with respect to development of improved methods of care, treatment, and rehabilitation of the mentally ill, including grants to State agencies responsible for administration of State institutions for care, or care and treatment, of mentally ill persons for developing and establishing improved methods of operation and administration of the institutions. Any grant under this section shall be made only upon recommendation of the National Advisory Mental Health Council.

"(b) The provisions of section 303 (b) shall be applicable to payments under this section to the same extent as they are applicable to payments under section 303.

"(c) For the purposes of this section, Guam shall be deemed to be a 'State'."

TRAINEESHIPS

SEC. 603. Part A of title III of the Public Health Service Act is amended by adding after section 305 (added by section 401 of this act) the following new section:

"TRAINEESHIPS IN MENTAL HEALTH

"SEC. 306. (a) In carrying out the purposes of section 301 with respect to mental health, the Surgeon General is authorized to provide, establish, and maintain traineeships in accordance with the provisions of section 433 (a).

"(b) The provisions of section 303 (b) shall be applicable to payments under this section to the same extent as they are applicable to payments under section 303."

EFFECTIVE DATE

SEC. 604. The amendments made by this title shall become effective July 1, 1955.

SHORT TITLE

SEC. 605. This title may be cited as the "Mental Health Grants and Traineeship Amendments of 1955."

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, D. C., March 24, 1955.

Hon. LISTER HILL,
Chairman, Committee on Labor and Public Welfare,
United States Senate.

DEAR MR. CHAIRMAN: This is in response to your request of February 2 for a report on S. 886, a bill to improve the health of the people by encouraging the extension of voluntary prepayment health services plans, facilitating the financing of construction of needed health facilities, assisting in increasing the number of adequately trained nurses and other health personnel, improving and expanding programs of mental health and public health, and for other purposes.

S. 886 embodies the Department's proposals for measures to carry out the President's recommendations for a reinsurance program to encourage the expansion of voluntary health insurance, Federal mortgage insurance to facilitate private credit for the construction of private health facilities, training programs to reduce shortages of health personnel, and for revisions to strengthen the present public-health and mental-health programs. These proposals were transmitted for consideration by the Senate on February 1, 1955, with a covering letter of explanation to the President of the Senate and summaries of each of the six titles of the proposed Health Improvement Act of 1955. A copy of my February 1 letter to the President of the Senate is enclosed for the convenience of the committee. There is also enclosed a list of typographical errors in the printed bill.

For the reasons indicated in the enclosed letter, this Department believes that enactment of the provisions of S. 886 would contribute materially to improvement of the Nation's health, and we urge its favorable consideration by your committee.

The Bureau of the Budget advises that enactment of this proposed legislation would be in accord with the program of the President.

Sincerely yours,

OVETA CULP HOBBY, *Secretary.*

LIST OF TYPOGRAPHICAL ERRORS IN AND SUGGESTED CORRECTIONS FOR H. R. 3458, H. R. 3720, AND S. 886

1. On page 16, line 8, strike out "4." and insert "(4)". (This error was in the draft version of the bill.)
2. On page 29, line 16, strike out the first comma.
3. On page 41, lines 6 and 7, strike out the words "with respect to such plans in order to obtain their advice and recommendations".
4. On page 66, line 19, insert a parenthesis before the word "including".
5. On page 73, line 13, after the word "option", strike out "; and". (This error is sense-distorting.)
6. On page 81, line 10, insert a hyphen after the word "working".
7. It would seem preferable that the word "fund" on page 97, line 5, and wherever else used in title II of the bill, be spelled with a capital "F".

Corrections could be made either by a star print or by committee amendments.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, February 1, 1955.

Hon. RICHARD M. NIXON,
The President of the Senate.

DEAR MR. PRESIDENT: I am enclosing for your consideration a draft of a bill to carry out the President's recommendations, made in his January 31, 1955, special message on health, with respect to a reinsurance service to give incentive to the expansion and improvement of voluntary health insurance plans, a mortgage insurance program to facilitate the private financing of health facility construction, measures to cut down critical shortages of health personnel, unification and revision of public health grants, and positive steps to strengthen mental health programs.

Draft legislative proposals to carry out others of the recommendations contained in the President's health message, such as improved financing of medical care for public assistance recipients, proposed revisions in grant structure for the Children's Bureau programs, and proposals for the revision and extension of the Water Pollution Control Act, are being separately submitted.

The enclosed draft bill comprises six titles as follows:

Title I. Reinsurance of Health Service Prepayment Plans
Title II. Mortgage Insurance for Construction of Health Facilities and Related Provisions
Title III. Practical Nurse Training
Title IV. Graduate Training of Professional Nurses and of Professional Public Health Personnel
Title V. Public Health Services
Title VI. Mental Health

A separate summary of the provisions of each of the six titles of the draft bill is enclosed. Only the major purposes and provisions of each title are referred to here.

REINSURANCE OF HEALTH SERVICES PREPAYMENT PLANS

Title I of the draft bill contains a proposed Health Services Prepayment Plan Reinsurance Act. It would establish within the Department of Health, Education, and Welfare a program of reinsurance to improve the public health by encouraging more extensive use of the voluntary prepayment method in the provision of personal health services.

The proposed reinsurance program would provide an attack on the problem of making needed health services and facilities available to the maximum number of people on a prepayment basis. The program is designed to encourage expansion and otherwise to stimulate private initiative in this field by making a form of reinsurance available for voluntary health services prepayment plans where needed to stimulate the provision of (*a*) better protection against exceptionally high costs of medical and hospital care; (*b*) coverage for a broader segment of the rural population; and (*c*) the development of health-insurance plans designed primarily to provide coverage for individuals and families with average or lower incomes. In addition to authorizing reinsurance of such plans, the proposal also would authorize reinsurance of other experimental plans aimed at improving benefits or extending coverage. The proposal also provides for technical advisory and informational services without charge to the sponsors of health services prepayment plans.

There are at present serious gaps in coverage by voluntary health insurance. Although important progress has been made in the extension of the voluntary prepayment method to a large segment of the American population, there remain important gaps in the number of individuals and families who are covered, and there is also need for broader benefits under many health insurance policies currently in force. The program proposed would continue to emphasize that voluntary health insurance is the soundest way for the American people to meet the unpredictable costs of medical, dental, and hospital care. It would preserve and strengthen the voluntary system, would protect the rights of the States to regulate insurance, and would provide greater opportunity for the American people to have better protection against the unpredictable costs of sickness.

The program is designed to be self-supporting over a period of years. It would permit carriers to experiment in broadening the benefits of the health insurance plans that they offer. Although authorization for a $100 million Treasury advance to the reinsurance fund is proposed, it is expected that premium income

from carriers reinsured under the program would in time be adequate to retire the advances from the Treasury.

To be reinsured a carrier must be operating according to law and the Secretary must make a finding that there is no reason to believe that the carrier is financially unsound or that its financial or other policies and manner of operation are unsafe or otherwise inconsistent with the purposes of the program. Reinsurance provides protection to the carriers only against costs in excess of those which can reasonably be anticipated; and protection of the fund is provided by the requirement of coinsurance by the carrier even with respect to these unanticipated costs. The proposal also includes other safeguards against unsound or unsafe practices on the part of the reinsured carrier.

Carriers could not be reinsured unless, in the Secretary's judgment, reinsurance on terms and conditions, and at premium rates, comparable to those offered under the proposal is not available from private sources to an extent adequate to promote the purposes of the program.

Administrative costs for operating the reinsurance program would be chargeable to the reinsurance fund. However, the proposal for studies, advisory and other technical informational services would be supported by general appropriations. An initial appropriation will be needed for fiscal year 1956 to establish the reinsurance fund and to provide for studies and informational services.

MORTGAGE INSURANCE FOR HEALTH FACILITIES

Title II of the draft bill contains the proposed Health Facilities Mortgage Insurance Act. It would establish within the Department of Health, Education, and Welfare a program of mortgage insurance to assist in financing the construction of privately owned and operated health facilities.

The proposed program is designed to complement the recently expanded hospital survey and construction program by facilitating, on a self-sustaining basis, an adequate and continuing flow of private credit for construction, expansion, and modernization of health facilities. In addition to authorizing a mortgage-insurance program, the proposed act would, with respect to the federally insured mortgages, remove some of the existing investment restrictions on certain federally regulated lending institutions. The existence of the program would also encourage the removal of similar restrictions imposed on such loans under State law.

The hospital survey and construction program, although broadened by the 1954 amendments to include additional assistance for the construction of hospitals for the chronically ill and to include assistance for the construction of nursing and convalescent homes, diagnostic, or treatment centers for ambulatory patients, and rehabilitation facilities, does not reach all types of facilities. Funds appropriated annually are necessarily limited and required to be allotted among the States on the basis of population and relative per capita income. The use of this program as a source of funds is further limited by its requirements as to ownership of the facility and by the priorities it places on unmet need.

For example, special clinics for ambulatory patients are not eligible for assistance under that program unless the sponsor is a State or other public agency or is a corporation or association which owns and operates a nonprofit hospital; facilities owned and operated by cooperative groups and restricted as to use to a certain membership group, are not within the scope of that program; and modernization required to replace obsolescence in long-established hospitals must wait to take its turn until after new construction in less-well-provided-for areas of the State has been financed. The size of the required loan, the length of the term required to finance the construction of this type of facility, and the proportion of capital which must be raised by a loan, now limit the availability of private or commercial credit in situations like these I have mentioned.

To encourage and assist private groups throughout the Nation to construct, expand, repair, remodel and reconvert hospitals, licensed nursing homes, diagnostic or treatment centers, and rehabilitation facilities, the program now proposed would insure, for a small premium, mortgage loans made by private lending institutions for these purposes. Compliance with applicable State laws and a finding of economic soundness would be required as conditions of Federal insurance. Questions of economic soundness in the case of hospital projects would be considered in the light of existing facilities and population-bed ratios, bed-utilization rates in the area, programed hospital construction, and other factors which would affect utilization of the proposed facility. The principle of coin-

surance would be applied to preserve the responsibility—and the economic stake—of the mortgagor and mortgagee, nor could the mortgage itself cover the full value of the property. The bill also provides safeguards against windfall profits.

The proposed mortgage insurance would provide stimulus and encouragement for a broader range of needed health facilities without Federal subsidy. It would permit the inclusion of types of sponsorship not wholly appropriate for a grant program.

A health facilities mortgage insurance fund will be maintained on a self-supporting basis from premiums charged for insurance, earnings from investments, fees, and other receipts. Insurance contracts would be entered into by the Secretary on behalf of the United States, but the fund, which is required to be operated in accordance with actuarial principles in order to assure that it will be self-sustaining over the years, would be primarily liable under the mortgage-insurance contract.

A $10 million initial appropriation would be authorized to provide initial working capital, with authorization for any necessary subsequent appropriations to provide additional working capital. Advances would be repaid from the insurance fund to the working-capital account with interest but, in order to permit the accumulation of an adequate reserve from premiums and from earnings of the fund, no capital would have to be repaid before July 1, 1965. In addition to this capitalization provision, the bill would authorize the Secretary (through issuance of notes purchased by the Secretary of the Treasury) to borrow up to $25 million or, if greater, up to 75 percent of the outstanding contingent insurance liability, to meet liabilities incurred under insurance contracts. Sums so borrowed would be repayable to the Treasury with interest. A program ceiling would be established, however, by a limit of $200 million on the authorized contingent insurance liability outstanding at any one time. This ceiling could be raised by action of the President by an aggregate increase of $150 million if he determined that such increases were in the public interest.

It is not expected that the enactment of the proposed health facilities mortgage insurance program will entail any increased cost to the Government over the long run, since insurance claims and administrative costs are to be borne from the fund. The initial appropriation will be needed for fiscal year 1956 to establish a working-capital account from which to meet administrative expenses and provide the capital in the early stages of operations.

PRACTICAL-NURSE TRAINING

Title III of the draft bill would authorize a 5-year program of vocational education grants to States for the extension and improvement of practical-nurse training of less than college grade. Grant funds would be available for costs of instruction and professional supervision of training programs. The program would make possible an increase in the number of trained practical nurses by enlarging the number of schools and by expanding those already in existence. To stimulate and encourage their more effective operation and to improve the quality of training offered, the bill would also authorize the provision of technical-assistance and nurse-consultant services.

Nationally, we are urgently in need of more nursing personnel. This title of the bill, along with other proposals for strategic attacks on the nursing-personnel shortage, suggests one of the quickest ways to increase the supply—the training of more practical nurses. The practical nurse is the trained worker who performs the simpler nursing functions and thereby releases the registered nurse to perform her professional duties.

After World War II the demand for nurses increased rapidly. The largest single factor in this increase was the greater complexity of medical care which requires so much more of the professional nurse's time. Larger numbers of practical nurses are now required to assist her with the care of the patient. The practical nurse is trained before her employment and is, therefore, of most assistance to the nurse.

The need to expand the training of practical nurses is urgent. Some of this training is being done, but to date many States still have only one program graduating about 15 to 25 students a year; a few States have none.

Experience in the past has shown that the most progress was made in practical nurse training when nurse consultants were available at both State and Federal levels to give professional guidance along with grant funds earmarked for the increase and expansion of such programs. Both funds and professional leadership are provided for in this proposal.

PUBLIC HEALTH AND GRADUATE NURSE TRAINING

Title IV of the draft bill would add a new section to title III of the Public Health Service Act to provide separate specific authority for traineeships for two groups of specialized health personnel in which great shortages now exist. These are:

1. Professional nurses trained for teaching or for performance of administrative and supervisory functions.
2. Professional public-health personnel, including public-health physicians, public-health nurses, and sanitary engineers.

Like the existing authority for training in research activities, these new traineeships could be established either in Public Health Service facilities or in educational institutions. The traineeships could also be financed by grants made available to public and other nonprofit institutions. The money value of the individual traineeships would be established by the Surgeon General and would include a stipend and allowances for such expenses as travel and subsistence.

The shortage of trained professional public-health personnel is one of the most serious problems in the development and expansion of public-health services today. The addition of health programs in new fields, the realinement of existing programs, the strengthening of local health services, all could move forward more rapidly and efficiently with a more adequate supply of trained public-health workers.

There is likewise a serious shortage of professional nurses trained to teach or to supervise or administer the wide variety of nursing activities. Lack of such trained personnel has been a serious handicap to highest quality and most economical nursing services in hospitals and health agencies throughout the country.

PUBLIC HEALTH SERVICES

Title V of the bill includes amendments to title III of the Public Health Service Act which would strengthen the protection and promotion of public health through improvement in the grants-in-aid to States and through special project grants addressed to specific public-health problems.

Grants to States for public-health services

The first major provision for Federal grants-in-aid to States for public-health services was enacted in 1935 as title VI of the Social Security Act. To this original authorization for assisting in the establishment and maintenance of adequate public-health services there have been added in subsequent years authorizations for several specialized grants. At the present time the Public Health Service administers such specialized grants to States for venereal-disease control, tuberculosis control, mental-health services, cancer control, and heart-disease control in addition to a grant for general-health services.

The impact of this Federal financial assistance on the protection and promotion of public health has been significant both through expenditure of the federally granted funds and through the stimulation which these grants have given to the appropriation of additional funds by State and local units of Government. The results of this cooperative Federal-State-local attention to the public-health problems of the United States are too numerous to mention in detail. They include, however, an increase in the number and quality of local health units, vigorous casefinding and control programs which have reduced the death rate from tuberculosis and the incidence of venereal disease, and other communicable diseases, establishment of clinics for early diagnosis of cancer and heart diseases, and public and professional health education services.

Great as the progress has been to date in improving the public health, the opportunities for future improvement are even greater. Not only are there large gaps in public-health services in terms of present scientific knowledge but our vast research effort is continuously adding to that store of knowledge.

One section of the draft bill is directed, therefore, at continuing and strengthening the legislative framework within which the Public Health Service provides the Federal financial assistance to the Federal-State-local public-health program.

Section 314 of the Public Health Service Act would be amended to authorize a single consolidated public-health grant to States in place of the present separate grants for venereal-disease control, tuberculosis control, general public health, cancer control, and heart-disease control. The grant for mental health would continue as a separate grant for 5 more years.

The new consolidated grant would be allotted among the States on the basis of the population, financial need, and extent of the health problems of the various States. On the basis of State plans submitted for approval by the Surgeon General, States would be entitled to receive a percentage of the cost of their public-health services. These Federal shares would vary in inverse proportion to the State's per capita income within the range of 33⅓ to 66⅔ percent.

In order to encourage the extension and improvement of public-health services, the Surgeon General would be authorized to provide that a portion (not to exceed 20 percent) of a State's allotment may be used by the State only for extending and improving its services. States would be entitled to receive 75 percent Federal participation in the costs of such activities for the first 2 years and 50 percent participation for the third and fourth years of such projects.

This proposal will provide greater flexibility in the use of the grant funds by the States, encourage improvement and extension of public-health services to the people, ensure matching from State and local appropriations in accordance with the financial ability of the States, and provide for continuation of the Federal-State-local partnership in the improvement of health protection.

Grants for special projects

Certain types of public health problems of special national concern do not lend themselves readily to solution through a type of grant-in-aid which requires distribution among all States. It is to assist in the effective and economical solution of such problems that the draft bill provides for special project grant authority.

This authority would enable assistance to be directed toward both operational and research activities which hold promise of making a significant contribution to regional or national public-health programs. This is the type of "pinpointed" assistance which will ensure progress in solving some of the more difficult problems through concentration of funds in selected areas on a pilot-plant basis.

MENTAL HEALTH

Title VI of the draft bill would authorize separate grants for mental public health for a 5-year period, in addition to the general public-health grants proposed under title V of the bill.

Mental illness is a major problem in the United States. One measure of its magnitude is that 47 percent of all the hospital beds in this country are occupied by mentally ill patients.

The Congress recognized the national importance of this problem by enacting the National Mental Health Act in 1946. In administering the provisions of that act, the Public Health Service has stimulated and conducted research, provided professional training opportunities through fellowships and traineeships, stimulated the development of community preventive programs through grants to States, and in other ways given leadership to improved services.

Title VI of the draft bill singles out for increased attention and priority two elements of the national program which hold great promise for reducing the magnitude of the mental-health problem. It is proposed to continue and extend for 5 more years separate authority for a specialized grant-in-aid to States for community mental-health services. Matching provisions and other administrative arrangements for mental-health grants would be modified slightly to conform to the draft provisions relating to grants to States for public-health services.

The Public Health Service Act would also be amended by this title of the bill to authorize special project grants for the development of improved methods of care, treatment, and rehabilitation of the mentally ill. The grants could be made to State agencies responsible for administration of State institutions for care and treatment of mentally ill persons, or to appropriate agencies for study of alternative or complementary methods of care and treatment. Because the nature of these special project grants does not permit any predetermined State-by-State distribution of grant funds, there is no allotment formula prescribed in the bill. These grants would be made only upon recommendation of the National Advisory Mental Health Council.

The cost of the amendments to the Public Service Act proposed to be made by titles V and VI of the draft bill will vary with the annual appropriation determinations made by the Congress. No provision of the draft bill would make

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mandatory any given level of appropriation. The magnitude of the problems which the bill is designed to alleviate, the reductions in illness, disability, and premature death which would result, and the economic losses which would be curtailed thereby need be weighed, however, against the expenditures which might be contemplated annually under the provisions of the bill.

These six titles of the draft bill sent to you herewith make up the main body of the Department's recommendations to give effect to the administration's health program. We shall appreciate it if you will be good enough to refer the draft bill to the appropriate committee for consideration.

The Bureau of the Budget advises that enactment of this proposed legislation would be in accord with the program of the President.

Sincerely yours,

OVETA CULP HOBBY, *Secretary.*

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, March 30, 1955.

Hon. LISTER HILL,
Chairman, Committee on Labor and Public Welfare,
United States Senate.

DEAR MR. CHAIRMAN: This letter is in response to your request of January 27, 1955, for a report on S. 724, a bill to establish a Commission on Mental Health, and to provide for a study of the problems of mental illness and for the development of a national mental-health program; and your request of March 1, 1955, for a report on Senate Joint Resolution 46, "providing for an objective, thorough, and nationwide analysis and reevaluation of the human and economic problems of mental illness, and for other purposes."

These two related legislative proposals have basically similar objectives. Their differences lie primarily in the means by which these objectives are to be attained.

S. 724 would provide for a President's Commission on Mental Health to conduct a thorough inquiry into the problem of mental illness, and to develop recommendations for "a comprehensive national mental-health program." Although the bill authorizes Federal appropriations for the work of the Commission, it also authorizes the Commission to accept supplemental funds from non-Federal sources.

Senate Joint Resolution 46 would authorize Federal participation in the conduct of a comprehensive mental health survey by means of a grant or grants to nongovernmental groups or agencies. Such grants would be made by the Surgeon General of the Public Health Service, upon recommendation by the National Advisory Mental Health Council. Although the "whereas" clauses of the resolution clearly contemplate use of the findings of the survey in the development of mental-health plans and programs, its operative provisions assign no specific program planning functions to the Surgeon General or to any nongovernmental grantee. Supplementation of Federal grant funds by funds from private sources is specifically authorized.

This Department is in accord with the objective of initiating a thoroughgoing "base-line" inquiry into all aspects of the national mental health problem. The extent of the current problem and the cost of administering preventive and treatment programs clearly indicate the need for a reappraisal of the problem and of present approaches to its solution.

We are also in agreement with two other premises underlying these related proposals: (1) that the interest of the Federal Government in problems of mental health justifies Federal participation in the cost of a fundamental survey and (2) that participation in the conduct and financing of such a study should be shared as widely as possible among the various groups, public and voluntary, in the field of mental health. Such a sharing of participation and support is essential, not only to assure coordination of the various interests and competencies, but also to lay the foundation for acceptance and utilization of the findings resulting from the study.

In view of the importance of such concurrence by the various interested organizations, your committee will undoubtedly wish to obtain a direct expression of their views on these similar proposals. From the standpoint of this Department, however, either the Presidental commission approach or the Federal grant device would be an acceptable method of providing Federal assistance.

One of the principal values of such a study is that it would provide a basis for the planning of better metal-health programs—both public and voluntary—and more effective enlightenment of the public as to the nature and extent of

mental illness and the need for progressive programs of prevention and treatment. We have two reservations, however, regarding the program-planning and public-education provisions of S. 724.

First, section 2 (b) of the bill authorizes and directs the Commission to recommend "a comprehensive national mental-health program, including * * * recommendations as to methods of financing the costs of such a program and the proper role of the local, State, and Federal Governments, and of nongovernment organizations and facilities in such a national program." Although we would not wish to preclude the Commission from submitting such recommendations as its findings may indicate, we doubt the wisdom of assigning responsibility for the development of such broad recommendations to an expert commission composed primarily of persons from the medical and related professions.

Second, we question the desirability of the "follow-through" functions prescribed for the Commission in section 3 of the bill. Although the extension of the term of the Commission for a brief period beyond the completion of its basic study and report might be warranted, we believe that a 10-year term is unnecessarily long and that some of the functions specified in section 3 might lead to the duplication of functions and responsibilities of other Federal agencies.

If the grant-in-aid approach is preferred, there may be some question as to the need for additional statutory authorization for such a grant. A specific authorization would not appear inappropriate, however, in view of the scope of study contemplated and the specific reporting obligations of the grantee. As presently worded, the provisions of the proposed new section 304 (a) of the Public Health Service Act are ambiguous and should be clarified. They would authorize a grant or grants to "such nongovernmental agencies * * * as may agree to undertake and conduct research into and study of all aspects of our resources, methods, and practices * * *." It is not clear from this language whether (*a*) the Surgeon General would be responsible for seeing that all aspects of the problem are covered by one or more grantees or (*b*) the prospective grantees would be required, as a grant condition, to develop among themselves a plan of coordinating study covering the entire problem. The latter construction would be preferable, in our opinion. If this is the construction intended, it could be indicated by amending lines 16 and 17 on page 5 of the resolution to read as follows: "* * * the field of mental health, as may agree among themselves to undertake and conduct a coordinated program of research into and study of all aspects of our resources, * * *."

In summary, we favor Federal participation in the cost of a basic study of the mental-health problem facing the Nation, and we believe that, subject to the reservations and amendments indicated above, either S. 724 or Senate Joint Resolution 46 would provide an acceptable means of achieving the desired objective.

The Bureau of the Budget advises that it perceives no objection to the submission of this report to your committee.

Sincerely yours,

OVETA CULP HOBBY,
Secretary.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, March 30, 1955.

Hon. LISTER HILL,
Chairman, Committee on Labor and Public Welfare,
United States Senate.

DEAR MR. CHAIRMAN: This letter is in response to your request of February 2, 1955, for a report on S. 848, a bill to amend the Public Health Service Act, as amended.

The bill would amend the Public Health Service Act to authorize the Surgeon General (1) to conduct studies and collect data on the incidence and significance of mental illness; (2) to assist in the coordination of public and private mental-health programs and activities; and (3) to collect and disseminate technical information and to provide technical assistance to public and other nonprofit organizations. The bill would also require, for the next 5 years, that grants to States for public mental-health services be separately appropriated. Finally, it would authorize for the next 5 years special project grants for mental-health purposes.

The amendments to section 303 of the Public Health Service Act proposed in section 3 of the bill would not add materially to the present authority of the

Surgeon General. Rather, they would amplify existing general authority through the addition of specific authorizations. Although this amplification is not essential from a statutory standpoint, we would have no objection to the proposed amendments if the Congress should wish in this manner to emphasize the importance of these aspects of the total mental-health program of the Public Health Service.

We are in complete accord with the objectives of section 4 of the bill, namely, to assure the continuation of categorical grants to States for mental-health services for a 5-year period. We believe, however, that this objective would more appropriately be included as part of a more general revision of the State grant provisions of the Public Health Service Act. We therefore prefer the related proposal contained in title VI of S. 886, which is also under consideration by your committee.

The special project grant authority proposed in section 5 of S. 848 is also similar to provisions contained in titles V and VI of S. 886, which this Department endorses. The principal difference is that the special project grant authorization proposed by S. 848, including grants for services as well as grants for demonstrations and experimental projects, would be subject to a 5-year limitation, while the comparable limitation in title VI of S. 886 would apply only to studies and demonstrations relating to improved methods of institutional care. We believe the provisions of S. 886 are preferable.

In summary, although we are in general accord with the objectives and provisions of S. 848, we believe that the mental health provisions of S. 886 offer a better means of achieving these objectives.

The Bureau of the Budget advises that it perceives no objection to the submission of this report to your committee.

Sincerely yours,

OVETA CULP HOBBY, *Secretary.*

EXECUTIVE OFFICE OF THE PRESIDENT,
BUREAU OF THE BUDGET,
Washington, D. C., March 29, 1955.

Hon. LISTER HILL,
Chairman, Committee on Labor and Public Welfare,
United States Senate, Washington, D. C.

MY DEAR MR. CHAIRMAN: This is in response to your letter of January 27, 1955, requesting the views of the Bureau of the Budget with respect to S. 724, a bill to establish a Commission on Mental Health, and to provide for a study of the problems of mental illness and for the development of a national mental-health program, and your letter of March 1, 1955, requesting our views on Senate Joint Resolution 46, a joint resolution providing for an objective, thorough, and nationwide analysis and revaluation of the human and economic problems of mental illness, and for other purposes.

The basic purpose of both proposals is to initiate a comprehensive study of the overall nationwide problem of mental health and to provide a reappraisal of our present approach in dealing with that problem.

The principal differences in the two measures are the means by which the objectives would be attained.

S. 724 would provide for the establishment of a President's commission to conduct the study and develop recommendations for a comprehensive mental-health program. After making its recommendations, within 30 months after enactment of the legislation, the Commission would have a continuing responsibility of reviewing the program and would have the direct responsibility for developing, coordinating, and initiating educational programs in mental hygiene and for the development of demonstration projects. The bill would authorize the appropriation of $1 million for the first year, $1,500,000 the second year, and such sums as may be determined thereafter.

Senate Joint Resolution 46 would amend the Public Health Service Act to authorize Federal participation in a comprehensive study of the mental-health problem by means of grants to such qualified nongovernmental groups as may agree to undertake such a study. The authorization for the grants stipulate that the research and study must be completed within 3 years from the time they are inaugurated and that annual reports must be presented. The resolution authorizes an initial appropriation of $250,000 and $500,000 for each of the 2 succeeding years.

This Bureau concurs in the views of the Department of Health, Education, and Welfare that participation by the Federal Government in a complete and thorough study of mental-health problems would undoubtedly be of value. While we believe that the present authority of the Public Health Service is sufficiently broad to encompass such a study, we recognize that an expression of congressional intent in the form of legislation may be desirable. However, legislation providing for the study should clearly avoid the establishment of functions which may duplicate those of the Public Health Service. The provisions of S. 724 which would set a 10-year term for the Commission and which grant it certain operating responsibilities after its study is completed may create such problems of duplication.

Accordingly, should the Congress determine that legislation authorizing a comprehensive mental-health study is desirable the Bureau of the Budget would prefer Senate Joint Resolution 46. If, however, a special commission is to be established, we would recommend that it be established for a short term and have no operating responsibilities.

Sincerely yours,

PERCIVAL F. BRUNDAGE,
Acting Director.

EXECUTIVE OFFICE OF THE PRESIDENT,
BUREAU OF THE BUDGET,
Washington 25, D. C., March 29, 1955.

Hon. LISTER HILL,
Chairman, Committee on Labor and Public Welfare,
United States Senate, Washington 25, D. C.

MY DEAR MR. CHAIRMAN: This is in response to your letter of February 2, 1955, requesting the views of the Bureau of the Budget on S. 848, a bill to amend the Public Health Service Act, as amended.

This proposed legislation would amend the Public Health Service Act to authorize the Surgeon General to conduct surveys and studies in the field of mental illness, to assist in the coordination of public and private mental-health activities, and to provide technical assistance and information to public and other nonprofit organizations. The bill further provides for the separate appropriation of grants to States for mental-health services for the next 5 years. In addition, section 5 of the proposal would authorize special project grants for mental-health purposes for a 5-year period.

In its report on this bill the Department of Health, Education, and Welfare points out that the provisions of section 3, while amplifying the existing authority of the Public Health Service in the mental health field, would not add materially to such authority.

It is also noted that the proposed legislation provides for a 5-year program of categorical grants to States for mental-health services and special grants for mental-health projects similar to the grant program proposed in title VI of S. 886. Although the Bureau of the Budget is in agreement with the general objectives of these grant provisions it is believed that any revision of mental-health-grant authority should be considered in the context of the general revision of public-health grants as proposed in S. 886.

Accordingly the Bureau of the Budget recommends enactment of the omnibus health bill, S. 886, in preference to S. 848.

Sincerely yours,

PERCIVAL F. BRUNDAGE,
Acting Director.

Chairman HILL. Now, our first witness this morning is Dr. David B. Allman, member of the board of trustees and chairman of the committee on legislation of the American Medical Association.

Dr. Allman has come from Atlantic City to be with us. We are delighted to have you with us. Will you come around, Doctor?

Senator PURTELL. Before the doctor testifies I wonder if we might have put in the record a study by the Library of Congress, which I requested, on past and present misconceptions about mental illness.

I think it would add much to the record that we have.

Chairman HILL. Without objection this study will appear in the record as though read.

(The matter referred to is as follows:)

PAST AND PRESENT MISCONCEPTIONS ABOUT MENTAL ILLNESS

In tracing the historical origins of public attitudes toward mental illness, we are able to see more clearly the prejudices and misconceptions inherited from an earlier day. This is an important step toward the more extensive measures which must be taken if we are to attain the high degree of mental health which modern life demands.

No chapter in the history of man's inhumanity to man is darker than that concerned with the treatment of those suffering from mental illness. Long regarded with superstitious fear, the insane were treated with a combination of cruel flogging and social avoidance. In an attempt to explain the incomprehensible, primitive man built up a well-organized belief in a spirit world. Modern manifestations of this phenomenon are still evident in some of the primitive tribes of the world. When in the course of events, man became mentally ill, he was considered "possessed" by a spirit—usually an evil spirit.

The growth of religion did not dissipate the widespread belief in demons and magic. Indeed a close connection developed between the spiritual world and the magical world. The Bible relates many instances of demoniacal possession. Most familiar, perhaps, is the New Testament account of Jesus casting out the devils from two possessed men and causing the evil spirits to enter a herd of swine, which forthwith plunged headlong over a cliff to their destruction. The first record of music being used as a therapeutic agent is recorded in the Old Testament. King Saul, suffering from a melancholia ascribed to an "evil spirit" sent down by God to trouble him, is cured by the harpplaying of David.

Early Greek and Egyptian writings contain numerous references to the notion of demoniacal possession as the explanation of mental illness. Fragmentary medical writings handed down from the Egyptians contain elaborate invocations and other measures for driving out demons, as well as pharmaceutical prescriptions for the use of opium and olive oil. The Greeks expressed their belief in demons in the saying: "Whom the gods would destroy they first make mad."

Not always, however, did insanity indicate the ill will of a god. In some cases, where mental illness was characterized by certain forms of religious delusions, the afflicted one was looked upon as being favored by the gods, and in communication with them, and consequently was revered as a holy man or prophet. There is reason to believe that the famed oracles at Delphi may have been partly recruited from this category of the mentally ill.

Therapeutic techniques in mental illness were based on the prevailing theory of causes. Greece, like Egypt, had healing shrines presided over by priest-physicians. Ritual and incantation served at first as the only forms curative treatment, to which the pharmaceutic remedies were gradually added. If the unlucky patient did not respond within a short period to the priestly rites and incantations, he was cast out from the temple as one unworthy of cure, since the gods, in failing to expel the demon from his body, had signified their displeasure with him.

With the development of the Greek spirit of inquiry, individuals such as Hippocrates began to question the supernatural origin of mental disease. He, and a few of his enlightened colleagues, began prescribing programs of physical and mental therapy which included bathing and exercise, theatrics, music, and sea voyages. These pioneering methods, however, were a leisure-class therapy for that time since they were available only to a small, patrician portion of the population. Early Christian writers indicate that among the poorer classes of Greece and Rome, the mentally ill were often put to death in the absence of public provision for their care.

Despite the sound foundations of inquiry and practice which were laid down by the Greeks and Romans, the Middle Ages brought a return to magic. The physician once more surrendered his art to the priest; science was submerged by superstition, operating under the guise of religion. During this period, the natural therapy of Hippocrates and his colleagues was succeeded by a superstitious mixture of astrology, alchemy, and a retreat to magic rites and exorcism.

The belief in demoniacal possession in its old forms and some newer and more frightful ones, captured the imagination of the medieval mind to a degree seldom approached before. Amid elaborate ceremonies that outdid the ancients for impressiveness, the rites of exorcism were performed. Faith in the efficacy

of these exorcising rites was matched by a belief in the black magic of the devil. According to the prevailing superstition of the Middle Ages, a favorite device of the devil was to induce human beings to sell their soul to him in exchange for supernatural powers to be enjoyed over a number of years. Witches, who thus entered into league with Satan, could work all manner of black deeds. To seek out and eliminate witches became not only a social but a religious duty. Nor did the revival of learning bring an end to the belief in witches. Scholars like Erasmus, jurists like Blackstone and scientists like Kepler implicitly accepted the witch mania.

The records of witch trials that have come down to us offer convincing evidence that a large percentage of those accused and convicted of witchcraft were really insane. Many were burned in consequence of their suspiciously "queer" behavior, for which the dominant ideology of the time offered no natural explanation. Many who confessed voluntarily without the application of torture, revealed unmistakable signs of psychotic behavior. Often these unfortunate, deluded persons implicated other persons in satanic plots that existed only in their own deranged imaginations, and drew these persons to the stake with them. What percentage of the witch mania were mentally unsound is beyond calculation, but it has been estimated that perhaps one-third of those executed were mentally unbalanced.

Here and there men of science could be found groping through the fog of ignorance, fear, and superstition that enshrouded the phenomenon of mental disease. Among the earliest of these was Paracelsus, the wonder healer and alchemist of the Renaissance whose feats led to the Faust myth. He ridiculed the notion of demoniacal possession. "Mental diseases," he declared, "have nothing to do with evil spirits or devils; the individuals who are mentally sick merely drink more of the 'astral wine' than they can assimilate. The experienced doctor should not study how to exorcise the devil, but rather how to cure the insane * * * The insane and the sick are our brothers. Let us give them treatment to cure them, for nobody knows whom among our friends and relatives this misfortune may strike."

The citizens of Gheel, Belgium, took practical steps to treat the mentally ill with sympathy and understanding. During the Middle Ages, a great number of people suffering from various mental disorders traveled to Gheel to visit its healing shrine which had become famous for miraculous cures of mental illness. Two small rooms in the church were used to shelter the pilgrims. Eventually, when the church could no longer provide adequate accommodation, the citizens of Gheel opened their homes to the sick people. Today, the original program, with considerable modification, is still in operation. Almost a fifth of Gheel's present population of about 20,000 are patients living in private homes, enjoying the freedom of the community and receiving treatment and supervision from a nearby mental hospital.

The late 17th century witnessed a growing revolt, participated in by philosophers and physicians, against the superstitions of witchcraft and the cruel effects on the insane. In 1736 the laws against witchcraft were repealed in the United Kingdom, but local persecutions against the insane suspected of practicing witchcraft and sorcery continued intermittently for a long time thereafter.

The witchcraft mania spread to the newly settled American Colonies. It reached its apogee in the famous Salem trials in 1692. The common tendency of the time was to identify mental illness and unusual behavior with demoniacal possession. Even educated men like Cotton Mather subscribed to this dogma.

The care and treatment of the mentally ill in colonial times were thus conditioned by the dominant ideology that mental aberrations were the work of the devil. During the Salem trials and elsewhere, the mentally ill were hanged, imprisoned, tortured, and otherwise persecuted as the devil's agents. By a peculiar twist of logic, which has not been completely dispelled in our day, they were regarded as subhuman beings and chained in cages like wild beasts or thrown into jails like criminals. They were sometimes left to wander about naked, driven from place to place like mad dogs, or subjected to whippings as vagrants.

Not until the reform movements which accompanied the political and social revolutions in America and France did an element of humanitarianism enter into the treatment of the mentally ill. Hospitals began to accept mentally ill persons as patients rather than malefactors. During the first quarter of the 19th century, special institutions for the insane were established in eight dif-

ferent States for the first time. These States were Pennsylvania, New York, Massachusetts, Maryland, Kentucky, South Carolina, Ohio, and Connecticut. Of these, 6 were founded as semipublic institutions by incorporated groups, and 2 were completely under State auspices. A ninth State, Virginia, established its second State hospital during this period. The initiative of laymen was mainly responsible for the establishment of some, and the enterprise of medical men for others.

While these institutions represented great strides forward, they could accommodate only a small fraction of the total number of persons suffering from mental diseases throughout the country. The dependent insane remained almost entirely neglected, although nominal provision was made in all existing public and semipublic asylums. In practice, most poor law officials considered it more economical to confine the dependent insane in almshouses and jails rather than asylums, as they were called then. In some communities the dependent insane were disposed of by the custom of bidding them off on auction blocks to private individuals, sometimes bringing actual profit to towns and communities in exchange for their labor value.

One woman, Dorothea L. Dix, was perhaps more influential than anyone in bringing an end to the inhuman practice of treating mentally ill persons as criminals. Her reports in the 1840's and 1850's galvanized the Nation into constructive action and set in motion a trend toward State care of mentally ill. This was undoubtedly a milestone in the history of treatment for the mentally ill. But many abuses still remained. Ancient obstacles to progress were yet to be overcome. It was one thing to try to eradicate longstanding evils by decree; it was far more difficult to put an end to them in practice.

Some of these difficulties were dramatically revealed a half-century later in the writings of Clifford Beers. His experiences as a mental patient in various types of institutions for the mentally ill revealed little progress in treatment methods. He was beaten mercilessly, choked, spat upon, and reviled by uninformed attendants, imprisoned for long periods in dark, padded cells, and forced to suffer the agony of a strait-jacket for long periods of time.

A large measure of this treatment had its source in the prevailing ignorance concerning mental illness. In spite of a growing enlightenment in medical and psychiatric circles, the general public still held mental disease in great awe and dread. It was regarded less as an illness than as a family disgrace and as a punishment for some evil or sin committed by the victim. Largely for that reason, State and local authorities did little to improve the deplorable conditions in the 20th century where mental patients were treated as subhumans and were meted out harsh punishments by attendants.

In his book, A Mind That Found Itself, Clifford Beers outlined a program of mental hygiene that included not only improved institutional care of mental patients but also provisions for the prevention of this affliction. The first mental hygiene society—and indeed the whole mental hygiene movement—is a monument to his important contribution. Through the revelations of his experiences during the years of his own mental breakdown and subsequent suffering, he called attention to the importance of dealing with mental patients as human beings, and the need for sympathy, understanding and friendships in bringing about a reeducation on a mental and emotional basis. Thus, 500 years after Paracelsus, the plea for humane and sympathetic treatment of mental patients is reiterated.

Shortly after Clifford Beer's death in 1944, two publications appeared which shocked anew millions of Americans and alerted them to the deplorable and revolting conditions that prevailed in mental hospitals. One was a book written by a former patient. Entitled "The Snake Pit" it quickly became a best-seller, and was made into a movie. The other was an article written by a reporter for Life magazine who accumulated evidence proving that many of the public mental hospitals in the country were little better than the filthy jails and almshouses of colonial days. Newspapers, magazines, and books backed the exposures with demands for reform. Five years later, Life magazine reporters and photographers revisited many of the mental hospitals previously exposed and found that, in this short interval of time, remarkable reforms and progress had been made. This is a dramatic example of what an aroused and informed public can accomplish.

The Council of State Governments, established and supported by the States to serve governmental progress within the States, has been active for several years in reviewing and evaluating the mental-health programs of the 48 States. In 1950 the council published the results of a comprehensive study prepared

at the request of the Governors' Conference, of State programs for care and treatment of mental patients. Another survey published in 1952 deals with training and research in State mental-health programs. Together, these extensive studies furnished the basic information for use at the first Governors' Conference on Mental Health held in 1954. States have joined together in regional conferences to work out plans for accelerating mental-health research and training of mental-health personnel. Both the Federal and State Governments have appropriated funds specifically earmarked for research and training.

As exemplary as these actions are, we cannot restrict our efforts to the mental-health programs devised by the Federal and State Governments. We must rely, as always, on the imagination and intelligence of the men and women at the local community level. First and foremost, we must provide these people with the means for distinguishing between fact and fancy with regard to mental illness. While progress has been made in informing the American people as to the nature and scope of the mental-disease problem, by and large we still tend to regard psychiatric illness as something to be ashamed of and largely because of this fact most of us still have no inkling of how grave the threat is.

Dr. Felix, director of the National Mental Health Institute, summed it up this way before a congressional group in August 1954:

"Have any of you ever heard of a person get up in public and say, 'I had a nervous breakdown,' or 'I had a mental illness. I have recovered'? I just pose that question, gentlemen. Is not this a terrible situation. We hide this thing and cover it up. We alibi for it and bury our heads in the sand, gentlemen, and this is the greatest problem, the most expensive health problem we have in this country."

What are some of the modern myths about mental illness? One of the most prevalent has its basis in the social stigma to which Dr. Felix referred. Many employers, for example, have a tendency to believe that any person who has had a mental illness—unlike a physical ailment—is permanently unreliable. Government workers have lost their jobs when it was discovered they were undergoing psychiatric treatment. Executive Order 10450 provides that any illness, including any mental condition, may be cause for dismissal. And yet psychiatrists tell us that many forms of mental illness do not seriously interfere with the performance of the daily job. Further, our diagnostic procedures for identifying mental illness, which are currently more advanced than our knowledge of treatment, enable psychiatrists to identify varying degrees of mental incapacity. This distinction is seldom made by employers.

These out-of-date notions affect many areas of legislation. For example, in many States an epileptic cannot get a license to drive a car and in some instances cannot even get married. Our immigration laws forbid admission of an epileptic. Yet epilepsy is 80 percent curable today.

Another popular misconception holds that all mental patients are violent. In 1953 a study sponsored by the New York State Mental Health Council disclosed that discharged mental patients commit proportionately less acts of violence than members of the general community who have never received psychiatric attention.

This study was initiated as a result of the sensational Bayard Peakes case in 1952. On the morning of July 15, 1952, Peakes walked into the American Physical Society at Columbia University and shot the young secretary at the desk, who was a stranger to him. Americans everywhere were shocked at the brutal slaying, and indignant when it was learned that Peakes had repeatedly been found mentally ill by United States Army and Veterans' Administration doctors. It was another in a long series of crazed killings that, many think, an alert society should be able to prevent. Nevertheless, it would be a mistake to think that every discharged mental patient is a violent killer, or that all mental patients should be kept off the streets.

More reasonable measures to prevent occurrences such as the Peakes case would include not only provision of adequate hospital facilities and personnel for proper treatment and screening of mental patients, but also mental hygiene clinical services in communities for the detection of potentially violent cases long before they erupt. Daily the newspapers carry accounts of acts of violence which might have been avoided through early clinical attention. The recent case of the successful young doctor in Oklahoma who killed his wife and three young children and then set fire to his home is an example. The controversial case of Dr. Sheppard leaves room for speculation as to what might have been accomplished had he received mental health clinical services earlier. As late as 1950, however, the ratio of mental health clinics to population for the country as a whole was below 1 to 100,000.

Another current misconception and one of the greatest hindrances to progress in the treatment of mental illness is the persistent and unfounded belief that it is dangerous and incurable, and that the best thing to do is isolate the patient from society. This attitude flies in the face of all that we have learned about mental illness in the last 100 years. It ignores the recent achievements of foster home care with certain mental patients.

As we know the practice, foster family care for the mentally ill is a method of caring for certain types of mental patients in the homes of selected families other than the patient's own. It is not a new practice. The citizens of Gheel, Belgium, developed a program of foster family care centuries ago. But it has been adopted in only a few States in this country.

There are many other misconceptions about mental illness, which are not so prevelant, but which nevertheless exist among certain groups in the population. Strangely enough, recent studies have shown that some people still attribute mental illness and juvenile delinquency to demon possession. Others erroneously believe that the use of certain drugs during the prenatal and postnatal care of the child causes mental illness.

We have come a long way from superstition to science in our attitudes toward mental health. Notwithstanding the progress we have made there is still much to be done to promote the public understanding which is the foundation for more extensive mental-health measures in this country.

Chairman HILL. Doctor, will you proceed in your own way, please?

STATEMENT OF DR. DAVID B. ALLMAN, OF THE AMERICAN MEDICAL ASSOCIATION

Dr. ALLMAN. Mr. Chairman and members of the committee, I am Dr. David B. Allman, of Atlantic City, N. J., and I am accompanied by Dr. Leo H. Bartemeier, of Baltimore, Md. At the conclusion of my brief statement I would like permission to ask Dr. Bartemeier, who is chairman of our council on mental health, to discuss the specific legislative proposals under consideration by your committee and the views of our association on these bills. We appear here today on behalf of the AMA and in support of title VI of S. 886 and Senate Joint Resolution 46. Because of our support of Senate Joint Resolution 46 as the preferable alternative measure, we have taken no position on S. 724 but have approved in principle S. 848.

In my capacity as a member of the board of trustees and chairman of the committee on legislation of the American Medical Association, I have been asked to give you gentlemen a short résumé of the history of our association's interest in mental health and some very brief comments relative to our more important current activities.

Although the American Medical Association has been interested since its inception in a general way in mental-health problems, a special committee in this field was first appointed by the board of trustees in 1930. This committee was continued for several years and although a permanent committee was not formed at that time, several recommendations made by the temporary committee were referred to other bureaus and councils of the association for action.

As the tremendous extent of the problem became more apparent and, with the growing recognition of the need for closer liaison between psychiatry and general medicine, it became evident that a special committee devoting its entire efforts to mental health was necessary. As a consequence, in June 1951, a committee on nervous and mental diseases was created by the AMA board of trustees, which on January 1, of this year, became known as the council on mental health.

During the first year of activity, the committee outlined the areas in the field of mental health in which the members felt they should take an active, though not exclusive interest. The areas outlined are as follows:

(1) A study of the influences of psychiatry in medical education in both undergraduate and postgraduate fields.

(2) The consideration of the responsibilities and training of adjunct personnel, such as the clinical psychologists and psychiatric social workers, in the total approach to mental health.

(3) The need for establishment of psychiatric units in general hospitals.

(4) The amendment of laws relating to commitment of the mentally ill.

(5) The need for laws regulating specific groups, such as sex offenders and criminals.

(6) The development of mental-health clinics.

(7) Public education in mental health through the general media, such as radio, television, magazines, and newspapers.

(8) The establishment of cooperative relationships with other national groups in the field of mental health.

(9) The development of a firmly coordinated relationship and cooperative planning between the AMA committee and the committees on mental health of the State medical associations and the county medical societies.

A national conference on mental health was sponsored jointly by the council on mental health of the AMA and the American Psychiatric Association in October 1953. Representatives of 50 mental-health organizations attended this meeting to develop a set of objectives and plans for cooperative work in the mental-health field. This interprofessional meeting is being scheduled on a biannual basis. A meeting with chairmen of mental-health committees of State medical associations was held in September 1954, to stimulate organization of effective mental-health programs at the State and county society levels. This meeting will also be held annually. Another conference, cosponsored by our council on mental health and our council on physical medicine and rehabilitation, was held in May 1954, to establish principles for integrating psychiatry and physical medicine in rehabilitation programs.

During the past year a subcommittee on alcoholism of the council has developed an 18-point program for work in the field of alcoholism at State medical association and county medical society levels. The creation of a subcommittee on narcotic addiction is planned for 1955.

The committee has also established liaison with all other organized groups working in the fields of psychiatry and mental health. In this way our association is offering the assistance, support and advice of its entire membership in the solution of mental-health problems.

Most recently, in January of this year, our council on mental health and the executive committee of the American Psychiatric Association met to consider the establishment of a Joint Commission on Mental Illness and Health. It was concluded that such a commission should be formed with two basic objectives:

First, to make a national survey of all aspects of the present status of resources and methods of diagnosing, treating and caring for the mentally ill and retarded, both within and outside of institutions; and

Second, to formulate, on the basis of this survey, a feasible program for the fundamental improvement of our methods and facilities for the diagnosing, treatment and care of the mentally ill and retarded.

This project was considered and approved by the board of trustees of the AMA at its meeting in Chicago on February 5 of this year. The similarity of the objectives of the proposed joint commission and Senate Joint Resolution 46, 84th Congress, is apparent. I am sure that Dr. Bartemeier will be able to enlarge on the views of the association in this regard, should the members of the committee desire additional information.

In conclusion, I wish to emphasize that the American Medical Association is keenly aware of the seriousness of the mental-health problems which exist today and is vitally interested in doing everything within its power to insure that the medical profession makes its maximum contribution in their solution.

I should now like to ask Dr. Bartemeier to outline for the committee the views of the association on the proposals under consideration. Following his comments, we will both be happy to attempt to answer any questions members of the committee may have.

Chairman HILL. Thank you, Doctor. Dr. Bartemeier, I have here a brief analysis of your great experience in this matter in mental health. I believe you are a past member of the National Advisory Mental Health Council; is that correct?

Dr. BARTEMEIER. Yes, sir.

Chairman HILL. This is a council set up by law to advise the Surgeon General of the Public Health Service and the National Institute of Mental Health on matters affecting the Public Health Service in mental health. This council reviews applications made to the National Institute of Health for funds and research and training in mental health and makes recommendations to the Surgeon General as to whether or not such grants should be approved. Is that correct?

Dr. BARTEMEIER. That is correct.

Chairman HILL. You are also past president of the American Psychiatric Association and past president of the Psycho-Analytic Association and past president of the International Psychiatric Association.

You are also a member of the Board of Directors of the World Federation for Mental Health and a former professor of psychiatry at Wayne University.

I believe you are presently clinical associate professor of psychiatry, Georgetown University Medical School and a member of the National Manpower Council.

I would be delighted, Doctor, to have you proceed in your own way.

STATEMENT OF DR. LEO H. BARTEMEIER, CHAIRMAN OF THE COUNCIL ON MENTAL HEALTH, AMERICAN MEDICAL ASSOCIATION

Dr. BARTEMEIER. Mr. Chairman and members of the committee, my name is Leo H. Bartemeier. I am medical director of the Seton Institute in Baltimore, Md., and chairman of the council on medical health of the American Medical Association. I am appearing here

today on behalf of that association to support title VI of S. 886 and Senate Joint Resolution 46, and, in principle, S. 848.

I do not believe it will be necessary for me to provide detailed statistics concerning the present status of the problem of mental health and illness in the United States. Over the past 5 or 6 years testimony has been presented to Congress concerning the extent of this problem as it affects the United States, and there has been a growing recognition both in Government and nongovernmental scientific circles of the graveness of the problem and the increasingly urgent need to bring to bear much more effective methods for combating it than we now have.

It bears repeating, however, there are about 9 million people in the United States suffering from some form of mental or emotional illness. About 8 percent of the men examined for service during World War II were rejected for neuropsychiatric reasons which amounted to a total manpower loss that would correspond to about 177 Army infantry divisions. The present actual cost of care for the mentally ill is about $1 billion yearly, and we can estimate an additional $5 billion in economic loss. More than 50 percent of all hospital beds in the country are occupied by patients with mental illness. Mental hospitals are overcrowded and are becoming increasingly more so. There is also a shortage of qualified medical and technical personnel. Even with all that has been done in past years to improve this situation, care for most mental patients, is still of a simple custodial nature.

It is evident then that what we are dealing with in this field is in the nature of the greatest epidemic or plague that this country has suffered in its history.

It is our understanding that title VI would amend the present Public Health Service Act to authorize a 5-year program of grants to States for mental-health services and to authorize a new 5-year program of special-project grants for the development of improved methods of care, treatment, and rehabilitation of the mentally ill.

This title provides for the temporary expansion of the activities of the National Institute of Mental Health in the field of training, in the development of improved methods of treatment and rehabilitation of the mentally ill, and in the provision of traineeships in mental health. The American Medical Association supports increased funds for the extension of these activities. We feel that the limited funds previously expended have been properly handled and have resulted in definite improvement of mental health work in the fields of training, treatment, and rehabilitation. We emphasize, however, that our support is limited to a temporary Federal program in this area, since it is our sincere conviction that the entire question of defining local and Federal responsibilities in the public health field should be carefully analyzed by the Congress.

With respect to the clause relating to direct grants to individual States for increasing community services, I can say that there is an urgent temporary need for grants of this nature for development work in finding newer and better solutions to the handling of hospitalized mental patients. During the past few years certain new approaches for the handling of the mentally ill have developed spotily in this and in other countries. These new approaches now show some promise of more effective methods of cutting down the length of hospital stay,

and greatly decreasing the percentage and necessity for rehospitalization after discharge. Among these approaches are development of programs of "total-push" treatment in mental hospitals, the use of posthospitalization rehabilitation clinics, the development of halfway houses and day care houses, the development of foster home care, new plans for care for the aged and senile many of whom do not require hospitalization in a mental institution, and the development of community services for the families of mentally ill patients in order to prepare them properly for the return of patients to the family circle. This last greatly reduces the kinds of family problems that create the tensions that again break down the patient requiring his readmission to the hospital.

Although there are many types of new approaches to the treatment of the mentally ill now being tried, the actual numbers of such projects are small. It is hoped, therefore, that with the additional funds requested under this act that all the States will be enabled to set up these and other new experimental treatment approaches so that as the evidence comes in from many sources, we will be better able to evaluate their usefulness.

Senate Joint Resolution 46 would promote an intensive survey in the field of mental health by authorizing the Surgeon General, over a 3-year period, and upon the recommendation of the National Institute of Mental Health to make grants to private nongovernmental agencies, best qualified by virtue of their training and experience. These grants would be used to assist in financing a thorough, professional, and impartial study of all aspects of the mental-health problem, including methods and practices in diagnosing, treating, and rehabilitating the mentally ill. We approve wholeheartedly of this bill.

Mental illness is intrinsically a medical problem. Psychiatry is the medical specialty concerned with illness that has chiefly mental symptoms. The psychiatrist is also concerned with mental causes of physical illness for we recognize that physical symptoms may have mental causes just as mental symptoms may have physical causes.

For several years we in the profession of psychiatry have been aware of the critical need for a survey and evaluation of our facilities and programs for the diagnosis, treatment, and care of the mentally ill and retarded. While the problems of mental illness appear to grow in almost geometric proportion, we find ourselves without a comprehensive, up-to-date, integrated body of knowledge in spite of the fact that many worthwhile surveys and studies in this field have been made. It is only with such complete knowledge that our present and future direction and programs can be properly planned. It is for the purpose of obtaining this knowledge that the American Medical Association is cosponsoring with the American Psychiatric Association the Joint Commission on Mental Illness and Health, which was mentioned by Dr. Allman in his testimony.

Underlying the proposal is the thought that out of such a project might evolve some fundamental departures from our traditional concepts and methods of dealing with mental illness and that it might lead to a far more effective attack on the problem than has thus far been devised. We believe that Senate Joint Resolution 46 provides the mechanism for accomplishing this purpose.

In solving health problems, stress is too often placed on the provision of physical facilities for diagnosis and treatment. We lose

sight of the fact that hospital buildings do not cure patients. The successful management of illness, whether physical or mental, comes only from the application of the art and science of medicine by a physician skilled in modern methods.

Particularly in the field of mental illness, we have mistakenly sought solutions to our problems by the construction and maintenance, at tremendous public cost, of institutions for custodial care of the mentally ill. We have good reason to question, fundamentally, the concept of a mental hospital as the primary tool for treating the mentally ill.

Within comparatively recent times the older concepts of treatment for physical illness have fallen to the assault of intensified medical research, and the wide application of new and healing techniques to diseases long thought to be incurable has been substituted. Smallpox, typhoid fever, yellow fever, malaria, all dreaded killers in their time have fallen. Tuberculosis, pneumonia, diabetes, and infectious diseases of childhood are no longer great threats. New hope exists for success in the fight against poliomyelitis, cancer, and heart disease.

Mental illness can succumb to the same attack. Patchwork, stopgap programs for the care of the mentally ill are keeping us on a treadmill and actually doing little to reduce and prevent mental illness. Where the same principles which have largely conquered so many dread physical diseases are applied to the study of mental illness, the results are heartening.

Patients in mental hospitals in the South with pellagra are practically eliminated as a result of the discovery that niacin prevents and cures pellagra. Recent studies indicate that niacin therapy is helpful in the treatment of aged mental patients, particularly those with illnesses due to hardening of the arteries of the brain. The number of patients with paresis due to syphilis has been cut due to the medical research discovery of penicillin as a treatment and cure for syphilis. Electric shock therapy has helped many patients suffering from certain types of schizophrenia and involutional melancholia. Recent improvements in electric shock therapy, coupled with the use of drugs, has made this treatment effective in cases where it was previously impossible.

Cretinism, which is a type of dwarfism and imbecility developing during fetal life or early infancy as a result of thyroid deficiency, can now be successfully treated with thyroid if recognized early enough. Recent investigations indicate the usefulness of cortisone and thyroid therapy in chronic or acute psychoses not otherwise responsive to treatment. Neurological research has produced the electroencephalograph and demonstrated the essential nature of epilepsy as a disorder of the energy and economy of brain cells, a disorder controllable by chemical means such as the drugs tridione and artane. The result is that 80 percent of the epileptics treated can now lead normal lives. New and more refined operations on the brain have been developed or improved in the field of psychosurgery. National Mental Health Institute scientists have developed new techniques which for the first time permit the measurement and analysis of blood flowing through the living, thinking brain. Using these techniques, fundamental studies may now be possible showing how conditions of the blood affect mental disorders.

I have enumerated only a few of the more dramatic developments in the treatment of the mentally ill. It will require much more research to determine the value of these developing therapies. There is reason to hope that, together with other noncustodial treatment techniques, these discoveries will prove to be the beginning of a new and successful approach to the staggering problem of mental illness. As it has in the past, the American Medical Association expects in the future to assist in a sound and orderly attack on the problems of mental health.

The joint commission to which Dr. Allman and I previously referred has already received the approval of the governing bodies of the American Medical Association, the American Phychiatric Association, and in addition some 16 other organizations of national importance in the medical and ancillary fields have accepted representation on the planning and study commission for this joint effort. It is generally agreed that the participation and backing of all of these other organizations will be necessary both in the scientific study itself, and in putting the recommendations of the report into effective practice once it is completed. Other organizations included in our planning and study commission are as follows:

American Association of Psychiatric Clinics for Children
American Association of Psychiatric Social Workers
American Assocation on Mental Deficiency
American Hospital Association
American Occupational Therapy Association
American Psychological Association
Central Inspection Board of American Psychiatric Association
Coordinating Council of American Nurses' Association and National League for Nursing
Council of State Governments
Joint Commission on Accreditation of Hospitals
National Association for Mental Health
National Institute of Mental Health
Social Science Research Council
Veterans' Administration
National Education Association
American Bar Association

The joint commission also plans during the course of the study to call in other national organizations and individual experts for consultative purposes.

The kind of result that we hope to obtain from the proposed study and report is not without excellent precedent in the medical field. I should like to bring to your attention briefly the so-called Flexner report on medical education which was carried out in the United States in the first decade of this century. At that time the schools of medical education in this country were in an almost hopeless situation. The country was overrun by about 200 second rate, third rate, and fourth rate medical schools. The student merely paid his fee, accepted his graduation certificate and entered the practice of medicine with little or no background in the knowledge needed for the proper treatment of patients. At that time there were 40 to 50 medical schools in New York State, there were about 37 in the State of Illinois, and the city of Cincinatti alone, supported some 25 schools of medicine.

What the Flexner report did for medical education is what we hope to accomplish through the Joint Commission on Mental Illness and Health. The Flexner report contained an exhaustive survey of the situation in medical schools and recommended goals and standards toward which medical education could strive. As a result of this study and the followup that has been given it, each of the States have arrived at the point today where only grade A medicals are recognized.

I want to emphasize that the work of our joint commission will not look toward the deficiencies of mental hospitals only, but will include a survey of all of the aspects of our society that are directly related to the mental and emotional health of our people and it will attempt to uncover some of the factors responsible for the increase of mental ill health.

This concludes my formal statement. I want to thank the committee for permitting our association to go on record in support of these bills.

Chairman HILL. Doctor, in your statement you speak of the successful management of illness, whether physical or mental. You state that it comes only from the application of the art and science of medicine by physicians skilled in modern medicine.

As I have stated not once but several times, the doctor is the central theme in the drama of medicine; everything else is simply to help him get the best results he can. Is that not true?

Dr. BARTEMEIER. That is true.

Chairman HILL. I am sure you have been thinking about it. How can we get the thousands of additional men needed to treat mental illness? How is the American Medical Association approaching this problem? How do they plan to get these men?

Dr. BARTEMEIER. Senator Hill, I would say in general that our undergraduate medical education now includes instruction and some training in the psychiatric aspects of illness and a good many of our medical schools are teaching medical students these applications from the time of their freshman year straight through to their graduation, and where we have departments of psychiatry in general hospitals, and they are, by the way, increasing in number; we have opportunity there to train medical and surgical interns and residents in our general hospitals.

I, for one, am convinced from what I have observed traveling here and there in the country that the more recent graduates of our medical schools, within the past, certainly the past 2 or 3 years, have much more ability to practice what you and I would call a comprehensive type of medical care.

In other words, with the results of this more complete form of medical undergraduate education, we are turning out, we are graduating large numbers of physicians who are, will be prepared and are prepared to take care of a great many of the patients whom older doctors who did not have this opportunity of the newer education now have to refer to psychiatrists. So that I think the time is coming when a great many of the general practitioners of medicine, the internists and other specialists, will be in a good position to take over much of the care of many patients now having to be referred to psychiatrists.

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And I think that is so. I think that is a great step forward. I think it is one of the outcomes of our experiences in medicine in World War II. It was on the way before, but I think the war accentuated it.

Chairman HILL. Even as a big step forward, do you think that in and of itself, great as that may be, it meets the situation?

Dr. BARTEMEIER. No; I don't think it meets the situation.

Chairman HILL. What would be your suggestion as to how to meet the situation?

Dr. BARTEMEIER. We have associated with us in medicine and in psychiatry, the specialty of medicine we call psychiatry, an increasingly large number of well-trained—we call them ancillary workers. They are professional workers, professional people of the quality and grade that medicine itself already has—in the laboratories, in the X-ray rooms, in the pathology departments, and so forth. These are the clinical psychologists, the psychiatric social workers, the trained hospital attendants, we used to call orderlies, now trained anywhere from 6 months to 2 years, and this large group of people are working as assistants in the field.

Chairman HILL. Don't we need more of both doctors and this group of trained personnel of which you speak today in the field of mental health?

Dr. BARTEMEIER. Oh, yes; we could use thousands of them.

Chairman HILL. Could use thousands?

Dr. BARTEMEIER. Could use thousands, yes.

Chairman HILL. What I am thinking about is how are we going to get them?

Dr. ALLMAN. The enrollment in medical schools has gone up.

Along the lines of what Dr. Bartemeier says, I think more people have become interested in this mental-health program with which——

Senator LEHMAN. Would you say that again?

Dr. ALLMAN. I think as more people become interested in mental health as we are trying to promote it along the lines we both just mentioned, I think more men who are not devoting much of their time to mental health now and are just shrugging it off as something they are not interested in will become interested and more of the present doctors will devote more time to mental health than they are doing today and as Dr. Bartemeier so ably says, the younger men are receiving better training now in the schools of mental health; as they come out they will be more interested and therefore more active.

Chairman HILL. Dr. Bartemeier said that is undoubtedly a great step but as I also understood him to say, that great as the step was, that one step did not meet the situation.

What I was trying to think of was how to meet the situation. Does either of you gentlemen have anything you might suggest about that?

Dr. ALLMAN. I think it will be a question of evolution. I think as the medical profession becomes more informed, there is more interest devoted to mental health. I think more doctors will go into that field and I think you will find it will be adequately taken care of with the adjunct services that Dr. Bartemeier describes. I mean great help comes to the psychiatrist from the ancillary help that Dr. Bartemeier just described, so they do not all have to be doctors. He is the key figure, as you said in your statement, particularly in mental health.

He can farm out, so to speak, a lot of the work to others, so that 1 doctor can take care of many more mental patients than 1 surgeon can take care of surgical patients, so to speak.

Dr. BARTEMEIER. If we stop thinking for a moment of the present large number of mentally ill, for which we have shortages in all fields, just as atomic energy has shortages among the nuclear physicists, industry has tremendous shortages among skilled labor, if we stop thinking about the present situation alone and try to view it in terms of the future, we see the tremendous need in public education for many sound programs which will spot youngsters who are already beginning to show indications of later emotional disorder.

This is not a new thought. This was advanced by Dr. Adolph Meyer, at Hopkins, whom we call the father of American psychiatry, as long as 40 years ago. He thought that there should be a doctor in every school, not only looking after the mental health, but the physical-health needs of growing children. This remains as one of the fundamental recommendations that we have never yet been able to carry out in any thoroughgoing and systematic manner, and it is the coming generation for whom we need to make great plans.

I feel personally very strongly about this subject.

Chairman HILL. Well, I agree with you, doctor. What I was thinking of was that it is going to take time; is that not true?

Dr. BARTEMEIER. It is going to take time.

Chairman HILL. A lot of time, but what I was thinking of was the present great shortages of personnel, both doctors and the other personnel to which you have adverted, in the meantime. You get these plans worked out. Even when you work out these plans you will have to have a lot of personnel.

Doctor, you spoke, and I was very much interested in what you had to say, about research. I was particularly interested in what you had said about what research had done in many other fields outside of mental illness. Coming from Alabama, I knew something of the old days of tuberculosis and typhoid fever and malaria and pellagra and those things. I saw their ravages at first hand. I know what research has done to eliminate those dread diseases.

What do you think it would take to really mount what we might call a major research offensive against mental illness?

Dr. BARTEMEIER. I think the kind of research that we have in mind is included primarily in the work, the future work, of our Joint Commission on Mental Illness and Health.

In other words, as we see it today, we begin to have some serious doubts as to the advisability of utilizing the mental hospital as a primary tool for the treatment of serious mental disorders; and we believe that as the work of this joint commission goes forward it will undoubtedly be involved in a great deal of research into studying very carefully what we are actually doing and what we are not doing and how we can do it better.

For example, as I have mentioned, we think of the establishment of in-between places from the time that the person leaves the hospital. We thing of the reeducation of his family. We think of provisions within the community for the care of perhaps quite a number of patients whom we now have to send to mental institutions, through courts of law, in many cases, people whom we can treat with newer

drugs and newer insights, and try to prevent them from having to spend a great deal of time, their lives, maybe, in mental hospitals.

So that I see the research as primarily concerned with the people who will be working on this joint commission.

Chairman HILL. Now, do you see much need for laboratory facilities, physical facilities for research at this time in the field of psychiatry?

Dr. BARTEMEIER. Well, Senator, I am here, as you know, this morning as a representative of the American Medical Association. That is a question about which I am really not prepared to discuss. I think that is prepared for in other legislation, proposed legislation that is before you. But my princpal preoccupation is with trying to determine the unintentional mistakes and trying to break with a good many of the old traditions of sending a patient immediately into a mental hospital because the family is frightened, because the local physician might be frightened, because the patient is really mentally ill, but it might be only transitory illness.

I see it in terms of working in interpersonal relations rather than in the construction of laboratories. I see it that way today.

Chairman HILL. The reason I asked my question: We have that legislation only in part, Doctor. I think you testified before a subcommittee of the House Appropriations Committee last year——

Dr. BARTEMEIER. Yes, I did.

Chairman HILL. About that same thing.

Dr. BARTEMEIER. I think that was another piece of legislation.

Chairman HILL. That dealt with funds for certain construction purposes, as I recall.

Dr. BARTEMEIER. Certainly we need laboratories. There is no doubt about that. But in my present thinking, in my present preoccupation, I am leaning very much more in the direction of what people, what doctors and nurses and hospital attendants are doing which may hinder recovery from illness which may even prolong illness, which may make subsequent recovery impossible because once you get into a mental hospital as a patient, your life and your way of thinking changes considerably, even though you are mentally sick; and unless you can change, unless you can manage to establish a rather quick recovery, the chances of your remaining in that hospital after 1 year have increased tremendously.

Chairman HILL. Doctor, I do not want to take all the time. I want my colleagues here to have a full opportunity to ask you and Dr. Allman any questions they may have in mind, but I do want to ask just one other question and that is with reference to your testimony about title VI of the overall health bill, S. 886. Is it not true that there is authorization now in the law under the Mental Health Act of 1946——

Dr. BARTEMEIER. Yes, sir.

Chairman HILL. To accomplish the same purposes that you would accomplish under S. 886?

Dr. BARTEMEIER. Yes, except that title VI would strengthen, I believe, the financial support to communities and local governments. I think that is concise. I think that the American Medical Association favors title VI. Title 848 is also very good proposed legislation but title VI seems to state it more, somewhat more concisely.

Chairman HILL. I happen to be a member of the Appropriations Committee of the Senate, and now I happen to be chairman of the sub-

committee that handles the appropriations for health. I think you will find that we have the authority to appropriate the funds for these purposes if we will only make the budget estimates, and then have the committee and the two branches of Congress act on the appropriations.

The fact of the business is, as chairman of that subcommittee of the Senate, I would be happy to have you and Dr. Allman come down at the time we have our hearings on the appropriation for the United States Public Health Service, to give us some testimony. It might be very helpful in getting some funds in the appropriation bill to carry out these purposes.

Dr. BARTEMEIER. I will be very glad to comment.

Senator PURTELL. I was most interested in hearing the doctor again.

As a member of this committee I want to thank him for his contribution. I submitted before the testimony was taken a study made by the Library of Congress on this whole question of mental health, and it is very interesting. I am sure it will be interesting reading for those who have not spent as much time as you have and other doctors here studying this.

One thing that it points up, however, is the fact that in the early days when we found we had mental illness confronting us, it was attributed to evil spirits within people and then we had fear of exposure about mental illnesses. I think that is carried down to the present time.

It seemed to me, too, Doctor, that we have had these peaks and valleys in public recognition of it.

I think Dorothy Dix at one time through a great deal of newspaper publicity was able to focus attention on mental illnesses and also a Mr. Beers, half a generation ago or so, wrote a book on his experiences.

Now, is it not a fact that one of our problems in dealing with this, Doctor, is the lack of recognition on the part of the public of the need for meeting this most pressing problem? Is that not right?

Dr. BARTEMEIER. I agree wholeheartedly.

Senator PURTELL. If we could focus attention on it with the public, don't you think that we could probably meet this problem quicker if we could get the people to understand what the problem is and continue to focus attention on it?

Do you not think that we would sooner, then, lick this problem?

Dr. BARTEMEIER. I think we would, and I think that in his testimony Dr. Allman has already pointed out the need for public education in mental health through the general media such as radio, television, magazines, and newspapers, but I think we should carry that program very intensively, but we must keep in mind that no matter how much education we do that these old beliefs that I was born under a certain star and therefore my whole personality and everything is determined, and we still have in our public press throughout the country the horoscopes and things, and that persists.

Now, public education in the field of mental health can gradually overcome that. We need to intensify that campaign very much.

Senator PURTELL. Do you not think that what we have to do is focus it as much as we can? Do you not think that—incidentally, I want to say this: That this is one type of legislation we are considering this morning about which there is no great vast area of disagreement.

We recognize the problem, this committee does, and I am happy to know it is recognized by most people who have given any study to it. So there is very little of controversial nature. We all want to help solve it. There is a difference of opinion as to how it might be solved the quickest. It seemed to me, Doctor, if we are going to make this study, and we do intend making it, that we ought to do more than that. We ought to include provision for the development of a national mental health program, not a Federal program—I am talking about a national mental health program.

It seemed to me, Doctor, that one way we can do that and continue to focus attention on this is by having done what I suggested—and I am not battling for my particular bill at all, because what I am interested in is good legislation that will help solve this problem or point it up, that will focus attention on it, and that will continue to focus attention on it.

It seemed to me we might have a vehicle or a means or a device to keep attention focused on it and to provide, as a matter of fact, that means which I think we lack in some of the other bills, the provision for the development of a national mental health program. So I have suggested a Presidential commission.

It seemed to me through the Presidential commission we would do three things. We would make our study and the Presidential commission would be a means of focusing attention on that and out of it would come also provision for the development of a national mental health program.

It seemed to me it has some merit, and I wondered what, if any, objection you might have to that particular type of program. It is more than just a survey, a study, gathering information, because we have done that repeatedly in other fields; but if we do not implement that with a program following, it seems to me that we are not going to do all the job that we might do.

Dr. BARTEMEIER. Senator Purtell, as you know, we all have great appreciation of your interest and great appreciation of the legislation which the appointment of a Presidential commission might result from, and all in the field of mental health. But we feel that as long as this could be carried out by nongovernmental agencies, it would not become involved in the risk of becoming a political football.

Senator PURTELL. Is it your opinion that a study of such a thing as mental illness would, through a Presidential commission, in any way develop into a political football? I cannot conceive it. I am not fighting for my bill, I simply wondered what your thinking was.

Dr. BARTEMEIER. We thought more favorably of its being carried out by a nongovernmental commission, by people who have experience, people who could be selected to devote their time and energies to this kind of research and survey and we would hope that it would not terminate at the end of 3 years. But that by further legislation the work might be continued.

Senator PURTELL. It is not provided for in the legislation that you feel should be adopted.

Dr. BARTEMEIER. That is true.

Senator PURTELL. Of course, you know, too, Doctor, do you not, that in the specific bill we are referring to—(that having to do with the Presidential commission—when you speak about having people

that are fitted for that particular thing, we are very specific, as a matter of fact, even more so than any of the other bills, I believe, in designating people with the necessary training. The only reason I mention it is because it seems to me that we have to do more than just study. We have to do more than just say that when the study is completed I hope that another step will be taken. I think we ought to take them, tie them together now. I think the way to do it is to set up a commission that will do exactly that. I think that will continue to focus attention on this subject. And I frankly feel that that type of commission will do more focussing of attention on the part of the public, more breaking down of that apparent fear, a real fear on the part of people, that there is a stigma attached to mental illness. I think it might do even more and prepare the people to make a very large, perhaps great effort, concentrated effort, to meet our problems when your study is completed. I cannot share with you the apprehension of this becoming a political football. But I do have a fear—I noticed it in the list of associations that you had in this joint commission which you referred to, that there are several that I believe are not listed, perhaps you intend ultimately to have them in but such an organization as the National Rehabilitation Association you have not included there. I wondered if this commission that will be set up will probably be one organization through which the bill perhapes will operate—is it not possible that you might cause perhaps some little apprehension on the part of some other associations that would not be included?

Dr. BARTEMEIER. As a matter of fact, Senator Purtell, I think your point of view is perfectly correct. But you will notice that after the listing of these particular groups——

Senator PURTELL. I know you say "others."

Dr. BARTEMEIER. We speak of other groups and certainly our good friend, Dr. Rusk, in the field of rehabilitation is one with whom we have worked and one whom we would not be inclined to preclude.

Senator PURTELL. Am I correct that is the chief objection to the idea of a Presidential commission—if you have others, I would like to hear them—is that it might degenerate into a political situation?

Dr. BARTEMEIER. No; I have no thoughts which I have not expressed to you. I have told you my feeling about it.

Senator PURTELL. Thank you.

Chairman HILL. Are there any further questions?

Senator PURTELL. No; I haven't any more.

Chairman HILL. Senator Lehman, have you any questions?

Senator LEHMAN. Doctor, I notice that you are the medical director of the Seton Institute in Baltimore. Is that a private or a public institution?

Dr. BARTEMEIER. That is a private mental hospital.

Senator LEHMAN. How many patients?

Dr. BARTEMEIER. We have beds for 320. We have about 270 to 275 patients.

Senator LEHMAN. I want to congratulate you on a very interesting and clear statement which I listened to with great satisfaction. I want to emphasize the fact that I fully agree with you with regard to the need of developing new methods and curative weapons in mental disease.

I have a very strong feeling that treatment of the mentally ill has made far less progress than any other branch of medicine in the past 35 years, when I first became greatly interested in it.

But you say on page 4—

> Particularly in the field of mental illness, we have mistakenly sought solutions to our problems by the construction and maintenance, at tremendous public cost, of institutions for custodial care of the mentally ill. We have good reason to question, fundamentally, the concept of a mental hospital as the primary tool for treating the mentally ill.

Now again, concurring in your opinion that we have to proceed with our research work and our study of new methods, if you don't have public hospitals for custodial care, in the meantime, until these new methods are developed, how will you treat these people? How will you care for them?

Dr. BARTEMEIER. That is going to be part of the work of this joint commission. It is a problem in which we are very much interested. We will always need a great many custodial hospitals for the mentally ill. There is no doubt about this. But we have been, we think, focusing our attention altogether too heavily upon the hospital.

In our travels to other countries, particularly to England, to Belgium, we have seen how in those countries many of the mentally sick are cared for outside of the hospitals.

For example, in Gheel, Belgium, which is a colony in a small city where the mentally ill are sent out of a 300-bed mental hospital into the homes of people in the communities where they receive excellent care, very humane, this has been going on since the 13th century.

In England, I was told by one of the outstanding leaders in medicine and psychiatry that he considered his problem—he is a superintendent of a mental hospital, and he considered his problem to be the total health needs of his community of 250,000 people and when I said to him, but I thought you were the superintendent of a mental hospital, he said, "Oh, yes, but that is the last in the long chain of various establishments within the community which look after mentally sick people" and he showed me his psychiatric ward in a general hospital, took me to another place where there was a big house in the community where they were looking after alcoholics, took me to another place where they are doing work with feebleminded children. It is a community problem.

Senator LEHMAN. Are these people who live in private homes where they receive humane treatment—are they in these homes generally as a result of a parole from the institutions or do they go to these homes initially?

Dr. BARTEMEIER. They go to the hospital first where they are examined and early treatment is instituted and as soon as possible and this follows the problem somewhat that Dr. Rusk has been carrying out—as soon as they are somewhat better, they are sent to these homes, so that their period of stay in the hospital is not as long as what I think we have it in our country.

Senator LEHMAN. We, of course, in New York, do parole a great many and place them in private homes. I think the handicap in carrying out that procedure on a much larger scale is due to the attitude of the public and the press. Every time, I found, that we paroled somebody after very careful investigation and study by the physicians, who believed that this man did not constitute a risk, and

then the man or the woman went wrong, committed some crime of violence, or some sex crime, every newspaper, of course, jumped on the doctors and on the institution that paroled him.

I know in my time, and I am sure it still is the case, that served to be a great deterrent to the much more humane, and I think much more useful, method of paroling people in the care of private families.

Dr. BARTEMEIER. We both agree with what Senator Purtell said about public education.

Senator LEHMAN. I think there is a great deal in that.

You referred to the new methods that have been discovered, new drugs that have been developed for the cure of many diseases, collateral to mental illness. Were most of these methods, and particularly the drugs, developed in mental hospitals or were they developed through private activities of research laboratories or privately owned companies manufacturing drugs?

Dr. BARTEMEIER. I am not prepared to give the exact information but I have the impression that they were developed privately through—particularly thorazine was developed in France and was brought to this country and refined by chemical laboratories, commercial laboratories, and serpasil and its products which were brought from India and had been used in India for a long time, and are now more refined forms are being used extensively.

I had recently conferred with one of the psychiatrists from Baylor University in Texas where I am told that whereas they had been committing 20 percent of their patients suffering from schizophrenia to public State hospitals, they are now only committing about 5 percent through the use of this new drug or these new drugs, which is a startling and dramatic thing.

Senator LEHMAN. In regard to these new methods to which you refer, were many of them or any of them developed in public hospitals, or were they done in research laboratories? I am referring, for instance, to your discovery of the use of the electoencephalograph which you describe as a great help in the treating of epilepsy, and the use of various drugs or methods to build up the thyroid deficiencies. Were those discovered in the hospitals or outside? And I want to tell you why I am asking you this question, and it goes back to the statement about custodial care in hospitals.

I was deeply disappointed in the years I was governor—we had at that time 100,000 patients in our State hospitals. I was deeply disappointed at the lack of the development within our institution through research work, through clinical observations, of new helpful methods. I ascribed that very largely to the fact that the duties, both of the head of the department, and the superintendent of the individual hospitals, were so heavy that they had to devote their attention almost exclusively to matters of administration.

Dr. BARTEMEIER. That is true.

Senator LEHMAN. And that there was very very little clinical study or research study or laboratory work that was done within the institutions for the cure or improvement of the condition of the patients. I think that has been a great handicap.

Dr. BARTEMEIER. Yes, it has, Senator Lehman, but I think in more recent times we see a very definite indication of change in this direction. The American Psychiatric Association, within the last 2 or 3

years, has established regional research conferences devoted exclusively to problems of research within hospitals in different parts of the country. There are probably—I can't give you the exact number—perhaps 5, 6, or 8 of these regional conferences, regional research conferences now being conducted in the United States and in Canada by members of the American Psychiatric Association and these conferences which last a full day or 2 days, are very carefully planned and medical men in the field of chemistry and physics and other specialties are being brought into these conferences, so that they are multidisciplinary in nature, and I believe that we are moving forward in this direction.

I think that the electroshock therapy which has been so beneficial and is now perhaps beginning to be somewhat replaced by the development of the newer drugs, was originally established by a couple of Italian physicians. I think that came directly out of medicine.

Senator LEHMAN. That was developed by foreign physicians. I remember that took a lot of pressure to get the method, that treatment, accepted in many of our mental hospitals.

Do you see any great change in the degree in which laboratory work is being done and particularly clinical work? I have always been so worried—I still am—that when a patient gets to a mental hospital he just becomes a number.

Chairman HILL. Becomes a forgotten person.

Senator LEHMAN. For practical purposes becomes a forgotten person and he receives very little individual treatment, or even very little individual study with regard to his condition.

Do you see any improvement in that?

Dr. BARTEMEIER. I see improvement in it, very definite improvement in it from the point of view of the great interest which American psychiatry and the nursing associations have also taken, for example, in the training of the attendants who spend—they are the people who spend most of their time right there with the patients and who live right with the patients and, as they have been taught and as they have been indoctrinated, I do believe that not only do they remain more permanently in the employ of the hospital, we have lost that quick turnover, but I think they have a much better influence in the rehabilitation of the patients.

Senator LEHMAN. We in New York, and I assume that is true of many other States, now house in our hospitals a great number of older people, senile, who are really not mental cases at all, and I notice that you referred to that. But they are there because there is no other place to take care of them.

Have you any conclusion for that?

Dr. BARTEMEIER. We are thinking, of course, about the establishment of hospitals or convalescent homes, or not particularly convalescent, but small institutions located within the community on the very edge of the community where the old people have access to their families, and the families to them, and where they have access to medical facilities, where they have access to the life of the community and with regard to—I would like to say one more word about research in hospitals.

It is going on. Dr. Francis Braceland at Hartford, Conn., has a tremendous research program going on in the Institute of Living.

Senator Purtell knows about this very well. There is research going on in the Midwest, in the Menninger clinic. In our large public hospitals, I think we regularly receive during the course of the year in the American Psychiatric Association reports of various kinds. There might be little pieces, but they are really researches that are going on. It does not amount yet to what we would like it to be, but it is on its way.

Senator LEHMAN. Just for my education, what is the "total-push" treatment?

Dr. BARTEMEIER. The "total-push" treatment is the establishment of the attitude that is an encouraging attitude that you will get well by everyone on the staff from the janitor up to the superintendent. Everybody has that same push, or same encouraging influence on all the patients to move ahead.

Senator LEHMAN. Is that used to any great extent?

Dr. BARTEMEIER. That is used in some of our State hospitals.

Senator BENDER. Of course, you are the representative of the American Medical Association, and for that reason I have great respect for what you say, Dr. Bartemeier. I wonder how you feel about S. 46? It contains nothing requiring reports by these nongovernmental bodies. Would you favor a requirement that reports be produced and published periodically?

Dr. BARTEMEIER. Yes, I would be very much in favor of that.

Senator BENDER. I notice in the House bill that was reported they amended it so that reports would be made.

Dr. BARTEMEIER. Yes.

Senator BENDER. You say you would favor that?

Dr. BARTEMEIER. I would favor that, certainly.

Senator BENDER. This question is a little involved, but for that reason I would appreciate if you would try to follow me:

The administration in its bill, S. 886, would amend the public-health sections of the Public Health Service Act, and S. 46 would authorize research and so forth by nongovernmental organizations more or less operating free from the Public Health Service.

Do you think we should enact both title VI of S. 886 and S. 46, or do they duplicate each other so that one, not both, are useful?

Dr. BARTEMEIER. I would like to suggest that both measures, title VI and S. 46, be brought together.

Senator BENDER. You think there is good in all of these bills and that they possibly should be merged?

Dr. BARTEMEIER. Yes, I do.

Senator BENDER. To eliminate any partisan approach but approaching the problem wholly from the standpoint of trying to reach the solution without anyone receiving any credit.

Dr. BARTEMEIER. Yes.

Senator BENDER. Do you think this should be kept in the Public Service Act as the administration provides or as this Senator Hill's bill provides for it being not a part of the Public Health Administration?

Dr. BARTEMEIER. I think it would be very much a part of the Public Health Administration as it is written because the psychiatrists and other specialists who would be working on this joint commission are people who have been closely associated and will be closely associated

with the National Institute of Mental Health in Bethesda and the council, the National Advisory Mental Health Council. I think that we should work all the time in connection with them, not foot-loose and fancy free. I think we should make reports at regular intervals and final reports and recommendations.

Senator BENDER. I am wondering how much attention the American Medical Association is giving to the matter of informing State legislatures and contacting them regarding the approach or some new approach to this whole problem? Do you have some way of contacting these legislatures, because, in the main, legislatures provide money for State institutions.

Dr. BARTEMEIER. We are in very close contact with the Council on State Governments, and as you see, we include them as one of the organizations in whom and with whom we would be working. And as you know, the governors would be holding regional conferences on mental health, the first one a year ago, in January in Detroit.

Senator BENDER. In your formal testimony and also in response to questions by the chairman, Senator Hill, you spoke of the shortage or the need for great number of physicians.

I would like to make an observation as a politician: That one of the principal sources of distress is the fact that there are so many young men and women who want to study medicine and there is not room for them in the recognized medical colleges.

Now, hardly a week passes that I fail to receive a letter from some individual wanting to get into a medical school and feeling that because I happen to be in public life that I might have some special influence. Why is it that we do not have greater facilities and why is it that so many of these people are not considered? They seem interested; they seem anxious to pursue the medical profession and yet there is a vast shortage of doctors.

Now, have you any comment to make on that?

Dr. BARTEMEIER. I have not any comments to make on it except to agree with you in everything that you have said. We have a great shortage in the number of approved medical schools and perhaps Dr. Allman can say something to that point.

Senator BENDER. Dr. Allman, do you have any comment on that?

Dr. ALLMAN. Except this, Senator, that in the enrollments, they are the greatest in medical schools, greater than ever before. The enrollment in medical schools is increasing faster than the population rate is increasing. We have now 6 new medical schools about ready to go and 3 others proposed. For example, in New Jersey, where I happen to come from, and I happen to know about, we are getting ready to open one medical school and we will soon probably have another so that the problem is being taken care of. It is not a thing you can accomplish by throwing the doors down and leave everybody in. And by the same token, with all due respect to your constituents, some of them may not be basically qualified to study medicine. That may be the reason they have not been accepted by schools. The difficulty about getting into medical schools as we heard about 3, 4, 8 years ago is greatly diminishing. I think that the vast majority of those qualified to enter the study of medicine are now being accommodated and more will be accommodated as time goes on.

Senator BENDER. This is not asked facetiously, and possibly should be asked off the record, and I wish you would keep this question off the record.

(Discussion off the record.)

Senator MCNAMARA. In a little more serious mood, is your State doing a good job in this department of helping out in the work of preparation, helping to prepare these students to treat this kind of case? Would you say the States are doing a good job or just a fair job, generally?

Dr. BARTEMEIER. I was thinking of the medical schools.

Senator MCNAMARA. I am, too, but you are talking of treating the mental patient in conjunction, or training the doctor in treatment for the mental patient in conjunction with the general practice of medicine. I am asking the question with that in mind.

Dr. BARTEMEIER. I think we are doing a very good job in medical schools, I really do.

Senator MCNAMARA. I was very much interested in your approach that the general training should include training to take care of these mental patients. I think it is particularly true because the specialist charges so much for his services, properly, that—I don't mean improperly charges so much—for instance, it costs about $25 an hour in an average community to get any sort of psychiatric help for a person. So that only the very poor, it seems to me, or the very rich, in our present society, are getting the proper attention because of the cost of it.

Now, if the general practitioner can do the job in the next generation, if your plan is successful, he will be able to, it will make this treatment of mental sickness available to a vast number of people who now just cannot have it.

Dr. BARTEMEIER. That is true.

Senator MCNAMARA. I think your program is marvelous because it takes in this group that now is apparently almost completely excluded from treatment.

I wonder if you had given any consideration to—you mentioned, or somebody mentioned, that you had been in Detroit, Wayne University. My home is in Detroit and I am now a member of the board of education. We built a nice psychiatric clinic at Wayne University. Are you familiar with that?

Dr. BARTEMEIER. Yes, I am.

Senator MCNAMARA. Is that being used with the training of medical students generally or are they training specialists in psychiatric treatment? Do you know?

Dr. BARTEMEIER. That will be used very much, probably both ways, but primarily as a teaching and training center and also for research for people who are graduated or are graduating from medicine. It is directed more toward the upper, the postgraduate, and would be very much like our hospital in Ann Arbor.

Senator MCNAMARA. Is there any merit in considering, thinking of Wayne again, the great shortage of teachers? They have a short, concentrated course; they turn out teachers in something like a year. They don't give them the certificate. But they use them to help out in this situation. Would there be any sense to a program such as that, training these specialists that you referred to, to help out the trained technicians?

Dr. BARTEMEIER. I think there would be, yes.

Senator MCNAMARA. There is no plan like that?

Dr. BARTEMEIER. No.

Senator MCNAMARA. You know what Dr. Lessenger does in turning out these teachers in concentrated courses, less than qualified for certification but nevertheless very helpful in emergency situations. Maybe in this transition period that we are going through, that kind of program would be helpful. I wonder if you had given any thought to it.

Dr. BARTEMEIER. I have not so far, Senator McNamara.

Senator MCNAMARA. I was interested in your comment on getting these mental patients out of institutions, particularly you mentioned in Belgium. Are they still wards of the State when they are transferred from the hospital to the private home?

Dr. BARTEMEIER. Yes, they are still wards of the State because they are committed and they have not been adjudicated from their status as mentally sick.

Senator MCNAMARA. The State pays the family that takes them in something for their room and board?

Dr. BARTEMEIER. That is true.

Senator MCNAMARA. I thought that the American Psychiatric Association would be more apt to be inclined to want to train specialists rather than to go along with your program. I am certainly glad to hear that they are joining with this thought of yours that it should be the work of the general practitioner.

Are they cooperating one hundred percent?

Dr. BARTEMEIER. We are getting very good cooperation.

Senator MCNAMARA. Up to now, there has been some thought that they were seeking legislation to keep their field apart from the general——

Dr. BARTEMEIER. That may have been true in the past when psychiatrists were much more isolated from the rest of the medical profession by virtue of the fact that most of them were working in these public hospitals, but I don't think it is true in the last years, and I think it was for one of these very reasons that the American Medical Association established its first committee and has now established its second committee which is working very closely all the time with the American Psychiatric Association.

Senator MCNAMARA. It is actually your plan carried to the full extent which would in a measure cut down on the need for the specialist.

Dr. BARTEMEIER. That's right.

Senator MCNAMARA. There will always be a need for him but it will not be as great.

Dr. BARTEMEIER. That's right. We must keep in mind that today and yesterday and years before the general practitioner and the various specialists in medicine have always been looking after a number of patients in their practice who were mentally sick, but if that number can be increased——

Senator MCNAMARA. I have only one further comment. I am certainly glad that we all recognize, apparently, today that the housing for the aged is an important part of this kind of a program and I am delighted that your report or your answer to the question indicated your recognition of that. I have always thought it was a serious part of the program.

Senator LEHMAN. May I ask one more question in line with the questioning of Senator McNamara?

You testified, Doctor, and Senator McNamara has emphasized it, that the doctor being trained at a medical school with the intention of going into general practice, or possibly even surgery, now receives in many cases some psychiatric training. That is fine. I think it is a very good arrangement, but isn't the number who can receive the psychiatric training limited, strictly limited by the number of doctors who are being trained today in our schools? That number seems to me, I always have felt, is quite inadequate. And you can't give some psychiatric treatment to doctors if you haven't got enough doctors in the pool to draw from who are being trained as general practitioners or surgeons. What is your remedy on that? It seems to me that we are today lacking very greatly the number of doctors who can be trained.

Dr. BARTEMEIER. I can't suggest any remedy for it, but I can say that I feel certain that this is one of the, and it is a very important question that you present, it is one of the central themes the Joint Commission on Mental Illness and Health is going to have to concern itself with and how to work it out.

Chairman HILL. Senator Purtell, you have a question?

Senator PURTELL. Yes, I noticed in the questioning previously you were asked about the senile, those who are really not mentally ill, not really mental cases but are confined in mental hospitals. I would like to call your attention, Doctor, (and I am sure you know it, probably it slipped your memory or perhaps it had not been brought to your attention) but last year the Administration's bill called for four new health categories. It came out; it was passed; it is law now. We have provided for facilities for the chronically ill and nursing homes for people who could go in those nursing homes. We hope the Appropriation Committee will appropriate the money we need in the legislation. Those will relieve you to a great extent of that type of case. I thought we might mention that and have it in the record because legislation is on the books and if we can get our good members of the Appropriations Committee to appropriate enough money we can have that type facility.

One more thing I would like to call your attention to because Senator Bender mentioned it. I had inadvertently neglected to put into my S. 848 when I presented it a portion of what I had intended to put in. So I would like to read it for the record. It goes along with the question of what help we will give to the State health divisions. I would like to read it.

Amendment intended to be proposed by Mr. Purtell to the bill, S. 848. Beginning with the word "make" on page 4, line 11, strike out all to and including line 17 on page 5, and insert the following:

"(1) to make grants to States, and with the approval of the State mental health authority, to interstate agencies or to political subdivisions of States for paying part of the cost of public health services in the field of mental health which are of importance to the solution of (A) emergency mental health problems in specific geographical areas, or (B) mental health problems no longer of serious concern generally but remaining acute in specific geographical areas, or (C) mental health problems common to several States, or (D) mental health problems for which the Federal Government has a special responsibility; and

"(2) make grants to State and local agencies, universities, laboratories, and other public or private agencies and institutions, and to individuals upon

recommendation by the National Advisory Mental Health Council for (A) the development of new techniques and better methods for the improvement of mental hygiene and the prevention of mental illness, (B) public education with respect to the causes of mental illness and methods of control and prevention, (C) the development of counseling and referral services to obtain full and effective use of community resources in the field of mental health, and (D) the development of prevention and control programs on an organized communitywide basis; and

"(3) make grants to State and local agencies, universities, laboratories, and other public or private agencies and institutions, and to individuals upon recommendation by the National Advisory Mental Health Council for (A) developing improved methods of care and treatment of the mentally ill, including grants to State agencies responsible for administration of State institutions for care, or for care, treatment, and rehabilitation of the mentally ill, (B) developing improved methods of operation and administration of such institutions, (C) reducing the length of institutional stay by improving or developing new methods for ambulatory care and for preparation for the return of the institutionalized patient to the life of the community, and (D) developing improvements in the design and equipment of physical facilities for institutional and ambulatory treatment of the mentally ill.

"(b) Subsection (j) of such section is amended by inserting after 'subsection (c)' wherever it appears the following: 'or subsection (1)'."

Senator PURTELL. I dont' expect you to comment on it. I wanted to call your attention to the fact it was intended to be included in 848 and since Senator Bender indicated in his discussion about aid to States and local health organizations, I thought I would like to mention it.

Now, I have one more thing to say. In the past, we have had periodic attention centered on mental problems. When I initially talked with you we found out that public attention lapsed after a while. There would be a big buildup and then interest would drop because there was not continuing attention focused on the problem; a little was done but spasmodically and not carried out completely. Therefore, I wondered if it is your opinion that perhaps we might improve the bills before us by providing not only for the study but for the use of the knowledge when we get it, by outlining a national program of some kind, and not wait until after we have made the study to find out whether at that time we might implement it by a program.

Let me point out why I say that to you, Doctor. I think you are interested in it.

We might well find, when we have focused attention on this problem and developed our studies, a picture much more horrible, perhaps, than the average person realizes and then you have it suddenly bursting upon people. I think you in your medical profession ought to give some thought to this: Will there at that time be a great demand, when this story is finally told, publicized, pointed up as it will be, for immediate action at the Federal level when you might find a demand for a lot of Federal controls you are not presently anticipating. I think that is maybe something we ought to think about. So I suggest that you give it some thought.

I would like to see us, Doctor, provide here now for a commission. I don't know what you would call it; nor do I care what bill it is in. But I am interested in this legislation. The heck with pride of authorship. But I think we ought to be careful about it and make sure we are doing two things, that is, making a study and utilizing that knowledge by previous direction in perhaps pointing up a program.

Senator BENDER. Mr. Chairman, is it not possible for us to leave this matter in the hands of the chairman and Mr. Purtell and work out a bill that would be agreeable all around?

Chairman HILL. As soon as we conclude our session, the subcommittee will go into executive session and consider the different facets of this matter fully.

If you gentlemen have any further views you would like to bring to our attention, we would certainly welcome them. Indeed, if you could come back or write us a letter, we would be delighted to have any further ideas or suggestions that you might have.

I know I express the sentiments of all of my colleagues on the subcommittee here in expressing our deep appreciation to you gentlemen for coming here and bringing us this very fine, informative testimony. We are most grateful to you.

Senator PURTELL. I want to add my word to that. I greatly appreciate it.

Dr. ALLMAN. We are glad to have had the opportunity to be here.

Chairman HILL. I have here a letter from Dr. F. E. Wilson, director of the American Medical Association, stating that the board of trustees of the American Medical Association at its recent meeting in Washington had given its approval to Senate Joint Resolution 46, and he would appreciate our letting him know how the American Medical Association can be effective in its support of this resolution. Without objection, the letter will go in the record at this point.

(The letter referred to is as follows:)

AMERICAN MEDICAL ASSOCIATION,
WASHINGTON OFFICE,
Washington, D. C., March 25, 1955.

Hon. LISTER HILL,
United States Senate, Washington, D. C.

DEAR SENATOR HILL: Senate Joint Resolution 46, Mental Health Study of 1955, sponsored by you and 29 other Senators, has received the active approval of the board of trustees of the American Medical Association at its recent meeting in Washington, D. C.

I would appreciate your letting me know how the American Medical Association can be effective in its support of this resolution.

Sincerely yours,

F. E. WILSON, M. D., *Director.*

Senator PURTELL. I would like to ask permission to have my remarks go in, Mr. Chairman, and several letters I have received, as well as a report by Dr. Braceland.

Chairman HILL. Without objection, that may be done.

(The remarks, the letters referred to, and the report by Dr. Braceland are as follow:)

Mr. PURTELL. Mr. President, I introduce for appropriate reference a bill designed to augment and accelerate our present efforts to solve the difficult, nationwide problems which have long persisted, and which continue to confront us, in our efforts to bring about a more universal understanding of the nature of mental illness and greater improvement in our methods of care, treatment, and rehabilitation of the mentally ill.

First, Mr. President, I am convinced that this Nation must step up its efforts to deal more effectively with the general problem of mental illness. From time immemorial the populations of the world have experienced the problems, frustrations, and despair, which, widely attended by ignorance of the nature of mental diseases, have accompanied the incidence of mental illness. Yet, we have made progress, so that today we have knowledge of many of the basic aspects of the

problem, which, if more widely and properly applied, would help to reduce the number of patients presently in mental hospitals and to prevent the admission of countless others. At the same time, there are many aspects of the problem about which we lack sufficient knowledge to enable us to proceed with any degree of certainty.

To the extent that we can reduce the population in mental hospitals but do not do so, for lack of adequate programs or for other reasons, we are merely continuing to add to the taxpayers' burden, as well as failing to conserve our human resources. It is a fact, Mr. President, that 98 percent of all our mental patients are in State, county, city or Federal tax-supported hospitals. We are spending over $1 billion a year in public funds alone on costs incident to mental illness. It is also a fact that more than 700,000 patients, or 54 percent of all hospital patients of all kinds, on any given day, are in mental hospitals. I also invite attention to the fact that 38 percent of the 5 million men rejected before induction by selective service during World War II were rejected for neuropsychiatric disorders of one kind or another.

There is no doubt about the need for action, Mr. President. As a result of my experience as chairman of the Subcommittee on Health of the Committee on Labor and Public Welfare, during the 83d Congress, I have reached the conclusion that the problems incident to improving our attack on mental illness, through improved care, treatment, rehabilitation, and preventive measures rank among the most serious problems with which we are confronted in any consideration for improving the Nation's health.

Accordingly, it is most gratifying that in his budget message last week President Eisenhower specifically singled out the field of mental health and made positive recommendations thereon. The President has recomended a budget increase of approximately $4½ million for various mental-health purposes.

The bill I have introduced would provide for the establishment of a Presidential commission, made up of experts, to make a thorough inquiry into the whole question, and to develop and recommend to the President and Congress a comprehensive, long-range program of action for dealing with the problem. Such a program, Mr. President, is not to be envisaged as a Federal program, but as a national program, which would clearly seek to achieve progress through the joint efforts of all levels of government and of the numerous nongovernment organizations which are now working in this field. The step that is needed is to arrive at a benchmark, as it were, and to set goals, so that the combined efforts of all agencies may be brought together with common purpose and focused on common goals. Further, the commission here proposed would not be merely another agency to make a study, and a report, to be filed away and perhaps forgotten. One of the fundamental problems confronting those who are trying to accomplish results in the mental-health field is that of bringing about a wider understanding of the true nature of the problems of mental illness and keeping public attention focused on the problem long enough to bring a lasting improvement in existing circumstances. Accordingly, it is proposed that this Presidential commission continue in existence after completon of its inquiries n order to follow up, for a reasonable period of time, its review of progress toward solution of the problems of mental illness, and to assist and cooperate with other agencies in informing the public through educational programs in mental hygiene. I believe this sort of approach is absolutely necessary if we are going to do anything to step up our efforts in the field of mental health.

Mr. PURTELL. Mr. President, I introduce, for appropriate reference, a bill to amend the Public Health Service Act in order to place greater emphasis on solving the problems in the field of mental health. This bill would not add any general authority that does not now exist in the basic law. But, Mr. President, it would augment the present law by making clear that mental-health projects, especially in basic mental-health research, the training of professional personnel, and grants to the States for mental-health purposes, are to be given special recognition for a reasonable period of time. I ask unanimous consent that the bill be printed in the record following my remarks, together with a statement I made yesterday concerning the President's health message.

THE UNIVERITY OF TEXAS,
MEDICAL BRANCH,
Galveston.

Senator WILLIAM A. PURTELL,
United States Senate,
Washington 25, D. C.

DEAR SENATOR PURTELL: Thanks for sending me a copy of your remarks in the Senate of the United States regarding a proposed mental-health program. It seems to me that you have covered the reasons for such a program in an admirable and clear manner.

From the many demonstrations that have been made in all parts of the country regarding an active effort to promote optimum mental health, it is evident that we do have the means available to prevent the terrific load of mental illness with which we now must struggle. Here certainly prevention is much more economical and satisfactory than any attempt at cure, no matter how sucessful the latter may be.

We are extremely interested in the promotion of mental health in this part of the country. The Hogg Foundation for Mental Hygiene of the University of Texas has been an important factor in promoting widespread interest in mental-health activties throughout Texas.

We are attempting now to promote an individual effort at wholesome healthy mental attitudes, so that individuals may benefit from that inner sense of security and self confidence which helps so much in the accomplishment of every day's work.

It is hoped that your project may find broad support. With thanks and best wishes, I am

Sincerely yours,

CHAUNCEY D. LEAKE, *Executive Director.*

YALE UNIVERSITY,
SCHOOL OF MEDICINE,
New Haven, Conn., February 25, 1955.

Hon. WILLIAM A. PURTELL,
United States Senate, Washington, D. C.

MY DEAR SENATOR PURTELL: I read with the greatest interest about the mental-health program which you introduced on January 26 and February 1 in the Senate. As chairman of the Yale department of psychiatriy, rated one of the outstanding departments for training and research in this field, and as a citizen of your home State, I am deeply impressed by your effort. I am convinced that a bill establishing a mental-health program would be of very far-reaching significance for the Nation.

Let me say at this point that I would be most happy if I could be of any service to you in connection with such an effort, and that I, as well as many of my colleagues, will follow your further efforts with the greatest interest.

Faithfully,

F. C. REDLICH, M. D.

STATE OF CONNECTICUT,
DEPARTMENT OF HEALTH,
Hartford, February 25, 1955.

Hon. WILLIAM A. PURTELL,
United States Senate, Washington, D. C.

DEAR SENATOR PURTELL: Thank you very much for the leaflet containing the proposals for a mental-health program that you have made in the Senate on January 26 and February 1. We are very much interested in the two bills you have introduced to set up a commission to study the problems of mental illness and to amend the National Mental Health Act. You are certainly to be commended on your proposals which so well complement the National Mental Health Act of 1946 in the fight against the Nation's No. 1 health problem—mental illness.

As some of us in this department studied your two bills on mental health, we were first struck by what apepared to be some deficiencies in Senate bill 724. Reading on through Senate bill 848, however, we were very pleased to find that some of the apparent lacks of the former bill were partially remedied by the latter. Nevertheless, I would like to offer a few suggestions that might be

included in Senate bill 724 to make a study you propose in it even more effective. I would like to say, first, however, that for myself and for others in the health department who have studied Senate bill 848, we are heartily in favor of the amendments to the National Mental Health Act proposed by you. We are particularly appreciative of the recognition you have of the contribution that public health can make to the control of menal illness.

In view of the fact that among the special grants for mental-health projects that you propose in Senate bill 848 are grants for work in mental public-health services, I suggest that the Commission to be established under Senate bill 724 be alerted to a study of this aspect of the mental-health problem, too. To some extent programs of prevention of mental illness and promotion of mental health are implied in the expression "mental-health services," but that expression is not well defined and frequently is used to mean many other things than preventive services. Actually, a great deal has already been learned and applied to the development of preventive and mental-health promotional activities. Much of it has been under the auspices and direction of the United States Public Health Service and other public-health agencies, especially since the passage of the National Mental Health Act. This area of activity is as much in need of strengthening as is treatment of the mentally ill, and if the problem of mental illness is ever to be brought under control it is even more important because in the long run the only possible solution is by prevention.

A relatively minor addition, as underlined, would change section 2 (a) to read as follows: "The Commission is authorized and directed to conduct a thorough inquiry into the problem of mental illness, including the status, progress, and problems incident to (1) the provision of hospital and related facilities necessary to the furnishing of care and treatment for the mentally ill, (2) the improvement and expansion of treatment both inside and outside mental hospitals, (3) the extension of programs for the prevention of mental illness and the promotion of mental health, (4) the availability and training of psychiatrists and allied mental-health personnel, and (5) the development of research into the causes, treatment, and prevention of mental illness."

It is generally recognized that the extent of the problem alone makes mental illness a public-health problem. Throughout the country, health departments are developing preventive programs that should eventually do to mental illness what has already so strikingly been done to typhoid fever, cholera, diphtheria, and the other physical diseases. You are no doubt aware of the fact that Connecticut was the first State in which it was recognized that the prevention of mental illness is a responsibility of the State department of health. In 1920 a division of mental hygiene was established in the bureau of preventable diseases of this department. Since then in the United States Public Health Service, its mental-hygiene division, and later the National Institute of Mental Health, have made great contributions in the application of public-health techniques to the prevention of mental illness. At present there are mental-hygiene programs of one kind or another in the health departments of 43 States, all 4 Territories, and the District of Columbia.

In view of the very great and widespread interest in mental health on the part of pubic-health people, and in view of the contributions public health can make to the prevention of mental illness and the promotion of mental health, I very strongly urge that there be included on the Commission proposed by your bill some representatives of public health. There are available outstanding authorities in psychiatry who are very familiar with the field of public health, such as Erich Lindeman, M. D., chairman of the department of psychiatry at Harvard Medical School. There are also authorities in the field of public health who are familiar with the problems of psychiatry and mental health, such as: G. F. Mathews, M. D., commissioner of health in Oklahoma; or Harold M. Erickson, M. D., State health officer for Oregon; or Hugh Leavell, M. D., dean of the school of public health at Harvard. Finally there are those who are experts in both fields, such as Paul V. Lemkau, M. D., professor of public health, Johns Hopkins; Robert Felix, M. D., Director of the National Institute of Mental Health; Mabel Ross, M. D., regional consultant in psychiatry in the New York office of the United States Public Health Service, and a relatively few others trained in psychiatry and public health who are directing mental-hygiene programs in State health departments.

In the last paragraph of your statement you mention your intention to introduce additional legislation in this field. I would very much appreciate being kept informed of anything new.

Sincerely yours,

STANLEY H. OSBORN, *Commissioner.*

TRINITY COLLEGE,
OFFICE OF THE PRESIDENT,
Hartford 6, Conn., March 14, 1955.

Hon. WILLIAM A. PURTELL,
United States Senate, Senate Office Building,
Washington, D. C.

DEAR SENATOR PURTELL: Thank you for sending me your comments concerning a mental health program which you made before the United States Senate on January 26 and February 1, 1955. I am very glad that you presented this bill. This problem is of such vital concern to us all that I do sincerely hope a Commission on Mental Health may soon be organized.

With best wishes for your continued success, I am,

Sincerely yours,

ALBERT C. JACOBS.

HOMBERG MEMORIAL INFIRMARY,
OFFICE OF THE MEDICAL DIRECTOR,
Cambridge, Mass., March 18, 1955.

Senator WILLIAM A. PURTELL,
Committee on Labor and Public Welfare,
United States Senate, Washington, D. C.

DEAR SENATOR PURTELL: Thank you for sending me a copy of your proposed mental health program which I think is a worthy attempt to initiate something on a Federal level. Certainly there is a tremendous need for intensive study and a vastly greater expenditure of public funds for this most serious of our health problems.

As you know, more than half the hospital beds in the United States today are occupied by patients suffering from mental illness. It is my considered opinion that many of these patients, now chronic sufferers and apparently resistant to all forms of treatment, might well have been, in some cases, prevented from reaching this sorry state had adequate preventive measures been instituted early enough and a sufficiently intensive study of all the factors that contribute to mental disease in the life of our country been adequately delineated.

Again thanking you, I remain,

Sincerely yours,

HERBERT I. HARRIS, M. D.,
Chief Psychiatrist.

NEW YORK, N. Y., *March 5, 1955.*

Hon. WILLIAM A. PURTELL,
Senate Office Building, Washington, D. C.

DEAR SENATOR: I have read with much interest the reprint (which you were kind enough to send me) of your remarks in the United States Senate made on January 26 and February 1, 1955, in respect of the bills S. 724 and S. 848, which you have authored and introduced.

Without burdening this note, I want to say that your efforts in this direction are most timely and it is my sincere hope that the long-overdue implementation possible under the aegis of your proposed provisions—if enacted into law—will go a long way toward prevention and amelioration of the scourge of mental illness.

If and where you feel I can help, please feel free to call on my efforts, which I am glad to put at your disposal consistent with the possibilities at my command.

With every assurance of my high personal regard, I am,

Sincerely,

LEWIS J. SIEGAL, M. D., LLB.

N. B.—I have taken the liberty to include a reprint on the feasibility of the Uniformity of Settlement Status as a Public Health Measure, which I delivered in May 1950.

L. J. S.

WATERBURY HOSPITAL,
Waterbury 8, Conn., March 16, 1955.

Hon. WILLIAM A. PURTELL,
United States Senate, Washington, D. C.

MY DEAR SENATOR PURTELL: Many thanks for sending me a copy of A Mental Health Program as proposed by you.

You probably are aware of the fact that in Connecticut we are sponsoring jointly between the Connecticut Hospital Association and the Connecticut State Medical Society a task committee to complete a program for psychiatric inpatient care in general hospitals. We feel that the local community has a responsibility in this regard, and we are wholeheartedly in favor of the program which you are planning.

Sincerely yours,

CHARLES V. WYNNE, *Superintendent.*

WILLARD, N. Y., *March 16, 1955.*

Hon. WILLIAM A. PURTELL,
United States Senator, Washington, D. C.

DEAR SENATOR PURTELL: I have read with interest the reprint which you sent me on the mental-health program which you propose for the future. Be assured, sir, that I am in full accord with the purpose and tactics of your plan for study and future solution of the mental-health problem. It is certainly a frightening picture if one were to project the statistics of mental illness into the future, considering the present trend.

Should your program be approved, may I respectfully suggest that this be kept on a basic level, with a minimal of theoretical doubletalk and a maximum of practical investigation and solution done by men of practical experience in the field of psychiatry and its associated areas.

Very truly yours,

OSCAR K. DIAMOND, M. D.,
Supervising Psychiatrist.

BRIDGEPORT 8, CONN., *March 9, 1955.*

Hon. WILLIAM A. PURTELL,
United States Senate, Washington 25, D. C.

DEAR SENATOR PURTELL: I have read with deep interest a mental-health program which you have proposed.

I believe it is sound, sane, and attainable. I shall watch its development with continued and special attention.

Sincerely yours,

D. P. GRIFFIN, M. D.

[Press release]

COMMISSION ON ORGANIZATION OF THE
EXECUTIVE BRANCH OF THE GOVERNMENT,
March 7, 1955.

WASHINGTON, March 7.—With more than half of the hospital beds in this country devoted to care of the mentally ill, about 250,000 new patients will have their first admission to such hospitals this year, according to figures made public today by the Commission on Organization of the Executive Branch of the Government.

At the present rate of illness, 1 in every 12 children born in this country will spend some time in a mental institution and the number of prolonged-care patients is steadily increasing at the rate of 10,000 a year.

These figures are contained in a special report on mental illness prepared under the direction of Dr. Francis J. Braceland, of Hartford, Conn., a member of the Commission's Task Force on Medical Services. Dr. Braceland is psychiatrist in chief of the Institute of Living at Hartford, clinical professor of psychiatry at Yale University, and former president of the American Board of Psychiatry and Neurology.

The report was the basis of the recommendation for additional attention to this phase of health care made to the Congress last week by the Commission

through its chairman, former President Herbert Hoover, as part of its recommendations for more efficient medical services in Government.

In line with Dr. Braceland's findings the Commission urged that the Advisory Council of Health which it proposed, study means of establishing cooperative planning among Federal agencies providing psychiatric care, and that the military services and the Veterans' Administration give greater emphasis to preventive psychiatric services. It also recommended that the Federal Government, through the Public Health Service, encourage wider research and training of psychiatrists and workers in allied fields.

The growing needs in this field are cited in the special study, and are reported to be largely the result of population growth and the larger proportion of older people rather than any upsurge in the rate of ailments of the mind. The survey stresses the need of recruitment and training of psychiatric specialists to cope with a problem which already is costing the taxpayers $1 billion a year without counting the "incalculable" losses in manpower.

It points out that most of the 650,000 prolonged-care psychiatric patients are being treated in State and Federal tax-supported mental institutions. It calls mental illness the greatest single problem in the Nation's health picture.

Although the study explains that exact figures cannot be compiled, it says that medical health surveys suggest that as many as 9 million persons, almost 6 percent of the population, suffer from some form of mental disorder. About 10 percent of these, or slightly less than 900,000, are considered in need of hospital care.

The most serious bottleneck in the way of proper care for all these cases, according to Dr. Braceland and his aides, is the lack of trained personnel—physicians, nurses, and other properly equipped professional and auxiliary workers.

The study cites a statistical survey by the National Institute of Mental Health which shows that in 1950 the need for full-time physicians in State mental institutions of the country was only "about half met," with one State having no psychiatrists at all. These State institutions, it says, also had fewer than 24 percent of the needed number of graduate nurses, 23 percent of the desired number of psychiatric social workers and fewer than 74 percent of the required number of attendants.

Although the medical health personnel situation has improved somewhat in recent years, it adds, shortages in this field continue "not only to hamper efforts to improve general conditions, but also to restrict efforts to discover new methods of treatment and even to prevent the wide application of known therapeutic procedures."

It is only within the past quarter of a century that an appreciable number of psychiatrists has entered private practice, the survey says. More than 4,000 now are active in this work privately. The chief need for private practitioners in this specialized field today exists in cities of fewer than 100,000 population.

State care accounts for about 85 percent of the patient load in mental hospitals, and about 70 percent of expenditures nationally. Second largest share of the burden is being carried by the Veterans' Administration, which at the end of the fiscal year 1953 had 35 predominantly psychiatric hospitals with 51,000 operating beds and 5,600 additional beds for psychiatric patients in its general and surgical hospitals.

Dr. Braceland indicates the main reasons for the personnel shortage. Lengthy and expensive training is one of the causes. A physician now must serve 2 years in the armed services, and the addition of 5 years of training and experience for psychiatric practice to his already long general medical preparation delays his advent into practice until he is in his middle thirties. Because of overcrowding in the hospitals, the workload is unusually heavy, he says, the pay often is inadequate, and job location frequently is in an isolated area, and "the whole picture is overwhelming."

"Although it is evident that the personnel situation is bad now," his report comments, "it has been kept from becoming even more serious by reason of the farsighted training program of the Veterans' Administration and the training stipends made possible under the National Mental Health Act."

The report notes that gratifying progress has been made, largely through basic and clinical research, in the handling of certain types of mental disease. Paresis, an organic disease of the brain due to syphilis, is being conquered. Formerly 10 percent of all persons with syphilis became victims of paresis; today, as a result of new therapeutic methods, fewer than 3 percent of patients who are adequately treated develop this illness, and the investigators make the happy

prediction that "it is not unlikely that this disease can be wiped out in this generation."

Research also has conquered pellagra, with its attendant mental ills. At one time it was estimated that 10 percent of patients in mental hospitals in the southern part of the country were there as a result of pellagra. With the discovery that this was a vitamin-deficiency disease caused by lack of nicotinic acid in the diet, it became responsive to treatment and is now readily preventable, the report points out.

Medical gains also are noted in other directions. The agitated depressions of middle life have responded dramatically to electric shock therapy, as have depressive illnesses in general. As late as the 1930's schizophrenia had a "spontaneous recovery" rate of only 15 to 20 percent; today 40 to 60 percent of such patients can be helped by modern treatment.

New methods also are bringing epilepsy under control. That illness a few decades ago contributed a number of patients to mental institutions.

The studies give recognition to the fact that senility often is accompanied by mental infirmities and disorders.

"There is an urgent need for research in the prevention and treatment of the mental diseases of elderly persons," the report explains. "It avails us little if the miracles of modern medicine spare the population for a longer life span if we are to end ingloriously with senile psychoses.

"It is becoming increasingly evident that the psychoses of the older age groups have psychological and social components which may be of as much or even more importance than the physiological and pathological factors.

"Loss of status and position, economic and emotional dependence, lack of useful occupation, and a feeling of being no longer worthwhile, all take their tolls in persons who are dependent in later years.

"Research directed at these various components of the illness, and treatment aimed at the alleviation of distressing conditions will not only bear fruit from a humanitarian standpoint but will salvage a number of people who otherwise would become wards of the Government."

A survey covering resident mental patients in 6 States showed that while in 1939 only 14 percent were 65 years of age, or older, by 1950 the number in this upper-age bracket had risen to 25 percent.

Dr. Braceland's report shows that although there is little difference regionally in the incidence of mental disease, the ratio of mental hospital patients to population varies widely in the States, from about 2 per 1,000 in New Mexico to 6 per 1,000 in New York. Although marked strides have been made, it says, in the rate at which patients are discharged, this gain has been more than offset by the higher number of admissions and the fact that mental cases now have longer life spans.

The rolls of the mental hospitals, the study found, give only a partial picture of the problem. The figures do not include the large number of persons suffering from mental disorders and kept at home or in sanitaria, nursing homes, and general hospitals whose patients are not included in the psychiatric hospital statistics.

Research also has brought progress in the field of psychosomatic medicine and has inspired a new recognition of the importance of emotional factors in many diseases formerly considered to be of obscure origin.

Asthma, colitis, gastric and duodenal ulcers, hypertension, and other ailments, some of which have become associated with the pace of life today, Dr. Braceland asserts, now are clearly recognized as having emotional components which must be recognized and treated if the illness itself is to be overcome.

The importance of this factor is emphasized by the report, which cites estimates that between 50 and 70 percent of the patients coming to physicians' offices today have sicknesses with emotional angles.

"It is only by means of continued research," Dr. Braceland concludes, "that any one of these serious psychiatric problems will be met, and research requires trained personnel and sufficient funds with which to accomplish it."

Community health services have been found to have a vital responsibility for recognition of mental illness at its inception and by scientific vigilance to get or give treatment for the patient before commitment is necessary or before tragedy occurs.

Chairman HILL. Dr. Blain, you are the Medical Director of the American Psychiatric Association?

Dr. BLAIN. Yes, sir.

Chairman HILL. You have been with our subcommittee before. We are delighted to have you here today. We appreciate your coming. We would be glad to have you proceed in your own way, please, sir.

STATEMENT OF DR. DANIEL BLAIN, MEDICAL DIRECTOR, AMERICAN PSYCHIATRIC ASSOCIATION, WASHINGTON, D. C.

Dr. BLAIN. Mr. Chairman and gentlemen of the subcommittee, I would like to say that I consider it a great compliment to the whole field of mental health that we have here the full subcommittee. I think it is really a most remarkable thing that all of you have this much interest. That is one of the reasons why progress is going to be made in the future as well as it has been in recent years.

I am a physician, 55 years of age, specialized in the practice of psychiatry. I have had experience as a private practitioner and as a mental hospital administrator. In World War II, I was a United States Public Health Service officer in charge of treating psychiatric casualties in the United States merchant marine. In 1946 I took over direction of the neuropsychiatric program of the Veterans' Administration. In 1948 I became medical director of the American Psychiatric Association, which has nearly 8,500 members, and which is the leading professional society for psychiatrists of the United States and Canada. I am also a consultant to the Veterans' Administration Department of Medicine and Surgery and a member of the Experts Committee of the World Health Organization.

Before going into my written comments on Joint Resolution 46 and S. 724, I would like to pick up something that was brought out in the committee earlier because I have this opportunity to speak to you and I may have the opportunity later, and that is on the general subject of research.

Now, research is something that we have all been talking about for some time. We all recognize that much has to be done in that field. There are many different kinds of research: there is administrative research, research in interpersonal relations, basic research in the fundamental physiology and growth and development of people, and in all of the basic sciencies.

Now, it is my feeling that one of the reasons that we have not made further progress is that the research that has gone on in the past has been in a very small way conducted in some medical institutions, medical schools, and that whereas this has been noteworthy in many respects, by and large it has not been carried out in the places where the mentally sick patients are. In other words, in the large mental hospitals.

Now, we talk about personnel and recruiting. We know perfectly well and we can demonstrate it with an example of what has happened to the Veterans' Administration since 1946, and that is, that where you have research and training going on in a hospital you can get staff to work there.

Furthermore, there are a few important jobs going on in research now in some of the public mental hospitals, for example at Worcester, Mass., and at the Elgin State Hospital in Illinois, and at Rockland State Hospital in New York State. But by and large there is very little real research going on and when we talk about this bill, which is

Senate Bill No. 849, I want to call your attention to the fact that it provides something which no other bill at the moment provides for.

As I understand it, the medical school construction bill, S. 1323, provides for construction of various types in medical schools but it does not include the hospitals which are not actually part of the medical school. That is, to me, an extremely important thing.

Actually, I have seen, in one hospital, out in Minnesota, where the superintendent used to go down and open his ice box and take out some eggs where he was studying chick embryos with regard to certain very specific things. He did it in a little old basement where he had no place to work whatever. There are a lot of people who want to do research. I am telling you that most of them have no opportunity. You can get more people to go into these institutions immediately if you provide for them laboratories for research. A laboratory for research does not have to be limited to test-tube operations. It will be the headquarters and center of all types of studies which will go on in that institution. Nearly all doctors have an opporunity, no matter how busy they are, and will take advantage of an opportunity to spend a little time in a laboratory. I am sure they will find the time to do it, and furthermore they will grow as doctors from the time they get into the State institution, instead of staying out and deteriorating as some of them do over a period of 10, 20, or 30 years because they have so little opportunity to do a decent medical job.

There may be other reasons why we should have this legislation, but in the field of mental illness, we are in a much worse position than all of the other specialties. The cancer field has had wonderful public support—deservedly so. But we have not had any large sums of money to put into research in the field of mental illness. There are no public funds like that being collected for our specialty.

I would urge strongly that this bill, research construction bill, Senate 849, be given every possible support by all of those people who are really seriously interested in the welfare of the mentally ill people. I do not see any reason why it should not be very strongly supported.

Now, with regard to Joint Resolution 46 and Senate bill 724, I would like to comment briefly on these two legislative proposals: 46 which provides for a national study on mental illness to be carried out by nongovernmental agencies and organizations; and S. 724 which would establish a Presidential commission to study the problem on a similar scale. There are, of course, several differences in the two bills, but the overall purposes of both are similar.

Let me say, gentlemen, that it has been thrilling to me and to my colleagues in psychiatry to witness the constructive concern of the Senate with the awesome problem of mental illness as it is reflected in these two bills. I should like to express my deep gratitude to Senator Hill and his 29 colleagues who have already indicated their bipartisan sponsorship of Joint Resolution 46——

Chairman HILL. May I say that it is now 31? We have two recruits.

Dr. BLAIN. That is fine. May I also express my deep appreciation to Senator Purtell who introduced S. 724, for certainly the kind of a nationwide study envisaged by these bills may, in the words of the House Committee on Interstate and Foreign Commerce—

Initiate another still better phase in modern psychiatry just as the National Mental Health Act of 1946 opened a new phase in the war against mental illness.

As I have explained to Senator Purtell, however, and without any prejudice whatsoever to the objectives of S. 724, we in the medical profession and the psychiatric specialties are most strongly of the conviction that the study envisaged should be carried out by a nongovernmental agency or organization as provided for in Joint Resolution 46. That is, we believe that the findings of a study carried out by professional organizations and agencies who are on the firing line from day to day in trying to improve the lot of the mentally ill, will find far greater acceptance and have greater impact on the American people than would be true if the study were exclusively a Government enterprise. Also, I have a special interest in this bill, because its provisions closely reflect the thinking of leaders in my own American Psychiatric Association and of the Council on Mental Health of the American Medical Association, with which we work closely.

It was our own Dr. Kenneth E. Appel, president of our association in 1953–54, who first started talking some 2 years ago about the need for a Flexner-type report on how we treat the mentally ill. His reference, of course, was to the famous Flexner report on medical schools in 1910, which was so largely responsible for raising the standards of medical education to the high levels that prevail today. In Dr. Appel's own words, he says:

> Planning on a nationwide, long-term scale is essential. A commission should be established to study current conditions and develop a national mental-health program. Patchwork, stopgap programs are keeping us on a treadmill and actually doing little or nothing to reduce and prevent mental illness. We resign ourselves to needless suffering and to the waste of money and human resources, instead of taking action. Mental illness is not a parochial problem. It must be attacked on a national scale. Psychiatrists should be leaders in this attack. We can contribute much in experience and insights. We should enlist the collaboration of all other professional groups that are concerned with the medical and social aspects of mental illness and mental health.

Senate Joint Resolution 46 would authorize the Surgeon General to make grants totaling a million and a quarter dollars over 3 years to a nongovernmental agency, organization, or commission composed of representatives of leading national medical and other professional associations active in the field of mental health, to carry out a program of research into and study of our resources, methods, and practices for diagnosing, treating, caring for, and rehabilitating the mentally ill.

Such an amount of money is probably only about half of what it will take to do the job that is contemplated. It is envisaged, therefore, that the remainder of the financial support needed will be obtained from private foundations; and, of course, the participating professional organizations will themselves contribute materially to the study by way of supplying expert personnel and facilities. I haven't the slightest doubt but that such support from private sources will be forthcoming, and I personally prefer it this way, for it emphasizes that this is not exclusively a Government project, but rather one in which the Federal Government will be a partner with private foundations and professional groups.

I would like to add here that we in the field of mental illness are in a somewhat peculiar position with regard to the whole health field. Since the first State hospital in this country was opened in Virginia in 1773 we have tended to rely more and more on tax-supported, or tax-raised money, particularly State hospital programs. We have let

them do the job. The results are before you. There is an accumulation of untreated patients. There are situations in the various States which are heart-rending, the kind which the leaders in those States would like to improve. But the burden becomes ever more serious as new patients pour into the hospitals every day to join the accumulated patient load which has built up over the years.

It is my own opinion that these ups and downs in public support, which Senator Purtell referred to, is partly due to the fact that the citizens themselves have been essentially lethargic. Their own organizations have not seen fit to go into this matter too much. They have not accepted very much of the responsibility—always let the Government do it, let the State government do it.

Now we see the Federal Government coming into the picture with tremendous assistance.

My own feeling is that Federal Government in Resolution 46 provides very properly for initiative, for assistance, for stimulation, if you like; but in my own opinion the operation contemplated had better be carried out by citizens themselves, because they have got to accept that responsibility from the beginning and they are the ones that are going to carry it on successfully if anybody does.

It is quite a thing, actually. We all know that if we don't take advantage, we professional people, we will say, of the present opportunity due to the present surge of interest of the people and of the governors and of the Congress, if something is not done now and done in the very best possible way, 95 percent perfect, if you like, instead of 85 percent, frankly we may lose our opportunity and have a tremendous reaction in the other direction in the next 10 years.

So, we look upon this as a very serious matter.

We feel unless the responsibility is placed squarely on the professionals in the country, both professionals and nonprofessionals, the medical and the nonmedical, that this thing will have less opportunity in the future than it would under the auspices that Senator Purtell recommends.

Senator PURTELL. Would you permit an interruption at that point?

You speak about the Government doing it. Actually, you have the Surgeon General who, under one of the bills, is authorized by the recommendation of the National Advisory Mental Health Council to make grants to State and local agencies, universities, laboratories, and other public or private agencies and institutions, and to individuals for such investigations, experiments, demonstrations, studies, and research projects in the field of public health.

Now, that may be one agency; it may exclude many. It may include some. But it might well build up resentment on the part of some agencies. It might even be that there are some agencies who feel that this might be one way of excluding them.

Now, as to the Government injection in this thing, what could be simpler than where we say that this shall be a Presidential commission composed of what type of people? Members of the Commission shall be eminent representatives of the field of psychiatry, mental-hospital administration, medical education, physical medicine, and rehabilitation, and allied mental-health fields.

It would seem to me that if the fear is Government interference, there is no more reason for thinking that you will have less of it under

the Surgeon General than you would under this independent Presidential commission.

Dr. BLAIN. If I might reply, not in opposition, entirely, to you, sir.

Senator PURTELL. I think we are trying to find an answer to the problem.

Dr. BLAIN. It is a question of doing it well or doing it better in another way.

Senator PURTELL. That's right.

Dr. BLAIN. I believe there is more to it than the question of the authority that the Government might have. There is the matter of throwing responsibility on to the professional groups and insisting that they take it up and do the job. I don't think there is need to fear that anybody will be left out because Senate Joint Resolution 46 provides, very properly, I think, that the Surgeon General shall be guided by the Advisory Council on Mental Health as to which "organization," as defined in the bill, shall be given this privilege of doing it, and they will undoubtedly see to it that it is properly representative. I would think so.

Senator PURTELL. May I call your attention to your testimony on page 3? You refer to Dr. Appel and you talk about the Flexner-type report. Let me quote your quote. You say:

> Planning on a nationwide, long-term scale is essential. A commission should be established to study current conditions and develop a national mental-health program. Patchwork, stopgap programs are keeping us on a treadmill and actually doing little or nothing to reduce and prevent mental illness. We resign ourselves to needless suffering and to the waste of money and human resources, instead of taking action. Mental illness is not a parochial problem. It must be attacked on a national scale. Psychiatrists should be leaders in this attack. We can contribute much in experience and insights. We should enlist the collaboration of all other professional groups that are concerned with the medical and social aspects of mental illness and mental health.

Now, as to a national mental-health program, if you subscribe to that, you haven't any such plan in Senate Joint Resolution 46 for developing a national mental-health program. It simply calls for the gathering of this information and you are not going to do anything about it when you get the information unless you provide for what you say you want here, Doctor.

You say you want a commission that would be established to study current conditions and develop a national mental-health program. Just finding out what the problem is, Doctor, is not our problem today; it is only part of it.

Would you, therefore, Doctor, like to see some provision made so that when the study is completed we would then have whichever organization might do it, as part of their duties, the programing on a national basis?

Dr. BLAIN. I think, sir, that the facts will have to speak for themselves. Exactly how this would develop, I don't know that I would be able to say just now.

I am thoroughly reminded of the fact that the States have certain private responsibilities individually. Just how we could say right now they should be brought together and sort of molded together in a national plan, I would not be able to say how it could be done. I would say, let's let the facts speak for themselves. Let us bring it out in the best possible way. Then anything that is best I would hope would occur.

Senator PURTELL. In other words, you feel that this planning on a nationwide basis, long-term, is essential. And you said in this quote:

> We should enlist the collaboration of all other professional groups that are concerned with the medical and social aspects of mental illness and mental health.

He expresses apparently there, I gather, not only the need for a study, but more importantly, it seems to me, the development of a national mental-health program. You subscribe to the idea of a national mental-health program, Doctor?

Dr. BLAIN. Yes, sir; and I think it should develop.

A national program really refers to the fact that a national concerted effort should be made by all the 48 States and Territories. They need to come together to look at the situation and then themselves, perhaps with the Federal Government create a national program.

However, when we speak of a national program, I do not think we have in mind a detailed blueprint for everyone to follow in exact detail, but rather to focus on the major problems and all possible ways of aproaching solutions. For example, we now say that the most important single problem is the personnel problem. Now, that problem cannot be settled in any single State. Why? Because it is a matter of the total pool of personnel. It is a matter of the number of people available and other things that you brought out this morning, and I might say I have some ideas concerning that and I don't know that we will have time to go into it.

Some States are extremely successful in adding 30, 50, and 75 percent to the number of psychiatrists they have, and I can name you those. Nevertheless, that is always done at the expense of some other State, as you can understand; there is no other way out.

So we must find out what is the reason, or what are the reasons which are behind this general need and shortage. There are many ways in which that has to develop. Perhaps I ought to indicate one or two of these things concerning this personnel situation.

By and large, if one looks at it from the bottom up, in a sense, and this is in terms of the total job to be done, we realize that the people in contact with the patients primarily are those in the attendant and psychiatric aid group—below them, even, there is a large mass of public people who form the bottom of a very important pyramid because the wider the base the stronger the pyramid. They are the volunteers and the other people in the communities that must be brought in.

As one goes up higher, you get in the realm of a rarified atmosphere of the people who have the most training, whether in research or psychiatry or what not.

We have got, therefore, to determine ways and means of doing better with what we have now. That is one of the primary things. So we may be able to catch up on the lag between what we now know and the delivery of that knowledge to the benefit of the patients themselves.

Along with it there is a matter of finding out what the doctor can legitimately turn over and delegate to someone below him in this pyramid, so that he can have his time for other things, and therefore not so many doctors might be needed as we now think.

Chairman HILL. That has not been definitely determined, has it?

Dr. BLAIN. No, sir. That has not been determined. We need to study that very much in the light of new treatment methods.

Well, sir, there are other things that one could say about personnel, but perhaps this is not the time to go into that.

As for the need for this survey, the bill speaks eloquently itself. It declares that there is no overall integrated body of knowledge concerning all aspects of the present status of our resources, methods, and practices for diagnosing, treating, caring for, and rehabilitating the mentally ill, and that only through the development of such a body of knowledge can the people of the United States ascertain the true nature of this staggering problem and develop more effective plans to meet it.

I have said that many fine things are happening in psychiatry. I know about them because of my extensive travels and contacts. Anyone can read about some of them in selected scientific journals. My office in the American Psychiatric Association has accumulated a vast amount of valuable though unintegrated, data. Surveys have been made in several States—many of them very worthwhile. Thousands of annual reports of mental hospitals are published in a few copies and stashed away to gather dust. Excellent studies have been issued by the World Health Organization but are virtually unknown in this country.

I would like to state that in connection with surveys we have made in several States that we have a list of some 16 types of subjects which we have been going into. These are examples of the kind of things that such a national survey might conceivably be interested in. I would imagine that this would all be included as well as other background material:

We have on our list demographic, economic, social, and related data concerning the people of the State in its various areas and regions; State government, organization, functions and interrelations, and correlation with private facilities in various parts of the country; the history and trends of the mental health activities in the various parts of the country, both the Federal, State, and private organizations; trends in the numbers of persons treated and cost of operations; trends in professional salaries and wages; problems of recruitment; comparisons with other States, and so on; then a very careful examination of existing facilities, in which we bring together the various studies that have been made and bring them all up to date; we study the patient load with reference to classification, psychiatric and socioeconomic problems, referral sources, geographic origin, length of stay, followup practices, readmissions, etc., personnel; needs in all categories including physicians, psychiatrists, clinical people, nurses, social workers, physical recreation, and so on; training and research; prevention and public education, including prevention in the field of various crises in the patients' lives, such as puberty, adulthood, marriage, and the job, the approach toward middle age, and death (those are enormous areas for preventive work in our field but they have not been organized thoroughly); functions of other State agencies outside of the Department of Mental Health; the costs of public mental programs, as well as private; mental health legislation with regard to all of the various legal aspects of mental illness and mental defectives; public health including the veterans' program; special problems, such as alcoholism, aging, and so on.

Now, those are the kinds of subjects that we feel would justify a type of study on a national scale.

I can say, without fear of contradiction from any of my colleagues, that there is no central, integrated, organized body of knowledge in this field. This is partly because of past indifference to mental illness, and partly because it has been left to each State to handle its own problems. Accordingly, there is a desperate and a very practical need to pull all of this information together, to summarize it, to sift the wheat from the chaff, and to make it available for the edification of all.

A basic assumption underlying the proposal is that out of such a survey will evolve some fundamental new departures from our traditional concepts and methods of dealing with mental illness, and that it will lead to a far more effective attack on the problem than has thus far been realized.

We are hoping that we will come across some new concepts. We will look into the new ideas that have been mentioned which are going abroad. Dr. Bartemeier mentioned in England and in various other countries and specifically some of the things going on in our own country. This will include what is being learned with regard to architecture, for example, of mental hospitals and our organization has had a very large grant of $155,000 just to study mental-hospital architecture. That has to be thrown into it. In the East, they are copying the mistakes of the West because they did not know that what had been tried in the West was a failure.

There is a crying need to reexamine our basic assumptions in the field, to see what actually takes place in hospitals with high discharge rates as compared with others with low discharge rates; to assess the factors which account for the tragic lag between the development of psychiatric knowledge and its application in the public mental hospitals; to determine the extent to which community services pay off in keeping people out of mental hospitals; to discover the most effective ways of utilizing present personnel; to find out more about the epidemiology of mental illness; to discover why it is that young professional students resist entering the field of mental illness; to find out exactly what our personnel needs are; to review our whole statistical system for gathering data on mental illness; to assess the contribution that psychiatry can make to the various social ills in which mental illness is a component such as alcoholism, drug addiction, juvenile delinquency and crime, broken homes, school failure, misfits in industry, accident proneness on the highway, suicides, and so on.

It should be pointed out that when the counterpart of this bill in the House, Joint Resolution 230 was considered by the House Committee on Interstate and Foreign Commerce earlier this month, it was felt that the original language should be clarified to make it clear that responsibility for the development of a coordinated program should belong to the prospective grantee and not to the Surgeon General of the Public Health Service. Accordingly, a clean bill, House Joint Resolution 256 was drafted to accomplish this and reported favorably to the House. I would like to state that the wording as now contained in House Joint Resolution 256 is entirely satisfactory.

Senator LEHMAN. It makes the intent clearer. It does not change the intent, as I understand it. Therefore, there is no reason why there should be any objection to the language.

Dr. BLAIN. In conclusion, gentlemen, let me say that the favorable action of the Congress on Joint Resolution 46 will carry all of us a long way on the road to answering the perplexing questions that confront us whenever we are called upon to do something about the mental-illness problem. Until we have accomplished this basic step, it is difficult for me to see how the American people are going to launch a bold attack on this great problem with a confident sense of direction.

There is also before the Senate, title VI of the omnibus bill, S. 886, which would authorize the Surgeon General to make allotments to the several States to expand public-health services in the field of mental health, including the cost of training personnel for State and local mental-health work. This seems to be a most useful proposal and one that is essentially in line with the Federal Government's policy of lending financial encouragement to the States in developing community mental-health services.

These same proposed amendments would also authorize the Surgeon General to make special grants to the States for the development and establishment of improved methods of operation and administration of mental institutions. This suggests a somewhat new emphasis in Federal policy, since it relates directly to mental hospitals, the operation of which is traditionally a responsibility of the State governments.

I think, however, that the proposal is a most useful and appropriate one for the Federal Government to undertake, for in essence it is a proposal to subsidize administrative research and experimentation. Experimentation and research in the methods of operation and administration of institutions is quite as urgently needed and can prove just as fruitful as research in any other field. The findings of such experimentation will be of nationwide value.

This is an area in which the Federal Government can be a good partner to the States in our overall national effort. It is my observation that the States themselves, saddled as they are with the burden of sustaining the operating costs of mental hospitals year in and year out, are understandably hesitant to appropriate funds for the types of pilot plans and experimental projects which could be initiated under this amendment.

I would like to suggest, however, that the wording of the amendment appears to me to be unnecessarily restrictive, by limiting the experimentation contemplated to the methods of operation and administration within institutions. I think the amendment would be strengthened if it were worded approximately as follows:

SEC. 304. (a) There are hereby authorized to be appropriated for the fiscal year ending June 30, 1956, and for each of the four succeeding fiscal years, such sums as the Congress may determine, to enable the Surgeon General to carry out the provisions of clause (2) of section 303 (a) with respect to development of improved methods of care, treatment, and rehabilitation of the mentally ill, including grants to State agencies responsible for care, or care and treatment, of mentally ill persons for developing and establishing improved methods of operation and administration of the institutions, *and community facilities which will foster better coordination between the hospital and the community in carrying out a total treatment program for the mentally ill.*

I am referring to the last part of title VI where he proposes in section 303 (a) to provide some moneys for appropriation to State institu-

tions and others for the development of studies in administration and methods of operation.

I want to suggest to you, sir, that this might be broadened a little because not only the methods of administration of hospitals are important, but also the methods of administration of something like a mental health center, and the whole matter of organizing private and governmental Federal and State resources, and the development of other types of institutions which might be in the country, in the community, or adjacent to an institution but not actually part of it.

So we would like to make the suggestion as contained in my notes that the wording toward the end of section 304 (a) be changed somewhat and be as follows, beginning with section 304 (a), and the following added:

and community facilities which will foster better coordination between the hospital and the community in carrying out a total treatment program for the mentally ill.

It would broaden the matter slightly so it would not be limited entirely to institutions for mentally ill in State hospitals but would give the opportunity to the Public Health Service to develop this.

What I have in mind here are experimental and pilot projects with adjunctive and modified types of hospital and community facilities which may be demonstrated to be effective in forestalling, preventing, or shortening hospitalization. Such facilities are variously called branch hospitals for the aged, day hospitals, night hospitals, halfway house, mental health centers, rehabilitation centers, and the like.

I would like to elaborate that slightly, sir. The concept of branch hospital for the aged has been used in a number of places. It looks to some of us as if it is probably the best answer to take care of large numbers of very old patients in our mental hospitals who I would say say do not belong there, for they do belong in a hospital under medical care, but they belong in a simpler type of regime. Therefore, a branch of that hospital, administratively under the same head, but perhaps located 5, 10, or 20 miles away, would make it possible for these old patients, if they suddenly get very ill, to be brought back to the other hospital without delay. But both would operate under the same administrative setup in the State.

You can understand that one of these, if it were under a Department of Welfare and another under a Department of Mental Hospitals, and those two happen to be under different divisions, it is not easy, as I discovered in the State of New York, to get people transferred from one institution to another in order to take care of them.

Now, if you can have a simple form of regime, making it administratively possible to bring those patients back as soon as they need it, then you can operate without neglecting the patient and not allowing the possibility of a chronic institution to develop into a poorhouse. That is a thing that we doctors are interested in. We do not believe that we can, as much as we would like to, reduce the mental hospital load by saying a lot of people do not belong here at all. Frankly, most of them belong in some sort of medical regime.

Senator PURTELL. It is interesting to note that the provisions were made last year in legislation passed. There are criteria. Do you subscribe to our thinking that where that type of facility is needed—I am not talking now about the administration of it—but will you

agree or do you feel, rather, that that type of facility can be built at lesser cost and therefore we can perhaps provide more of it with the same number of dollars?

Dr. BLAIN. No question about it. I can tell you two places in Canada where it is being done. I am sorry I have to go to Canada to illustrate it but in the Province of Alberta, they moved several of these patients out from the State hospital and took them down 100 miles away and put them under one registered nurse and a number of very fine motherly practical nurses. There were no psychiatrists, but several general practitioners were in the area.

The result has been that those people have over a period of 6 months, the first 6 months—this will illustrate that they obviously were better off—under the same diet as they had in the mental hospital and for the same expense for food, you understand, gained on an average of 15 pounds each.

Now, that is a physical testimony to the fact that they were obviously more contented; they were getting along better. It has worked beautifully.

That is a major source of hope for the future. I wish we had a chance to demonstrate that in 1 or 2 places in this country and get some of the money for construction of such facility.

In the Province of British Columbia I visited two places quite close by where they have done exactly the same thing. They call them HA—Homes for the Aged—but they are under the administration of a nearby mental hospital.

Senator PURTELL. A wonderful suggestion. It is possible, incidentally, under our present legislation, to do it if we stress the fact that it ought to be done.

Dr. BLAIN. Yes; I think the Hill-Burton mechanism is available for that right now, if you want it to be done. It is largely a matter of experimenting and demonstrating what can be done.

The mental-health centers which I mentioned here is a product of the World Health Organization. That was developed in their report in 1953, I guess it was, and it is somewhat like some of our diagnostic health centers in this country, but there has been no elaboration of its organization in this country as yet. It provides primarily for the organization on a voluntary basis of all the health facilities in our field, sometimes associated with the public-health center, if it is proper and suitable, or otherwise maybe it is on its own. It doesn't matter, but it provides an opportunity to bring in private practicing doctors, public-health nurses, the local general hospital, outpatient clinics, and the nearby hospital which may not be very near but nevertheless is brought into the whole organization as an administrative unit.

Now, the State could operate the administrative unit, if they wanted to, or it could be a local agency. But in any case, this is one of the ways in which there is some hope for building up the community side of this whole problem. It is a very specific and practical way of doing it.

I might say it does exist in the place that Dr. Bartemeier mentioned this morning over in Croydon, England. There is one there going on. Ours would have to be somewhat different because they have complete control of all health in that country. We have to get voluntary cooperation between all of our different——

Senator PURTELL. In the history I submitted this morning, you will find reference to that English setup.

Dr. BLAIN. Let me say also that I am very much impressed with the language of Senate bill 848 which in many respects more adequately provides for the kind of experimentation I refer to above than does title VI of the omnibus bill. Indeed, I think it would serve most usefully if some of the broader language of S. 848 could be incorporated into title VI.

In concluding my comments about title VI and S. 848, I should like to emphasize the point that shortage of personnel in all categories in our field is the greatest single handicap to progress. We have to approach the problem in two basic ways: (1) We must train and recruit more personnel as rapidly as we can; (2) we must make more effective use of the personnel we have.

It is in connection with the second alternative that these proposed amendments will serve usefully. There is no doubt in my mind that through administrative experimentation we can discover ways of using our present personnel more efficiently. It is my observation in my travels that highly trained key personnel in the hospitals are performing functions and duties which they would like to delegate to less highly trained personnel if a method for doing so could be worked out. There is a tendency to confuse the role of top-level leadership on the one hand with operational and technical performance on the other. Hospital administration is hampered by traditional and rigid conceptions of personnel policies. I am certain that administrative experimentation will show ways of breaking through these barriers, thereby releasing more personnel time for the benefit of the patients.

Gentlemen, in closing my comments today, I want to stress my personal conviction—and I cannot stress it too vigorously—that now is the time to strike at mental illness and strike hard. For it seems to me that it is only when there is an atmosphere of realistic optimism about our capacity to cope with a major problem that we find a will to action. I think that such a time is now upon us with reference to mental illness.

The despair that consigned the mentally ill to simple custody for life in mental institutions is rapidly being displaced by the realization that mental illness is not hopeless and that the great majority of the mentally ill can be treated and returned to the community in a relatively short period of time provided they are seen early.

The Governors of the States have reflected this new spirit, by making clear their determination, by work and by action, that improving the treatment and care of the mentally ill is one of their major concerns.

By supporting enormous capital investment in new mental hospital construction, the American people have demonstrated their growing understanding of the economic and social cost of mental illness, and their willingness to sacrifice to overcome it.

The Federal Government by supporting a program of neuropsychiatric care "second to none" in the Veterans' Administration, and by implementing year after year the letter and spirit of the National Mental Health Act of 1946, and in other ways, has demonstrated its willingness to be a partner with the States and the professions in combating mental illness on a national scale.

Dramatic advances are being made in psychiatric therapies on all fronts, and most dramatically so with the new drug therapies utilizing chlorpromazine and reserpine.

Another most auspicious change in peoples' thinking lies in the general trend toward deemphasizing the conventional mental hospital as an almost exclusive tool for dealing with mental illness. This has been in no small measure due to the wisdom of the Congress in encouraging the development of community clinic services under the National Mental Health Act and through the Veterans' Administration. Increasingly, the mental hospital is thought of as merely part of a network of community services all of them designed to forestall or prevent hospitalization if possible, and to shorten it if not.

So I say a new spirit is rampant in the field, shared by the men on the street, the governors, the legislators, the professions, and indeed, by our President himself.

I think your favorable action on Senate Joint Resolution 46 and title VI of S. 886 will go far to give effective expression to this new spirit and to help all concerned to apply themselves with renewed vigor to our common task of salvaging the lives of nearly three quarters of a million mentally ill and retarded who may be found in our mental hospitals and institutions on any day of this year 1955.

Chairman HILL. Doctor, let me ask you this question. I notice the emphasis which you put on the shortage of personnel in all categories. What a great handicap it is! Is there room in our present schools of medicine for any real increase in personnel? Senator Bender spoke about this earlier, as you recall.

Dr. BLAIN. To increase the number of graduates, the number of graduates and others to be turned out?

I would like to say that there is some danger in having a medical school increase the number of students that it takes until it is ready to do it. That is a very important professional matter. The number of new psychiatrists in this country is about 400 a year. The number of students coming from medical schools who want to go into psychiatry is increasing rapidly and last night a professor told me that in his medical school 25 percent of all the graduates want to go into psychiatry. That poses a very interesting problem which we need further facts to handle, and that is, how these people are going to be trained? Supposing in one medical school which has 130 students, something like 35 students want to enter psychiatry in 1 year. The training opportunities there may not be sufficient to handle them. The institutions which are being brought in in a small way do not have the kind of things which would encourage people to go out rotating in their training. So all of these things are a real problem, all these things we are talking about. It is a real problem as to whether we are going to have enough doctors. I am not the one to answer that. I would say that our information is not conclusive by any means. It is a matter of distribution. It is a matter of how much each doctor spends doing what with his time. Such things are extremely important.

I would like to give you an example of an extreme action that was taken in a legalistic fashion over in Japan. I was over there about a year ago for World Health Organization. The Armed Forces of this country decided they needed more doctors. So an order was issued which had the force of an Emperor's edict.

Because of the attitude of the Japanese and the power of the Allied forces, they said that every province should have a medical school and it should be opened in 30 days and sure enough they did open them in 30 days. And they had hundreds of boys and girls running around lined up as students of these medical schools. They had no laboratories, no teachers; they did not even have enough building to get in all at one time. Do you know that a large number of medical schools were founded overnight and on paper, here they were.

Since we got out of that country they are closing them up pretty fast—just like the Flexner report did in the United States back in 1910. You cannot do this by legislation and have anything accomplished overnight. So that the temptation is to say, we have got to have more medical schools. I say it has got to go in line with your development of teachers, the availability of all the things that we need. And I think that that is moving along fairly fast. Whether it is moving fast enough, I am sorry that I do not have the information. But I think it is an important point that we doctors have responsibility that we turn out people who have proper training and their 4 years medical school shall be properly used since it is an extremely expensive matter.

Chairman HILL. You said there is what?

Dr. BLAIN. I said there was a considerable increase in the number of medical students in the country; new schools are being started. I think we had testimony on this earlier this morning but I am not informed as to the exact number. I think there are many States which are planning to have schools open. I happen to know of 2 or 3. And when the time comes that they can get their proper standing, I am sure they will. That plus the tremendous problem of distribution which is again being solved by some pretty good community efforts to bring doctors from the city to the country. Those things are going to improve the matter considerably.

I do not have the answer, though, as to how many doctors we need here and there. I frankly do not. I have not a great deal of confidence in the studies made. I think they are too piecemeal, these studies which have been made here and there. I have heard it said that we need four times as many psychiatrists in the country. I do not think we need 40,000 psychiatrists, frankly. I think that we can find better ways of using their time, better ways of using the part-time services of those in private practice, and other ways of utilizing our medical knowledge. So that I would rather see the time and expense for training four times as many specialists in psychiatry put into the general medical profession, as it has already started to do. So that everyone coming out is able to assume far more of the psychiatric load than doctors used to do and furthermore that those who are already out and do not have the advantage of this training, can be given the type of postgraduate courses which are being very carefully worked out and done on a large scale in many places in the country. This is being done by cooperation between our organization, the American Psychiatric Association, and the American Medical Association.

Our association is not, frankly, committed to increasing the number of specialists, particularly. We are in a sense looking for ways and means of doing with less psychiatrists, that is, per patient, per hundred patients, per thousand patients, than there is now.

In fact, with a grant, from the Public Health Service, our association held two conferences on the subject of psychiatry and medical education, each of which cost around $60,000, which have been about the best thing that ever happened in this field. The first conference was on the place of psychiatry in undergraduate medical education and the second on postgraduate and residential training.

There is a lot being done. We look upon this proposed national study to help us to pull together an awful lot of unrelated and unknown factors that lie hidden away here and there to improve the whole situation tremendously and quickly.

Chairman HILL. Are there any other questions, gentlemen?

Senator BENDER. In closing your testimony, you emphasized the need for change in title VI.

Dr. BLAIN. I mentioned some of the language in Senator Purtell's bill.

Senator BENDER. I think you said something about the extension of community responsibility for mental health.

Dr. BLAIN. I am very much in favor of that. It stimulated local work such as nothing else which has ever happened.

Senator BENDER. One more question. Do you feel, Doctor, that special project grants for studies and demonstrations would be useful.

Dr. BLAIN. Yes, sir.

Chairman HILL. Senator Purtell, do you have a question?

Senator PURTELL. Not at this time, Mr. Chairman.

Senator LEHMAN. I just wanted to make a very brief observation and ask one question.

I want to compliment Dr. Blain on what I think is a most helpful and constructive memorandum. I am very fully in agreement with almost everything in the statement.

I think the paragraph which impressed me the most—there were many others which did—was on page 10. You said—

> The despair that consigned the mentally ill to simple custody for life in mental institutions is rapidly being displaced by the realization that mental illness is not hopeless and that the great majority of the mentally ill can be treated and returned to the community in a relatively short period of time.

The first mental hospital that I inspected was in 1928; that is 27 years ago. I shall never forget the discouragement, the shock I had, not from seeing the physical condition of the hospital, but seeing the hopelessness in the faces of the people in the hospital and the hopeless faces of the visitors, the relatives who were in the hospital.

Later, I visited, of course, frequently all of the hospitals. I know that these hospitals have improved, but the improvement with regard to treatment is pathetically slow. I think you laid your finger on another most important matter and that is the almost complete lack of laboratory and clinical facilities in the hospitals. Here we have this great reservoir of live cases that can be observed, can be treated actively and yet we have virtually no adequate facilities in any of the State hospitals to do that.

I agree with you, too, that had we that kind of facilities, we would not only be tremendously aided in determining what new methods can be used, but also in attracting personnel who want to come to the hospital but won't come unless they feel they can do scientific research work.

Just one question I want to ask after that observation of mine.

You were asked here whether there were sufficient doctors, psychiatrists. I asked the same question of the previous witness. I do not know whether we need 4 times as many as we have now or 3 times as many or twice as many as we have now. I am talking about medical men, not only medical men generally. I am convinced that our facilities, both physical and fiscal, for the training of men for the medical profession leave us with a very great gap between available supply and the number that are needed.

You said, if I understood you correctly, you would not favor necessarily training large numbers of additional people as specialists, as specifically and exclusively psychiatrists. I assume that you meant that you would like to have people trained in general medicine or surgery with some training in psychiatry. I think that is a sound proposal, but what I do not understand is how you can expect ever to get that additional supply unless you have a reservoir of medical students to draw from. Under the best of circumstances the number of additional medical students that can be trained within a reasonable time is pretty small, but we are not increasing the number to any great extent of doctors that we are turning out largely because of lack of physical facilities, equipment, and money.

Now, unless you have that reservoir of people who are going into the medical profession, not with the idea of specializing, who later may become very useful doctors in psychiatry, I don't see how you are ever going to have a material increase in the number that can be used in this highly important work.

Dr. BLAIN. It is not an easy question to answer, Senator. I don't think I have an answer. But I would like to say that there is one method, I think, of achieving your object simpler than any other which, if it can be brought about, will help and that is, double the techniques that any single doctor can use. If you will double his techniques and give him ways of treating patients which he can do quickly, new methods which we do not have, there is no reason in the world why every doctor cannot treat twice as many patients as he does now. That is easier than trying to double or triple the total number of doctors in the country. You cannot do it; it would be unsound to attempt it.

As to whether or not the present rate of progress is fast enough that I cannot answer. But this research matter, getting back to that if you like, research in methods, research in administration, research in organization, research in new methods of treating certain specific illness—frankly, there is the answer from the long-range point of view.

Senator LEHMAN. Is it not a fact that the trend today is toward specialization? In my younger days a general practitioner would diagnose and treat any disease. Today, if he feels there is attention needed to the heart, you go to a heart specialist. If you have some trouble with your intestines, you to an internal man, doctor of internal medicine. If you have any one of a dozen different diseases or symptoms you will use specialists. It seems to me that has inevitably reduced the supply of general practitioners. Certainly, in the large cities.

Dr. BLAIN. I do not know what the trend is there. I would like to know if any recent studies have been made, whether the trend is accelerating or not in the matter of specialization. It is my own feeling and I would guess that the trend in that direction has leveled off quite a good deal because the general practitioner is learning to do many more things. A lot of people found out it is a rather narrow field to get into a specialty. The age of specialization started with the discovery of certain bacteria, laboratory methods, and the development of various instruments. Then going over a period of a couple of decades, the subject matter in medicine got so broad we were not able to encompass it all in 4 years of study. So various people followed natural inclinations and started up specialization, mostly between 1933 and 1940, although a few had antedated that.

Why was it necessary to specialize so much? I think because the special knowledge at that time had not been in existence long enough to allow the general principles to be distilled out, so to speak, in a simple fashion so that the general practitioner could make use of it.

In psychiatry, we are arriving at that place where we can lay down certain fundamental principles about the handling of a patient, a lot of things which a good doctor can do in the way of handling more problems than he did before.

I have said to my own professional groups many times, that I think the trend toward specialization is leveling off. I hope it is; that these highly specialized people do the research and the training if you like, but let the practitioners be able to do all kinds of things that any one individual patient needs.

Senator LEHMAN. Thank you, Mr. Chairman.

Chairman HILL. Dr. Blain, I want again to thank you, sir, and tell you how very fine and helpful you have been here this morning and how deeply grateful we are to you for your excellent testimony.

Dr. BLAIN. It is always a pleasure and a privilege to appear before your committee, Mr. Chairman.

Chairman HILL. Thank you, sir.

Gentlemen, we have two other witnesses, Mr. Mike Gorman and Mr. Whitten.

If it is agreeable to everyone, I suggest we recess now. Can you gentlemen be with us this afternoon?

Then we will reconvene at 2:30 in room 212, in the Senate Office Building. That is the Armed Services Committee room.

(Whereupon, at 12:45 p. m. the noon recess was taken.)

AFTERNOON SESSION

The CHAIRMAN. The subcommittee will come to order. We will continue our hearings of this morning on our mental health bills.

Mr. Mike Gorman, executive director of the National Mental Health Association, Will you come around please, sir.

STATEMENT OF MIKE GORMAN, EXECUTIVE DIRECTOR, NATIONAL MENTAL HEALTH COMMITTEE

The CHAIRMAN. You may proceed in your own way, sir.
(Mr. Gorman's prepared statement follows:)

STATEMENT OF MIKE GORMAN, EXECUTIVE DIRECTOR, NATIONAL MENTAL HEALTH COMMITTEE, WASHINGTON, D. C.

(Mr. Gorman is a former newspaperman and magazine writer who has specialized in the mental health field for the past 10 years. In 1948, his book Oklahoma Attacks Its Snake Pits was condensed as a book supplement in the Reader's Digest. He has written numerous magazine articles on mental health.)

THE BIG NEEDS IN THE FIGHT AGAINST MENTAL ILLNESS

Mr. Chairman and members of the committee, I appear here today on behalf of the National Mental Health Committee, an organization dedicated primarily to the promotion of State and local efforts to prevent mental illness through research, training, and clinical services. I am proud to state that 46 State governors are honorary chairmen of our committee and we work very closely with them in many joint endeavors.

Rather than indulging in a recital of statistics about the extent of the problem, I would prefer to convey to this committee the official findings of the governors. In February 1954, the Council of State Governments held a national governors' conference on mental health in Detroit, Mich., the first conference of this kind in the history of our country.

At that conference, the governors were presented with a massive study of the cost of current mental-health programs. They were told that in 1953 mental illness cost this Nation approximately $2,500 million. Of this sum, $1,400 million was in direct costs for maintenance of mental patients and pensions for psychiatrically disabled veterans and approximately $1,100 million was the aggregate loss in earnings and loss in Federal income-tax revenue.

Even more startling, from the point of view of the chief executives of the 48 States, was documentation indicating an annual rise of 16,000 patients a year in the State mental hospital system with an annual cost increase exceeding $100 million.

In the keynote speech at the conference, Gov. G. Mennen Williams, of Michigan, pointed up the problem in these words:

"I have never been able to understand why we spent only 5 percent of our medical-research investment on mental illness, a disease which fills more than 50 percent of our hospital beds, and costs us more in taxes than all other afflictions combined.

"The 48 States, with a tax burden of half a billion dollars a year for mental illness, spend only $4 million a year on research. Small as it is, this State expenditure is more than one-half of our Nation's total mental research fund."

At the conclusion of the conference the assembled governors adopted a 10-point program which has become known as the bill of rights for the mentally ill. The key recommendation adopted by the governors states:

"Training and research in the field of mental health are essential elements of effective mental health programs. The serious accumulation of patients and costs can only be reduced by discovering new knowledge and new methods of treatment, and by more adequate training and development of mental-health personnel."

Following this historic national conference, several regional conferences were sponsored in various parts of the country.

The 16 governors belonging to the southern governors' conference unanimously adopted a resolution for a year-long study of the problem in the South. The final report, unanimously approved by the same 16 governors in October of last year, was a further dramatic demonstration of the desperate need for a wholly new approach to the problem. For example, the report pointed out that in 1949 there were 25,560 first admissions to State hospitals in the southern region, but that by 1975 the annual admission rate will be 42,000. Contrast this with the psychiatric personnel available to treat mentally ill people in the South. In 1954 there were only 795 psychiatrists in all the tax-supported mental health agencies

of the 16 Southern States. There were 257 budgeted vacancies in the State mental hospital systems and, over and above this, a need for 608 more psychiatrists to meet minimum staff standards. When to this is added the figure of the number of psychiatrists needed in private practice, the total number of psychiatrists needed in the South today is 4,260. As against this, the entire Southland will graduate only 272 psychiatrists in the next 3 years. The same situation holds for clinical psychologists, psychiatric social workers, psychiatric nurses, etc. The report concludes:

"The region must multiply its production by five to meet personnel needs within 10 to 15 years * * *. We do not have enough trained people to use the knowledge that we already have. There are people in hospitals today who could be returned to productive lives if available treatments could be given them. Many others could be released from hospitals, with savings to the State, if there were personnel to help them adjust in the community."

As to psychiatric research, the report has this to say:

"We need more knowledge. Research can pay off, sometimes in spectacular fashion. There is a long list of dreaded diseases that have been wiped out by research. Schizophrenia, now the 'hard core' of mental disease, may one day be on this list. As a result of research, the psychosis associated with pellagra, once prevalent in the South, is almost never seen in mental hospitals, and admissions to mental hospitals due to syphilis of the brain have been cut in half in the last 15 years. Hospitals for epileptics have been closed as a result of discoveries of drugs that control seizures. Comparable advances in the treatment of other mental disorders may come with increased knowledge.

"* * * Yet in spite of the magnitude of the problem, the tremendous burden it places on people, and our relative ignorance of causes, prevention and treatment, research on mental health is not getting the support it needs * * *. Nine times as much is spent per patient on polio as for research on mental illness."

On November 19, 1954, I sent out a newsletter to the governors and to 700 State legislators who are deeply interested in the work of our committee. It was an attempt to summarize the significance of the southern regional effort, and I quote the following from it:

"On July 27, 1954, I sent you a brief report on the southern regional conference on mental health training and research held in Atlanta July 21 to 24. At that time, I pointed out that 170 official delegates from 16 States had adopted a series of sweeping recommendations for a new attack upon mental illness in the South. According to Dr. Nicholas Hobbs, director of the mental-health project, these recommendations were the end result of intensive work by more than 2,000 professional and lay people in the southern area.

"Things have been moving at a breakneck speed since then. At a legislative work conference in Houston on September 16, key legislators from the Southern States not only enthusiastically endorsed the major training and research recommendations, but requested legislative participation in any organization set up to achieve the Atlanta objectives.

"The climax was reached at the southern governors' conference at Boca Raton, Fla., November 11–13. The chief executives of the 16 member States voted to establish a regional council on mental health training and research finanaced by an annual contribution of $8,000 from each participating State. The council will employ a highly qualified technical staff to further the 14 specific training and research objectives listed by the governors. The major objectives include increased State legislative appropriations for mental health research and training; regional compacts and arrangements for both the training of professional personnel and the development of regional mental health research centers; training and research fellowships, either at the State or regional level, and the organization of regional conferences to stimulate interest in mental health research and training among key legislators and citizens.

"It is also important to remember that each of the 16 Southern States has completed an exhaustive survey of its mental health research and training potential. The recommendations of these individual State survey committees call for the expenditure of additional millions of dollars in the launching of research projects and the training of increased professional personnel within State boundaries. The Atlanta conference recommended the continuance of these State research and training committees on a permanent basis, and a number of governors have already taken such action."

In the summer and fall of 1954, 10 Midwestern States—Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Nebraska, Ohio, South Dakota, and Wisconsin—held several conferences called by the governors of the midwestern area. Their

official report issued in November 1954 noted that State expenditures for mental health had increased more than 300 percent in the last 10 years. Shortages of psychiatric personnel were almost as great as in the southern region. For example, the 10 States in the midwestern survey could use immediately 1,010 additional psychiatrists; 338 additional clinical psychologists; 589 additional psychiatric social workers; 8,365 additional nurses, etc. The research findings were almost identical with those in the South. Although the Midwestern States spent $124 million for the care and treatment of 121,000 mental patients in 1953, they spent less than $2 million for research.

In the keynote address at the November 30, 1954, midwestern governors' conference held in Chicago, Gov. William G. Stratton, of Illinois, expressed the core of the problem in the Midwest in these words:

"Our conference concentrates on two very important factors in the care and treatment of the mentally ill; research and training. It is our hope and expectation that through intensified research we can develop improved methods of treatment and establish better preventive and remedial programs at the community level. We are acknowledging the need for an increase of trained research personnel to carry out such a program. While it is our hope that research will eventually provide many of the answers, we realize we must immediately take steps to obtain additional personnel to treat those patients now in our hospitals."

The other regions of the country are taking up the torch. In the Far West, 80 legislators and administrative officials met in September 1954 and voted for a survey of mental-health training and research facilities in that area. Just last week the governors and legislative representatives of the 11 Western States met in San Francisco and made final plans for the survey. In New England a regional compact on higher education has been signed by the participating chief executives. At a conference of New England mental-health officials and their colleagues from New York, Pennsylvania, Ohio, and Delaware, held last October in Hartford, Conn., proposals for regional mental-health agreements in research and training were discussed.

In testimony submitted this year to the House Appropriations Subcommittee on Labor, Health, Education, and Welfare, the National Mental Health Committee pointed out that there is an "erroneous impression that the States are not doing their share in the fight against mental illness. In addition to the activities listed above, State bond issues for mental hospital construction reached a new high in 1954. More than $500 million in construction money was approved by the voters last November; this is 35 times the amount of the present budget of the National Institute of Mental Health."

With this by way of background, I would like to discuss now the specific mental-health proposals of the Eisenhower administration and other legislation in this area.

I will not deal at great length with the administration's fiscal 1956 budget for the National Institute of Mental Health, since I have submitted a separate statement to the House Appropriations Subcommittee on Labor, Health, Education, and Welfare. However, I would like to point this out: In a Meet the Press broadcast on October 24, 1954, the Secretary of Health, Education, and Welfare said that the budgets for the research institutes are made up and recommended by the advisory councils of the various institutes. The National Mental Health Advisory Council recommended a budget of $30 million for the National Institute of Mental Health for fiscal 1956, yet the administration ignored this recommendation and proposes only $17,519,600.

There is no increase over last year's figure for grants-in-aid to research projects, and this in spite of the fact that there are research projects in all parts of the country which are being held up because of lack of financing. For example, there are two new drugs, chlorpromazine and reserpine, which have been tremendously successful in the treatment of certain types of mental illness. The Veterans' Administration and State hospitals in New York, California, Illinois, Louisiana, and Virginia have reported remarkable results with these drugs in discharging patients and even in reducing the number of psychiatric personnel needed to care for disturbed individuals. At a New York Academy of Sciences conference on the new drugs in February of this year there was impressive clinical evidence from all parts of the country indicating an important new breakthrough in the fight against mental illness. Yet there must be much more research on drugs of this kind, and there are scores of places where this could get underway if there were adequate financing.

In the March 7 issue of Time both the impact of these new drugs and the need for more research is excellently summarized in these words:

"The treatment of mental illness is in the throes of a revolution. For the first time in history, pills and injections (of two inexpensive drugs) are enabling psychiatrists to (1) nip in the bud some burgeoning outbreaks of emotional illness; (2) treat many current cases far more effectively, and (3) in some instances reverse long-standing disease so that patients can be freed from the hopeless back wards of mental hospitals where they have been 'put away' for years.

"* * * At the same time, even the most enthusiastic advocates of the drugs were at pains to emphasize that by themselves the pills and injections probably do not cure anything; in the main, they make other treatments more effective. They are not going to empty the State hospitals, and far from reducing the need for more intensive research into psychic disorders, they accentuate it and facilitate the work."

Cognizant of these facts, the report of the medical task force of the Hoover Commission described mental illness as "the greatest single problem in the Nation's health picture." While recommending a reduction of over a quarter of a billion dollars in annual Federal expenditures in the health field, the task force forthrightly recommended an additional $5 million a year for "research and training grants in psychiatry, and grants to States for community mental health programs."

As pointed out above, the administration did not raise the research grant-in-aid figure 1 cent over last year. The House, aware of the need for an expanded research program, added $250,000 to the administration figure. It is our fervent hope that the Senate will add an additional $1,250,000 to bring the research grant-in-aid program up to the minimum described in the Hoover task-force report.

The task-force report is deeply critical of the cuts in Federal aid to States and localities for the establishment of clinics and other community services designed to treat mental illness in its early stages. Pointing out that between fiscal 1950 and fiscal 1955, this program was cut by 35 percent, the task-force report states:

"Although we believe that the Federal Government should gradually reduce its grants as the States take up the load for any given health activity, we conclude that the recent reduction in Federal support has been too abrupt."

Although the administration proposes an increase of $675,000 over last year's appropriation for clinics, this falls $550,000 short of the 1950 figure. In fact, the total administration proposal is $2,825,000 short of the minimum Hoover recommendations.

Now as to title VI of S. 886, which is the administration bill for expansion of mental health services. We are gratified at the retention of the separate mental health grant-in-aid for a period of 5 years. I cannot avoid mentioning the fact that the retention of that grant is due entirely to the Congress, which a year ago amended an administration bill which would have abolished the mental health grant-in-aid. The mental health movement in this country is deeply in the debt of your committee and the Congress for this great service.

The second half of title VI refers to special projects in mental health, for which the Secretary requests new authority. The administration is to be commended for wanting to initiate special demonstration projects, but it is the feeling of the National Mental Health Committee that there is ample authority for these activities under both the National Mental Health Act of 1946 and the omnibus amendments to the Public Health Service Act passed in 1950.

It is the considered opinion of the National Mental Health Committee that there are two pieces of mental-health legislation introduced in the current Congress which would do more to further the fight against mental illness than any other proposals being suggested.

The first of these is House Joint Resolution 230 introduced by Congressman Priest. The companion resolution in the Senate, Senate Joint Resolution 46, is sponsored by 30 Senators. The resolution would provide for a limited Federal contribution to a non-Government 3-year nationwide evaluation of every aspect of the problem of mental illness. We believe there is great urgency for this kind of study, and for a fresh medical approach to mental illness. We need a long, hard look at the present State hospital systems. We need to find out why we are unable to attract into psychiatry the thousands of young people so desperately needed. We need to find out why the treatment of mental illness has somehow become isolated from the general stream of American medicine. I will not deal further with the obvious needs for this kind of study, since the American

Medical Association and the American Psychiatric Association will testify much more competently in that regard.

The National Mental Health Committee is deeply gratified with the administration's endorsement of House Joint Resolution 230. In her testimony before the House Interstate Commerce Committee, Mrs. Hobby expressed the opinion that the grant-in-aid be made to a group capable of developing a coordinated plan of study. This is an exceedingly important point. It will take a tremendous amount of unified effort to make this massive survey, and it is our considered opinion that the grant should be given to a nongovernmental body which submits an acceptable plan for a 3-year nationwide study.

The National Mental Health Committee is also deeply grateful to Senator Purtell for his introduction of S. 724, calling for a presidential commission to conduct a survey of the problem of mental illness. While our committee is in agreement with the American Medical Association and the American Psychiatric Association that greater partcipation can be secured for this study by designating a nongovernmental body to do it, it wishes to express its deep appreciation to the Senator from Connecticut for his continued interest in the mental health problem. As chairman of the Health Subcommittee during 1953 and 1954, he earned the admiration and gratitude of all of us.

In our opinion the most important mental health legislation in the Congress this year is the Medical Research Act of 1955, H. R. 3459 (Priest) and H. R. 4114 (Wolverton). The companion bill on the Senate side, S. 849, is jointly sponsored by Senators Lister Hill and Styles Bridges. It allocates up to $30 million a year for 3 years, or a maximum total of $90 million, in matching Federal moneys for research construction in the fields of heart, cancer, mental health, etc.

Since the National Institute of Mental Health was set up by law in 1946, it has not received 1 cent of research construction money. At the present time there are on file with the Institute, applications for psyciatric research construction totaling approximately $22 million from hard-pressed nonprofit foundations, medical schools, and hospitals all over the country. A year ago Dr. Jacques Gottlieb, chairman of the committee on research of the American Psychiatric Association, testified before the Congress on the desperate need for psychiatric research facilities. He presented a wealth of documentation to the effect that major psychiatric research in practically every region of the country was severely handicapped by the lack of laboratory facilities. I will not go further into the documentation at the present time since it is our understanding that your committee will hold separate hearings on medical research construction.

The National Mental Health Committee wishes to thank your committee for the opportunity to appear here today.

Mr. GORMAN. I just wanted to identify our organization because we are very proud of the fact that we have 46 State governors who are actively concerned. In fact, they are the real backbone of our organization. We have two holdouts among the governors but spring training isn't over yet and we may sign the boys up and I won't go into who they are.

Now, Senator, the import of my testimony is simply to the effect that the States are doing a tremendous job in this field. There is a somewhat erroneous indication that the States are sitting back in this problem. That is not true any more. It may have been a few years ago.

I spend most of my time talking to State legislatures and I have just come back from two meetings in the State of Connecticut. I know what the States are up to. There has been a tremendous upsurge of interest in this problem. There is a feeling we can lick it. It is a medical problem, it requires research but it is no longer something to be stigmatized and something that we treat as a superstition. It is something that must enlist the full support of Government.

I might say on this problem there is not a governor in this country today who doesn't know that if we continue to merely maintain custody of these patients rather than treatment, we just have impossible budget situations. In New York State, for instance, in the current

year, the current budget in New York State for mental hospitals is $158 million. That is 35 percent of their operating budget. This is a tough proposition for a governor to face who is trying to run the State and have this enormous load. This would be comparable in Connecticut, it is certainly comparable in Ohio.

Last November, Mr. Chairman and Senator Purtell, the voters went to the polls and voted $750 million in bond issues for building, construction alone, in mental hospitals. This is an enormous figure. In New York State it was $350 million.

I have always regarded this since my newspaper days—and I started in this in 1945, as a very unimaginative waste—this constant building with bricks. I recall telling the Governor of Oklahoma in 1946 when he was very proud of a building he had there, I said, "Some day you are going to use brains to get these people out. These are just monuments to incompetence and inability to treat people."

The problems are not solved in housing these people.

The State of Ohio is faced with a bond issue for $150 million. Michigan has had two bond issues since the war. You go on and on, build the bricks and you put them away.

The point of my statement generally is that the States are becoming aware of this problem. The personnel shortages are enormous.

I won't go into this at great length, but our committee has made a very valiant effort, mainly as a result of a request presented to me by the governors, on our committee, to find out what the major bottleneck is in getting more psychiatrists, which is the essential item in this problem. This is only something that will be solved by enough psychiatrists and treatment.

Our answer is, fundamentally the bottleneck starts with medical school. There are not enough medical school graduates coming out of the schools today.

I noticed this morning Dr. Allman stated that today we have more doctors per people than we had a few years back, or a generation back. I respectfully submit that he is mistaken. We have just completed a 9-month survey. It shows that we are graduating now 6,800 medical students a year. This is the level we have reached. It is true as Dr. Allman said that we have raised enrollment in the medical schools about 1,000 in the last 5 years. However, our population increases have been so enormous that today we have a less favorable doctor-per-patient ratio than we had in 1950.

Now, for further documentation, Mr. Chairman, I would refer Dr. Allman and others to the health resources office report by Dr. Howard Rusk, associate editor of the New York Times, which makes this point very clear, with a number of charts and graphs, that we are actually in a less favorable position of doctors in the community.

I might say, too, Mr. Chairman, I am somewhat perplexed by such loose use of facts as I heard this morning. I suppose I am always perplexed because I was trained as a newspaperman.

This Rusk report was issued in February of this year. It is heavily documented and shows that the shortages exist not only in the field of mental hospitals. There are 1,200 vacancies in local and State health departments—money appropriated by the legislature and they can't hire the individual doctor.

My point in making these statements is that we will not supply, Mr. Chairman, the increased psychiatric personnel needed until we

raise the basic potential. You can't get a psychiatrist until you get a medical school graduate. You must grab the man and try to persuade him. It is important, yes, to educate the general practitioner along these lines; but to maintain that you don't need several thousand additional psychiatrists flies in the face of a 2-year governors' report, a southern regional report of 16 different States—and I have the figures in here, Senator, that show shortages of as high as 1,000 in a region. You can't do this without people.

You are not going to get these people tomorrow and you can't build 10 or 20 new medical schools, but I think it is quite a disservice to the Congress in its deliberations to somewhat delude it about what the actual situation is.

For instance, in the summer and fall of 1954—and I attended all these conferences—10 Western States, Illinois, Indiana, Iowa, Kansas, Michigan, Nebraska, Ohio, South Dakota, and Wisconsin, held several conferences called by the governors of the midwestern area. Their official report issued in November 1954 noted State expenditures for mental health had increased more than 300 percent in the last 10 years.

Chairman HILL. In the last 10 years!

Mr. GORMAN. Three hundred percent in the last 10 years; and these are actual budget figures. And the shortages of psychiatric personnel were almost as great as in the southern region. For example, the 10 States in the midwestern survey—and this is supposed to be a well-favored area economically and populationwise—they could use immediately 1,010 additional psychiatrists, and so on down the line.

These reports are available to those who deny doctor shortages. I think some of these people suffer from a lack of reading available material.

Now, the other regions of the country are concerned about this, too. I might say—for instance New England, Senator Purtell, a regional compact on higher education was started several years ago. It is now in process of ratification by individual State legislatures. It will provide for training on a regional basis. And I attended a conference of New England mental health officials and some outlaws from Ohio, New York, Pennsylvania, and Delaware, held last October in the beautiful city of Hartford, and there were 2 days of very deep discussion of how we could get more doctors into these hospitals and how we could do the job.

It is of nationwide concern.

I state in my testimony that in testimony submitted this year to the House Appropriations Subcommittee, on the appropriations for 1956, the National Mental Health Committee pointed out there is an erroneous impression that the States are not doing their share in the fight against mental illness. And I point out that more than $750 million in construction money approved by the voters last November in bond issues is 35 times the amount of the present budget of the National Institute of Mental Health. I think that gives some idea that somebody is doing something in this and the voters approve this.

I would like to discuss briefly the specific legislative proposals and I will conclude. I don't want to deal——

Chairman HILL. Before you get into the specific legislation would you care to say something about research and go into that a little bit? I don't know whether you contemplated that in your remarks or not

but I notice a statement here—a quotation, I believe, of Governor Williams of Michigan—

> Only 48 States with a half billion dollar budget for mental illness spend only $4 million a year on research.

Mr. GORMAN. Yes. I will put it this way, Mr. Chairman. We spend this exact total for mental illness in this country—we spend $1,100 million for custody to State mental patients and pensions for psychiatrically disabled veterans.

We lose in additional Federal income-tax revenues, and income generally, another billion and a half. So it is generally agreed by—statisticians and others so informed, that it costs us 2½ billion a year to merely maintain the load of this kind of problem. We spend about $8 or $9 million a year on research against this disease.

Now, I think there is a great discrepancy, to put it mildly, between the two types of expenditures. I think that research has paid off enormously in the field of mental health. As Dr. Bartemeier pointed out this morning, the conquest of pellagra, alone, in the South, for instance—pellagra at one time—it is due to a deficiency—a malnutrition due to a deficiency of niacin but until it was found out by Dr. Joseph Goldberger and others, as high as 10 percent of admissions in some State hospitals were victims of pellagra. Research on pellagra has meant a savings of millions of dollars to southern State mental hospitals today.

I think if this kind of thing were done generally and we put much more research knowledge into it, I think the payoff would be fantastic. We really know very little about the causes of mental illness.

Now, I speak as a layman but I have been deeply concerned. I have written a book about it, I have written a number of articles. I don't know whether the articles are good or the book is good, but I have talked to several thousand psychiatrists. I have probably been in as many State hospitals—mental hospitals as any human being outside of Dr. Daniel Blain and I know this, fundamentally—this is a new specialty, we know very little about the human mind and the thing is to bear down in terms of getting some of this skilled personnel into the pursuit of ways of treating this imponderable. And it will become, then, subject to treatment.

I remember when the new drugs came out for tuberculosis I was a working newspaper reporter. I went to the dean of tuberculosis specialists in the Southwest and I said, "Doctor, I hold great hope for these new drugs."

He said, "No, tuberculosis is a complicated disease that will never submit to drugs."

We have three drugs which either separately or in combination have closed TB hospitals in many parts of the country. Last year New York City closed 3 tuberculosis hospitals at a budget saving of $2.5 billion a year. I understand that made the mayor of New York City a very happy man. It also made the families of some of these people very happy.

So when I hear the talk of some who are a little pontifical and remind me that all things are imponderable, all things eventually seem to succumb to the human mind and human initiative, but it takes a little money in this area. We haven't had the people in research.

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State mental hospitals have had few research people, their salary scales have been low and the people have been attracted to other lines of endeavor. They can go to work for du Pont and make nylon stockings and this is more productive economically for themselves and maybe more esteemed by society, I don't know. This is a personal predilection of people. I would prefer a greater degree of mental health than a greater degree of nylon stockings but I guess this is a matter of taste.

Senator PURTELL. I don't think we are forced to the choice. I think we can have both.

Mr. GORMAN. I would think so, Senator Purtell. I couldn't argue that point.

Chairman HILL. That is what we are all seeking.

Mr. GORMAN. I don't want to attack the nylon industry because I need all the friends I can get in this fight.

Now, to come to the specific proposals, Mr. Chairman, that are before your committee currently—as I said I didn't want to deal in detail with the budgetary items because I understand that you will hold hearings of the Senate appropriations subcommittee on the specific budget but I am a little disturbed and do say so in my statement, that the administration this year in its budget recommendations fall far short of the Hoover medical task force recommendations.

I do say this, that cognizant of these facts, the report on the medical task force of the Hoover Commission described mental illness as "the greatest single problem in the Nation's health picture." While recommending a reduction of over a quarter of a billion dollars in annual Federal expenditures in the health field, the task force forthrightly recommended an additional $5 million a year for "research and training grants in psychiatry, and grants to States for community mental-health programs."

Now, the administration did not raise the research grant-in-aid figure 1 cent over last year and I go on to state that I hope the Senate in its wisdom may see fit to increase the minimums to that of the Hoover task-force report which I think did a very careful job in this area. I am not qualified to speak in any other areas.

Of course, the task-force report is deeply critical of the cuts in Federal aid to States and localities for the establishment of clinics and other community services. It points out there was an abrupt reduction of 35 percent in a 5-year period, in this problem.

Now as to title VI of S. 886, which is the administration bill for expansion of mental-health services: We are gratified at the retention of the separate mental health grant-in-aid and I am very grateful to Senator Purtell here, who is a member of the subcommittee which heard us and helped a great deal in retaining that separate grant-in-aid.

Now, the second half of title VI refers to special projects in mental health, for which the Secretary requests new authority. That is demonstration projects, and so forth.

The administration is to be commended for wanting to initiate special demonstration projects but it is the feeling of the National Mental Health Committee that there is ample authority for these activities under both the National Mental Health Act of 1946 and the omnibus amendments to the Public Health Service Act passed in 1950 but I am not a lawyer and maybe that point is moot.

I agree that the administration's language in regard to grants for special projects in mental health is too restrictive and confines interpretation to operations within State institutions.

Now, the National Mental Health Committee prefers the broader language in the measure introduced by Senator Purtell. This section of the bill authorizes a wider type of experimentation in public-health services, public education, and so forth.

I think if you are going to do these demonstrations and pilot projects, it is important not to confine them merely to operations within the State institutions. There are many things that you can do as Dr. Blaine explained this morning in terms of halfway houses, day hospitals—I think the day hospital offers a tremendous opportunity, where the patient is returned to his family at night. You could do a lot of work in clinics, community services, rehabilitation. These are excluded pretty much by their restrictive language of title VI, so we prefer the language of S. 848.

Now, it is the considered opinion of the National Mental Health Committee that there are two pieces of mental-health legislation introduced in the current Congress which would do more to further the fight than anything else suggested. The first is Senate Resolution 46, now sponsored by 30 or 31 Senators. It provides for a limited Federal contribution to a non-Government 3-year nationwide evaluation.

I have thought for a long time that this is the approach to the problem, and we have to do a very basic type of study. The National Mental Health Committee is deeply gratified with the administration's endorsement of the joint resolution and in her testimony in the House, Mrs. Hobby expressed the opinion that the grant-in-aid be made for a coordinated study and I think that is important. It ought to be one unified outfit and they should not be given a fragmented series of grants going to different bodies maybe not working in integration.

The National Mental Health Committee is also deeply grateful to Senator Purtell for his introduction of S. 724, calling for a Presidential commission to conduct a survey of the problem of mental illness. While our committee is in agreement with the American Medical Association and the American Psychiatric Association that greater participation can be secured for this study by designating a nongovernmental body to do it, it wishes to express its deep appreciation to the Senator from Connecticut for his continued interest in the mental health problem. As chairman of the Health Subcommittee during 1953 and 1954, he earned the admiration and gratitude of all of us, and I mean that very seriously.

Senator PURTELL. You are going to make a study, but what about setting up some sort of a national program? Not a Federal program. A national program. Don't you think that is as important as your study? If you don't implement your legislation by setting up some provision for focusing attention on this problem, and then coming out with a program, you may well find yourself accomplishing much less than you thought you were doing.

Mr. GORMAN. I could not agree with you more, Senator. I think more important, too, is the mechanism that is going to carry out the recommendations of the study.

Now, I think that somehow, in executive session, that members of this committee would possibly work something like that out.

Senator PURTELL. I am sure we will try.

Mr. GORMAN. May I stress that I would rather have the nongovernmental approach, in terms of putting the responsibility for making the survey on many. I think many of these organizations in the past have not done very much about it. I would say very frankly, now, and very much on the record that I think the American Medical Association has in the past been delinquent in this area.

They have recently discovered there is a problem of mental illness. I am glad they have discovered this obvious fact. But until 3 years ago there was very little done by State medical associations and by the national organization about this problem. I, in my newspaper career many times went to State medical associations and said, "If you fellows would but go to your legislators and tell them this is really a medical program, this should be staffed, if you could bring the prestige of the medical profession to bear, we would have no problems," but they thought the mental hospitals were, as they referred to them, eleemosynary institutions and were not related to the main stream of American medicine. Maybe this is somewhat of an obsession with me. I like to congratulate people on coming to an obvious truth. I want to congratulate them for that.

I am happy to see them in this type of a study because I think that the identification of the AMA and its very large membership, 110,000 doctors, in having a joint responsibility for this thing, I think is going to change this. It is going to make this really a study which will have great impact, let's say, on the average family doctor. But, the point about the mechanism, I would say it is terribly important. If you just get a study out and it fills a library shelf and is referred to years later but is not used—I think some sort of mechanism should generate out of this, but maybe you would want to put into the legislation a suggestion for something of this kind.

Senator PURTELL. To me it is most important.

Mr. Chairman, I am taking over some of your prerogatives.

Chairman HILL. Go right ahead, sir. Go right ahead.

Senator PURTELL. I think we have had much experience where we have gone out and found a lot of facts and not found a means by which those facts would be employed immediately.

And you find this, too, I'm afraid, that many that might not be attracted to the initial study, or the desire for the initial study, might want to do something with the study when it is developed that might not be as helpful to solving this problem as it would be if you started out with that body, seeking the facts and using those facts to set up a national program.

I really feel that it is an area in this legislation that hasn't been clearly explored and it should be before we decide to go ahead without setting up some sort of a programing committee of some kind.

Chairman HILL. I wish you would think that through carefully and give us the benefit of your thoughts, suggestions or ideas that you might have.

Mr. GORMAN. I might bring to the attention of the Senator from Connecticut some documentation of his very point. The South made a complete, imaginative and amazing survey of the 16 Southern States as far as research and training in mental health is concerned. It is a beautiful study. At the end of the study, however, they were faced with this problem:

We have the study, what do we do now; how do we implement it?

At the Southern Governors' Conference last November which I attended in Florida—out of this immediate need there came the creation of a Southern Regional Council on Research and Training in which each individual Southern State is contributing $8,000 to set up—that is 16 States contributing $8,000 apiece to set up a permanent mechanism to carry out the recommendations of the year-long survey. I think that sort of substantiates your point, Senator. They felt the need at the end of the year, that they didn't want a library study, and that they now have a staff.

Senator PURTELL. I feel, too—and I don't charge that this is the thinking of any of the witnesses today, but so often, when the Federal Government finds it necessary to get into a field such as we do here, to set up a means by which we can determine what our problem is, the scope of it, and how we can operate in it, quite often you find that people are fearful that it is another attempt of the Federal Government to get in and do something and set up another Federal program, another Federal body and another Federal bureau. And I think many times that sort of thinking keeps them from doing that which is best in the particular instance, and I can't help but feel that if we approach this problem with the idea that we must be careful not to let the Federal Government get its nose, as they like to say, under the tent, that we may well be blocking off in this most necessary investigation—we may be setting up, rather, a roadblock that we don't realize at the present time. I don't fear the Federal Government getting into this thing in any manner at all so as to control it—in other words, imposing some controls over your medical profession. I don't visualize that at all and I will fight strongly against it. But, I do feel there are times when that type of thinking perhaps makes us seek other answers to problems when there are better, easier answers available to us.

Mr. GORMAN. Yes.

I feel, of course, in this type of study, Senator, there would be interim reports to the Congress, which would be very important, and a final report, and I have no fear of the Federal Government in this area. I think that the program under the National Mental Health Act of 1946, in which you first established the training and research grants, no one has ever charged there has been any interference with local initiative and in fact when the program was originally established in the clinic area, for every Federal $2, the localities were putting up $1.

Today, for every Federal dollar there are 5 to 6 local dollars, so it seems to me the idea about it being a catalyst, is an important one.

Senator PURTELL. Or that it might become a political football, I think, lacks the weight that has been given it.

Mr. GORMAN. I think that is a somewhat exaggerated fear, if I may say so.

Senator PURTELL. I think so.

Mr. GORMAN. To conclude on the legislation currently before the Congress, in the opinion of the National Mental Health Committee, the most important mental health legislation in the Congress this year is the Medical Research Act of 1955. It is sponsored by the chairman of this committee and Senator Bridges, and it allocates up to $30 million a year for 3 years, or a maximum total of $90 million in matching Federal moneys for research construction in the field of

heart, cancer, mental health, and so on. Since the National Institute of Mental Health was set up by law in 1946 it has not received 1 cent of research and construction money. At the present time there are on file with the institute applications for psychiatric research construction totaling approximately $22 million from hard-pressed nonprofit foundations, medical schools, and hospitals all over the country. A year ago Dr. Jacques Gottlieb, chairman of the committee on research of the American Psychiatric Association, testified before the Congress on the desperate need for psychiatric research facilities. He presented a wealth of documentation to the effect that major psychiatric research in practically every region of the country was severely handicapped by the lack of laboratory facilities.

I will not go further into the documentation at the present time, since I understand Thursday and Friday of this week the committee will hear witnesses specifically qualified in reasearch background, and also doctors from the American Medical Association, too, and that they will testify as to specific needs.

In my journeys about the country I will say this and say this very flatly: I know of no area where there is not need for the creation of laboratory facilities. I find it disgraceful that Dr. Menniger's medical foundation uses for its research facility a converted tombstone factory and two barns.

Now, I like Kansas barns, they are very pretty. But to house animals in these things, to ask a young scientist to come into this area is an impossibility.

The same thing is true of the Austen Riggs Center. The same thing is true with the Hartford Institute for Living.

Senator PURTELL. You feel that is inadequate? In space, equipment, or what?

Mr. GORMAN. The doctors would like additional research equipment.

Senator PURTELL. I don't know of any man in research who wouldn't like additional equipment. If they are interested in it they would, obviously.

I must say I can't agree with you at all in your observation as to the Institute for Living, with their equipment. It could be improved upon, but anything can be improved upon, I guess, unless you buy everything new every day. I would say it is a long way from being, however, housed in a couple of barns.

Mr. GORMAN. I was talking about another foundation then and not Frank Braceland's place in Hartford.

You are right, it is a beautiful place and he would like an additional wing for research and he is having tax problems. I understand currently before the legislature——

Senator PURTELL. We are getting some relief for him on that, I understand.

Mr. GORMAN. There is a financial problem.

Chairman HILL. He means physical facilities for research, you mean building.

Mr. GORMAN. Yes.

Senator PURTELL. He is doing some remarkable work up there now, Senator.

Mr. GORMAN. It is a totally private institution. This isn't a question of getting country club research. This isn't a question of saying to somebody, "You have a beautiful building, but you could use a wing," and prod him to ask for it.

This is something we have been working for since 1950, something similar to Hill-Burton which would make the local institution or the hospital put up 50 percent of it so that they could get some young people in and house their animals.

For example, a year ago, Dr. Gottlieb was down in Miami running a research situation there in a private institution. He got some money from the local community and started a research building. However, he could not raise additional moneys to house animals needed in a great deal of physiological research. He lost 3 of his 4 young research workers.

Now, I think that is a crime, because these men left because of lack of facilities. They left because they did not have the chance to do basic physiological work in schizophrenia. This was so discouraging that Dr. Gottlieb left Miami to go to Michigan where Governor Williams will employ him in Detroit and give him animal laboratories.

Now, it is that simple. He goes where he can take his young men and provide them with animal and other laboratory facilities. There are very few places in the country where this—and you just can't do this in a barn or in a basement, just the same as you can't do effective cancer research or heart research in that kind of facility. Modern medicine needs very expensive facilities. That is why our committee says that this is the most important piece of legislation. We have thought so since 1950 and we have been trying to get some way to get this—now some people say, "Well, why don't these psychiatrists go out and try to raise this money?"

I'll tell you this. Dr. Bill Menniger who is a very fine psychiatrist, since 1948 has been on the road like a salesman, hat in hand—no longer practicing psychiatry which is a great loss to psychiatry—going around the country addressing meetings. He raises about $600,000 a year which provides for a small amount of research, but he cannot put up a research building. There is not that kind of private money in the United States to do that kind of thing.

That is one example.

Dr. Knight at Stockbridge, Mass. is the same way. In fact, I call him a traveling saleman. They are on the road all the time. They go to industry and get a little nibble. Senator, these people are not just sitting back and waiting for the Federal manna to fall in their laps, they have gone around the country and made every effort to do it.

Chairman HILL. In other words, they are struggling to do this job.

Mr. GORMAN. Yes. The reason Dr. Menniger cannot appear tomorrow is because he is in Phoenix, Ariz., trying to get money. He may get a couple of thousand dollars out of a speech in Phoenix, Ariz.

Senator PURTELL. I want to exprss to the witness my appreciation for the way he covered the subject.

Chairman HILL. The witness always makes an exellent presentation and he certainly made a very excellent one here today and brought us some most helpful and very fine testimony. We are grateful to you, Mike. Very, very grateful.

TESTIMONY OF E. B. WHITTEN, EXECUTIVE DIRECTOR, NATIONAL REHABILITATION ASSOCIATION

Chairman HILL. Mr. E. B. Whitten, executive director of the National Rehabilitation Association, another old friend of ours.

Mr. WHITTEN. Senator, I have a brief statement which I would like to file for the record but I would like to speak orally from some notes that I have here instead of reading the statement.

Chairman HILL. Your statement will go in, in full, in the record and you may proceed in your own way.

(The statement referred to above follows:)

STATEMENT OF E. B. WHITTEN, EXECUTIVE DIRECTOR, NATIONAL REHABILITATION ASSOCIATION

Mr. Chairman and members of the committee, I should like to thank you for inviting the National Rehabilitation Association to express its views on the legislation under consideration and for the opportunity of expressing a few views on the current mental-health problem of our Nation.

Before relating some of the views of rehabilitation, I should like it clearly understood that most people engaged in rehabilitation today freely admit the limitations of their skills and programs as they are currently applied to the problems of our mentally ill. For many years, those concerned with rehabilitation were interested in applying the techniques of their work to the problems of the mentally ill, but it was not until the passage of Public Law 113 in 1943 that those in the public programs were legally allowed to enter into this field. With little or no experience to guide them, the State-Federal programs of rehabilitation entered this new phase of their work. From 1943 until now, rehabilitation programs have gained valuable experience in psychiatric rehabilitation. All, however, admit that their attempts have been inadequate. In attempting to do this job, many obstacles have become apparent: Few mental hospitals understand the concepts and goals of rehabilitation. Rehabilitation counselors often have difficulty in understanding psychiatric terminology and applying it to rehabilitation techniques. For the most part, rehabilitation counselors and other workers were and are inadequately trained to understand the needs and limitations of the mentally ill. Communities have frequently failed to understand the implications of mental illness, particularly with respect to rehabilitation.

Renewed emphasis must be placed on the rehabilitation of the mentally ill. Therefore, it is heartening to see that this committee is giving serious deliberation to Senate Joint Resolution 46, S. 724, title 6 of S. 886, and S. 848. We heartily support the intent and goals of this proposed legislation. We believe that its passage will result in findings that should lead to better services to our mentally ill, and more skillful tools to assist them in their recovery and readjustment.

You already have before you sufficient evidence for determining the magnitude and scope of America's mental-health problem. In terms of people and of dollars it has been correctly described as "staggering" and "colossal." The size and cost of this problem is such that funds channeled to arrest it cannot be considered spent or expended. Rather, and rightly, they should be considered an investment in our economic and mental well-being.

For the remainder of this statement, I should like to speak briefly on what I believe to be the role of rehabilitation in the problem of the mentally ill and something of our initial efforts.

Let me begin by saying that very few psychologists or psychiatrists discharge a person as cured. To a degree, all of us are mentally ill at times. Most patients, discharged from treatment or a hospital, are classified as symptom free, well oriented or rational. Many different adjectives are used. In more cases than not, the individuals still have certain tensions and anxieties, now under much better control. They have reservations as to how quickly they can adjust to community life and whether or not the community will accept them. It is precisely at this point where I believe the work of rehabilitation and rehabilitation counseling can do them the most good. So to speak, rehabilitation is the hardening-up process which prepares them for vocational, social, and economic living under normal conditions, without support and guidance during

this period, many relapse and return to institutions; others, flounder for years dependent on friends, family, and community. It is not enough for a person to leave a hospital as just symptom free. In addition, he should be well on the way to adjustment to job, family, friends, and community. Here is where the work of the rehabilitation counselor begins. He gives vocational counseling and guidance, the job training or placement. He acts as liaison with prospective employers, and he assists in a careful reintroduction to community life. He supervises training programs, ever watchful for strain or anxiety.

Psychiatric rehabilitation is an intercurrent process between the acute phases of mental illness and community integration. You will note that I did not say between the end of treatment and community integration, for we are finding out all over the country that many persons get well more quickly while training and working than while confined to a hospital or home, and that medical supervision is still needed after discharge from an institution.

The development of programs of psychiatric rehabilitation has been very slow. Despite this, they have proven their worth and have stimulated additional projects and programs. Let me illustrate this by sighting some of the things that have been done right here in the District of Columbia.

Some months ago, the District of Columbia Department of Rehabilitation made a study of 30 psychiatric cases, patients of St. Elizabeths Hospital, which were successfully rehabilitated by them. At that time, the cost of maintenance of a patient within the hospital averaged $4.90 per day. Based on these figures, were the 30 patients to remain at St. Elizabeths Hospital for an additional year, it would have cost the taxpayers $53,655. The savings to the community are obvious, but we must bear in mind that probably none of this could have come to pass had not St. Elizabeths Hospital the excellent medical and psychiatric services that it has and a realistic and progressive rehabilitation philosophy which permeates all levels of the hospital. Be that as it may, this proved conclusively to the District of Columbia Department of Rehabilitation and others that close work and cooperation with a progressive mental institution could result in successful rehabilitation, of value to the community and the people that it serves. The cost of rehabilitating these 30 cases was a fraction of the cost of their hospitalization for just 1 year.

It is not for lack of interest, enthusiasm, or demonstratable worth that more rehabilitation of the mentally ill is not done. Rather, it is because of the complexity and difficulty of the problem, and our lack of technical know-how, some of which I have already mentioned. It is little wonder, then, that we heartily endorse the legislation presently under consideration. It will stimulate greater interest in the problem of our Nation's mental health. It will ultimately result in better understanding of our mentally ill and the kinds of services, programs, and personnel needed to serve them.

More specific to those whose chief concern is rehabilitation, we believe the type of legislation you are now considering will materially assist in determining what the role of rehabilitation should be in our overall mental-health program and where, precisely, can the skills of rehabilitation fit into a comprehensive service program which includes all aspects of the problem of the mentally ill.

Mr. WHITTEN. I appreciate the opportunity to have come here, today. I wanted to come, really, because, I was afraid that if I did not come or someone representing my organization, the rehabilitation aspects of this very important problem might not be emphasized to the degree that I, at least, felt that they ought to be emphasized.

I think that some of the problems that are in the minds of the common people, as well as the professional leaders in this field, have been illustrated by a trip I made last week out to Indianapolis, where I was asked to be a participant in the annual meeting of the Marion County Health and Welfare Council. After the noon session, a small group asked if I could make myself available in the afternoon to talk about some problems that were more intimate and about which they wanted to ask specific questions.

Now, I am not an expert in mental health. I had not spoken upon the subject of mental health. I had talked abou rehabilitation in general. And yet I was rather surprised at the questions that were propelled to me that afternoon. Most of them were directed to prob-

lems in the area of mental health, instead of other areas of rehabilitation in which I had thought they might be more interested.

Here are some of the questions they were asking.

How can we get our mental hospitals interested in rehabilitation?

What is the State-Federal program of rehabilitation doing to rehabilitate the mentally handicapped?

What could it do if it had the resources, money, and personnel that it might have?

How do we go about getting counselors, psychiatric, and social workers, psychiatrists, and so forth, to do this job that we all recognize has to be done?

What would it really cost to put on in our community or in the State, a really comprehensive, complete program of mental health?

What kind of research is being done by the public-health services in this area?

People know money is being appropriated, but many don't know just what is being done with it.

What are these halfway houses that we hear about, with respect to mental health?

Where could we find one?

Where is there one we could go to visit to find out what promise they have in meeting our own particular problems?

Of course some of these questions we tried to answer. Others we just frankly stated we couldn't answer. We didn't believe the answers were available.

It was encouraging, though, to be able to tell them that this problem is very much on the minds of Members of Congress, that a hearing had just been conducted in the House, that a hearing was going to be conducted in the Senate in a few days, and that the indications were very good, that the Federal Government was going to assume a greater amount of leadership in this field than it had in the past, and that they need not feel hopeless with respect to the solution of this problem, that something was being done and would continue to be done.

Now we are particularly concerned, ourselves, with that part of the area of mental health which is concerned with the social and economic adjustment of individuals after, we might say, the more intensive part of the medical care process is completed.

Now we know that medical care is going to be needed by the mentally ill person probably for months or even years after he leaves an institution. But there comes a time in the process of the treatment of this individual when he sees less and less of the doctor and has to see more and more of the social worker and the rehabilitation counselor, if he is going to make the desirable adjustment to living at home, and to making a living for himself on a job, which we hope is the ultimate aim of all of this.

Mr. PURTELL. That may well be the most important part of the treatment of that particular case, too.

Mr. WHITTEN. It is certainly therapeutic as well as vocational. I want to say I feel this so-called bridge between institutions and complete adjusment at home and on a job, is probably the most neglected of any particular segment in the whole area of mental health.

Chairman HILL. Of course very, very little is being done there.

Mr. WHITTEN. Not a great deal. I wanted to review with you some efforts in this field performed by pioneers.

For instance since 1943, the State-Federal rehabilitation program has had the authority to rehabilitate the mentally handicapped. They have long realized—the leaders in this field—that they had a responsibility that they were not meeting to any considerable degree.

Many States, I think I can say most of the States, have in recent years attempted to make a beginning in this field. Some of the things they have tried to do are along this line. In the first place they came to realize that even those people who were referred to them for physical disability often had emotional problems that were more of an interference to their rehabilitation than was the physical problem, itself.

Chairman HILL. Although they had been referred on the basis of physical disability.

Mr. WHITTEN. That is exactly right. I have been a counselor myself and I know the frustrating experiences. You have a physically handicapped person come to you and you think the problem is relatively simple, and when you think a plan has been worked out for rehabilitation you find the whole thing bogs down because of emotional problems that you had not sensed in the beginning and which you might have sensed had you been better trained, you see, along the lines of psychiatry and mental health.

So they have tried to train their staffs to recognize these problems and be able to deal more effectively with the people that are referred because they are physically handicapped.

In addition, many States have tried to put on special programs to deal with the mentally handicapped as such.

Now, a couple of ways they have of going about this are interesting. One method has been to go to a mental institution and make arrangement with the head of that institution to allow a vocational rehabilitation counselor to be established, sometimes with an office in the building, to work with the staff of the hospital in trying to get acquainted with the people who are going to be discharged, to participate in the screening process to determine whether these persons can be rehabilitated vocationally, and then to help to bring together the gap between institutions and the home situation that the person is going to have to live in.

I think there are 12 or 15 States that have one or more counselors now working in the mental hospitals. In practically all instances those arrangements have been made at the initiative of the rehabilitation people and not at the initiative of the people who operate the mental hospitals. And I regret to have to say that, because I think the initiative really should have come from the other direction.

Then another thing that rehabilitation agencies have done, as the word gets around that a mentally handicapped person is eligible for rehabilitation, private psychiatrists begin to refer cases, or other people who recognize emotional problems refer them to the rehabilitation agencies, so some of the States have put on counselors to work with private practicing psychiatrists in an effort to rehabilitate the clients of these psychiatrists. I might add here that I think a relatively small percentage of the psychiatrists really feel the importance of this enough to use them very much, and yet many are beginning to do so. The District of Columbia, for instance, has one person working with private psychiatrists alone in trying to work this out.

Chairman HILL. Do many of the States have that service?

Mr. WHITTEN. The State rehabilitation agencies?

Chairman HILL. Yes.

Mr. WHITTEN. There are less than half of them that have anything that I would call a program. They may be doing just a little bit on the edge.

Now to show you the extent to which this has gone, in 1954, 3,790 mentally handicapped people were rehabilitated by the State agencies—rehabilitation agencies. That number constitutes 7 percent of the total number rehabilitated during the year, although I am sure everybody would agree that the potentiality for caseload there is many times as high as that proportion would indicate. As your question indicated, or my answer to your question, it is indeed spotty. Where one State may be getting into it in a pretty lively way, another is hanging back for some reason—usually a good reason—sometimes just fear of getting into a field with which they are not too well acquainted.

Some problems have been revealed in this experimental work in rehabilitation. For one thing it has been awfully difficult for rehabilitation agencies to find the people to do this job.

In the first place it is difficult for them to get consultative services from psychiatrists and from psychiatric social workers who might be expected to lead in the training of the remainder of the rehabilitation staff in order to handle these cases more efficiently. We don't think it is practical to assume that a psychiatric social worker, or anyone with graduate training at that level, can be found for many, many years to come, to assume this entire burden but it is even difficult to get the people to train the other members of the staff.

Now another problem that has been run upon is this, that even where you go to a mental institution and you make arrangements to provide the institution with this counseling service aimed at job placement, and you place your counselor there, you find after a year or two of frustration that the concept of rehabilitation is not really accepted by the people in the hospital. They have given academic acceptance to it by allowing a counselor to come there, but the concept has never trickled down, at all, from the person who gave permission to place a counselor there, to the members of the medical staff and other staff, so the counselor finds himself in a straitjacket wondering for a long time why he can't get anything done, and, finally, it dawns on him that they don't really understand what he is trying to do.

In fact some people feel very sincerely that unless a mental institution has a strong department of social service as a part of its total program, that it is almost futile to try to work in that institution with a rehabilitation program.

Where there is a well-trained staff of social workers, let us say, in the mental institution—and some of them have such—these people are very conscious of the need of rehabilitation and they, taking the medical advice on the one hand, serve as liaison between medicine and the counselor, shall we say, and the process speeds up a great deal.

Another problem that the rehabilitation counselor has is that after everything else seems to be getting along all right it is awful hard to get jobs for these people. In other words our communities are not yet ready to accept them. Of course, there are notable exceptions, and I want to say this, that apparently larger industries that have well-

staffed medical departments are more prone to take the mentally handicapped than are the small employers who, without that medical service, have a fear that does not exist in the minds of the personnel executives in the large institutions.

Chairman HILL. You are speaking of the general rule, now?

Mr. WHITTEN. That is right. A tremendous educational job is needed, of course, and the educational work is going to have to be intensified to make people realize that mentally ill people are, after all, just ill people who do recover and should be going back to work and to live normal lives.

Now, I think that we might be able to summarize the situation with respect to rehabilitation by saying that there is no legal obstacle to the rehabilitation agencies playing an important part in this program.

Chairman HILL. In other words, so far as the law is concerned, they could move right into their field today, is that true?

Mr. WHITTEN. That is exactly right. But that rehabilitation agencies do not yet know just what the best approach is to take, having tried and failed in some areas. It is not clear in their minds just what the most practical approach is to take, and frankly it may never be that there will be one pattern that will apply everywhere, but they need more guidance with respect to how to approach this problem. They lack the personnel and the funds to enable them to make a substantial inroad in the problem, and there is a great deal of misunderstanding on the part of the general public with respect to mental illness which, of course, makes their job more difficult.

Now, with respect to these specific phases of legislation—and I am concerned here particular with these two that involve the study, because these are the ones that we have given the most intensive consideration to.

Our people lean toward the idea that it would be better to carry on the study under the plan in Senate Resolution 46, but in doing that, we say also that we would have been perfectly happy to support the Presidental-commission idea and would have had no fears whatsoever with respect to what would have come out of it, if that bill will be in the Congress without the other one by the side of it. It is just a matter of choosing 1 of 2 good propositions.

We recognize very strongly the fact that it is hard to focus public attention upon a piece of research that is done by private organizations, that it is easier to attract public attention to something that comes out of a Presidential commission.

We hope in working out this bill some way will be found to make it more probable than it otherwise would be, that the proper sort of emphasis is going to be put on what comes out of this.

Some suggestions have already been made, and you have asked for others. I wonder if the people making this study could not be charged that, in addition to their factfinding and general recommendations, that they themselves be responsible for recommending a method of implementing the study which they themselves have made, or something of that kind.

I think you are exactly right, Senator Purtell, that if this just becomes one of those reports with a lot of facts and everybody goes off on his own without any central guidance, that we are not going to be a great deal better off than we are at the present time.

This, I think, summarizes pretty generally the feeling that I have and the people I represent have.

Incidentally, I did not mention this at the beginning, which is the proper place for it, that the National Rehabilitation Association is composed of over 16,000 individuals, lay and professional, who are interested in the overall rehabilitation program, and it is for that type of membership and that kind of organization that we bring you this appeal this afternoon. We think the study is a very important thing to do and hope that you will go ahead with it.

Chairman HILL. Mr. Whitten, refresh my recollection. How much money did we appropriate this year in Federal funds to assist the States in rehabilitation?

Mr. WHITTEN. It was about $30 million for all purposes.

Chairman HILL. That would take in the whole field of rehabilitation.

Mr. WHITTEN. That is right, including the administrative expense.

Incidentally, I hope to have an opportunity to discuss with the Appropriations Committee some of the problems in connection with this program and trace some of the developments in it under this law, when you have your hearings on that subject.

Chairman HILL. We will be glad to have you come. We will be glad to have you come.

Now, you speak of the $30 million in Federal funds. Do you recall how much the sum total is in State funds?

Mr. WHITTEN. Probably about $20 million, or something along that line. This program has been running approximately 2 Federal dollars to 1 State dollar, but the States have been going up faster than the Federal Government in the last few years.

Chairman HILL. I recall last year, Senator Purtell, when you had that legislation, that the Federal Government had been doing a good deal more than the States, and in the legislation we passed last year we sought to encourage the States to carry a larger share of the responsibility.

Mr. WHITTEN. I think you will be interested, both of you, to know that this year—and we think it is because by the impetus of this new legislation—there will no doubt be the largest increases in State appropriations for rehabilitations than have been seen for this program.

All States are not being able to make arrangements to get the money to match the Federal money which we hope will be available, but quite a noticeable number have been able to get their legislature to make substantial increases.

Mr. PURTELL. That is an accomplishment in itself, isn't it?

Mr. WHITTEN. Yes; if it did nothing but that it would be well worth while.

Mr. PURTELL. I will voice what I am sure our chairman will voice, my gratitude for your coming here. You have been helpful in bringing to us information that has been helpful to me and, I am sure, to the other members of the committee in our deliberations.

Chairman HILL. You have always been most helpful and we deeply appreciate your testimony, Mr. Whitten. We will look forward to seeing you before the Subcommittee on Appropriations.

Mr. WHITTEN. I will be sure to be there.

Chairman HILL. The subcommittee will meet tomorrow morning and hold a hearing at 10 a. m. in the administrative building at the

Institutes of Health at Bethesda, Md. The subject will be Senate bill 849, sponsored by Senator Bridges, of New Hampshire, and myself, which would authorize the maintaining of grants for construction of non-Federal laboratory research facilities throughout the country. Facilities which would be like and would be used for the same sort of disease-killing research as are the laboratories at Bethesda. Because of this, and in order that members of the subcommittee can see exactly how those facilities at Bethesda are utilized, the 10 o'clock hearing will be preceded by a tour of the National Institutes of Health which will begin at 9 a. m. and start at the administration building. Members of the press will be welcome to accompany the members of the subcommittee on that tour of the National Institutes of Health.

Hearings on Senate bill 849 will be continued on Friday and will be held in the Old Supreme Court room beginning at 10 a. m. We will shortly announce a hearing some day next week at which representatives of the administration will be asked to testimy on the bills which we have considered today and also on Senate bill 849, which we are taking up tomorrow.

The subcommittee then will stand in recess until tomorrow morning, when we meet at the National Institutes of Health at Bethesda at 9 o'clock.

(Whereupon, at 3:35 p. m., the committee adjourned subject to the call of the Chair.)

MENTAL HEALTH

WEDNESDAY, APRIL 13, 1955

UNITED STATES SENATE,
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D. C.

The subcommittee met pursuant to notice at 10:10 a. m. in the Old Supreme Court Chamber, United States Capitol, Senator Lister Hill (chairman) presiding.

Present: Senators Hill (chairman), Lehman, Bender, and Smith of New Jersey.

Also present: Stewart E. McClure, staff director, Roy E. James, minority staff director, and William G. Reidy, professional staff member.

Chairman HILL. The subcommittee will come to order.

We will proceed with hearings on Senate Joint Resolution 46, S. 724, S. 848, and title VI of S. 886, providing a nationwide analysis and reevaluation of the human and economic problems of mental illness.

Now we have Mrs. Hobby. We are delighted to have you here. Will you come around, please, ma'am? We would like to have you proceed in your own way.

STATEMENT OF HON. OVETA CULP HOBBY, SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY DR. ROBERT H. FELIX, DIRECTOR OF THE NATIONAL INSTITUTE OF MENTAL HEALTH; MRS. LUCILE LEONE, CHIEF NURSE OFFICER OF THE PUBLIC HEALTH SERVICE; JAMES H. PEARSON, DIRECTOR OF THE DIVISION OF VOCATIONAL EDUCATION IN THE OFFICE OF EDUCATION; ASSISTANT SECRETARY ROSWELL B. PERKINS; DR. CHESTER S. KEEFER, SPECIAL ASSISTANT FOR HEALTH AND MEDICAL AFFAIRS; AND DR. LEONARD A. SCHEELE, SURGEON GENERAL OF THE PUBLIC HEALTH SERVICE

Secretary HOBBY. Thank you, sir.

Mr. Chairman and gentlemen of the committee, before proceeding with our prepared statement, I would like to explain that we are presenting two separate statements this morning.

The first deals with the mental health problem, and particularly with the provisions of title VI of S. 886.

The second contains our views and recommendations relating to practical-nurse training. Although we shall present these statements consecutively, we believe that the separation of our prepared testi-

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mony into two parts will facilitate its incorporation into the record of these hearings.

We are pleased to have this opportunity to present the views of the Department of Health, Education, and Welfare on the several health bills under consideration by this committee. Our prepared statement is addressed solely to the mental health provisions of S. 886. Our written reports on the other bills—S. 724, S. 848, S. 849, and Senate Joint Resolution 46—have been transmitted to your committee. We have no additional comments to offer on these bills, but we will be glad to answer any questions you may have regarding the views expressed in our reports.

S. 886 is the omnibus health bill introduced to implement certain of the health proposals recommended by the President in his special health message to the Congress on January 31. It contains six titles, aimed generally at improving methods of prepaying for the costs of medical care, stimulating construction of health facilities, helping to alleviate personnel shortages, and strengthening our public health and mental health programs. The objectives and provisions of all titles of the bill are summarized in a supplementary statement submitted herewith.

Mr. Chairman, if I may, I would like to have that in the record.

Chairman HILL. It will be in the record at this point without objection, so ordered.

(The supplementary statement referred to is as follows:)

SUPPLEMENTARY STATEMENT OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON OBJECTIVES AND PROVISIONS OF S. 886

TITLE I.—REINSURANCE OF HEALTH SERVICES PREPAYMENT PLANS

Title I would establish within the Department of Health, Education, and Welfare a health reinsurance program. The objective of this proposal is to accelerate the extension of voluntary health insurance. Although important progress has been made in extending voluntary health insurance to a large segment of our population, there is still room for improvement. There is need for increasing the number of individuals and families who are covered by health insurance. There also is need for broadening insurance protection to cover a larger share of the health expenses of those who are insured.

The health reinsurance proposal is designed to encourage insurance carriers to experiment more freely in the development of improved coverage and benefits. It would enable the insurance carrier to obtain insurance against the hazard of heavy loss incurred as a result of its experimentation with types of insurance policies or plans for which an actuarial basis has not been fully developed.

Reinsurance would be granted only if it would promote the purposes of the program as defined by the Congress. It would not be granted unless the insurance carrier is operating according to State law. Furthermore, reinsurance would not be provided by the Federal Government for any plan if the carrier could obtain it from private sources on comparable terms and at comparable premium rates.

This program is designed to be self-sustaining. The appropriation of $100 million would be authorized as an advance of working capital—to be repaid to the Treasury from reinsurance premiums. The proposed 1956 budget calls for an immediate appropriation of $25 million.

Reinsurance premiums would be fixed at rates sufficient to achieve the objectives of the program and at the same time make the program self-supporting. Premiums would be related to the type of plan being reinsured.

There would be close collaboration with State insurance departments or other State agencies supervising health insurance plans. Supervisory or regulatory control of the insurance industry by the Federal Government would be prohibited specifically.

Although there is no difference is basic principles, title I does differ in several significant respects from the reinsurance bill proposed by the administration in the 83d Congress. The principal differences are:

First, this year's bill specifies three distinct types of health insurance plans which would be eligible for reinsurance, along with other plans. These special types of plans are:

(*a*) Those designed primarily to provide coverage for individuals and families with average or lower income;

(*b*) Those which provide insurance against major medical expense; and

(*c*) Those which are designed to provide protection primarily for persons in rural areas.

A second significant change is that, for the first two categories of plans, there are specific statutory standards on health insurance benefits, and standards relating to limitations contained in health insurance contracts.

Third, in the case of plans providing coverage for rural families, the carrier may elect—if it is more advantageous—an alternative definition of administrative expense for purposes of establishing the reinsurance obligation. The change was made in recognition of the higher administrative costs involved in extending coverage to farmers and their families.

Fourth, to underscore the self-financing feature of the program, administrative expenses for its operation have been made payable out of the reinsurance fund. In the earlier bill appropriations from general funds were authorized to meet administrative expenses for a limited period of 5 years. However, in the present measure, as well as in the earlier bill, separate appropriations are authorized to provide advisory and informational assistance to health insurance plans.

Fifth, title I authorizes a maximum Treasury advance to the reinsurance fund of $100 million, whereas last year's bill called for $25 million. However, a limit of $25 million has been retained as the maximum advance to any special account. For the program as a whole the total has therefore been raised to the combined figure of $100 million.

Finally, amendments have been incorporated into the provisions outlining the relationships of the reinsurance program to State regulatory responsibilities in the insurance field. Annual formal consultation with State insurance agencies would also be required.

[NOTE.—The President's health program includes a related proposal which is embodied in another bill, S. 1198, which has been referred to the Committee on Finance. This proposal is designed to benefit the neediest group in our population, composed of people who are clearly unable to purchase voluntary health insurance for themselves.

[This companion proposal would make possible better health services for the approximately 5 million persons who are now eligible for federally aided public assistance—dependent children, the totally disabled, the blind, and the aged. At present, the Federal Government is authorized by the Social Security Act to provide only very limited help to the States in meeting medical-care costs of persons in these four categories. Under the proposed amendments to that act, additional Federal funds would be specifically earmarked for the purpose of matching State medical-care expenditures for these public assistance recipients.]

TITLE II.—MORTGAGE INSURANCE FOR CONSTRUCTION OF HEALTH FACILITIES AND RELATED PROVISIONS

The principal objective of title II is to provide another stimulus to the construction or renovation of the additional health facilities which are needed in all parts of the country. This program would complement the recently expanded hospital survey and construction program by assuring an adequate supply of private credit for the construction and modernization of health facilities.

The present construction-grant program has accomplished much since 1946, and its usefulness was further enhanced by the amendments enacted last year. But we cannot depend on Federal grants alone to stimulate the additional construction required. We need a new program to aid those sponsors of health facilities who could finance the costs of construction if adequate credit were made available from private sources. Title II would meet this particular need.

This proposal is designed to encourage banks and other private lending institutions to make substantial loans for the construction of health facilities. Where such credit is now available, it is usually limited to such a low proportion of the total construction costs as to make it impossible for many prospective sponsors to provide the remainder as a "downpayment."

Title II would adapt the mortgage loan insurance device—which has proved so effective in housing and other fields—to construction loans for health facilities. Federal insurance would be made available, in return for premiums paid by the lending institutions, for loans to nongovernmental sponsors for the construction or renovation of hospitals, clinics, nursing homes, and related health facilities.

No loan insured under the bill could cover more than 80 percent of the estimated value of the completed project, or such lower percentage of the value as might be prescribed by regulation for all or particular types of facilities. The maximum period for which an insured loan could run would be 30 years.

A ceiling of 1 percent would be set on any insurance premium, with rates fixed administratively to cover expenses and reserves for possible losses.

The program would be administered by the Secretary of Health, Education, and Welfare, with authority to utilize other agencies. An appropriation of $10 million would be authorized as working capital for the first fiscal year, and thereafter such additional sums as may from time to time be required as working capital.

The maximum insurance liability for the program as a whole would be $200 million, but this could be increased by an additional $150 million if found by the President to be in the public interest.

TITLE III.—PRACTICAL NURSE TRAINING

The third and fourth titles of S. 886 under consideration are aimed at reducing some of the shortages of trained health personnel which are obstacles to the improvement of essential health services.

Title III is concerned with one of our most conspicuous shortages—that of nursing personnel. Its purpose is to stimulate an immediate increase in the number of practical nurses trained to perform those duties which do not require the skills of a professional nurse. By increasing the number of trained practical nurses we can reduce our total nurse shortages and at the same time achieve better utilization of our limited supply of professional nurses.

The provisions of this title would expand the practical nurse training now being offered under existing State vocational education programs. At present 45 States are providing such training on a limited basis, but there are many parts of the country where there are no training programs available, and the total supply of trained practical nurses falls far short of present demand.

Title III would authorize a 5-year program of earmarked grants to State vocational education agencies for the extension and improvement of practical nurse training programs. Grant funds would be available for costs of instruction and of professional supervision of training programs. To encourage the extension of training programs and to improve the quality of training offered, technical assistance and consultation services also are authorized.

For the first year of this 5-year program an additional grant appropriation of $2 million is authorized; for the second year, $3 million; and for each of the remaining 3 years, $4 million. These funds would be allotted among the States on the basis of their populations. For the first 2 years of the program, the matching-fund requirements call for at least 1 State dollar for every 3 Federal-grant dollars. For the remaining 3 years there would be a dollar-for-dollar matching requirement, as in the case of regular vocational-education-grant programs.

TITLE IV.—GRADUATE TRAINING OF PROFESSIONAL NURSES AND OF PROFESSIONAL PUBLIC HEALTH PERSONNEL

Title IV is directed toward relieving two other health personnel shortages—(1) professional nurses specially trained for supervisory and teaching positions, and (2) professional health personnel with advanced training in public-health skills.

The shortage of nurses with advanced training is accentuated by the need for better utilization of nursing skills, to which I have already referred. To conserve the time of our most highly trained nurses—and to supplement their services with those of practical nurses and nurses aides—requires a high degree of competence in planning and supervision. It also requires nurses who are qualified to train auxiliary-nurse personnel.

The present supply of nurses with supervisory and training skills is inadequate even to fill present demands. The difficulty lies in the fact that to few nurses who have completed their basic training can afford to leave their employment for an additional year of advanced schooling. School enrollment figures show that

approximately two-thirds of the nurses taking advanced-training courses are enrolled on a part-time basis. Consequently, training which would require only a year or so of full-time study is extended over a period of 3 to 10 years.

A somewhat similar situation is found among professional health personnel—such as physicians, sanitary engineers, and nurses—who have supplemented their basic professional education with graduate instruction in public-health problems and methods. Although there are not enough such specialists to meet present requirements, and although the need is steadily increasing, the current level of enrollment in advanced-training programs is insufficient even to offset annual attrition rates.

Here again the cost to the individual is a primary factor limiting enrollments. While State and local governments, as well as Federal agencies, are helping to meet this problem by underwriting training costs for some of their employees, additional financial support is urgently needed.

To help meet these two basically similar personnel shortages, title IV would authorize the Surgeon General to provide traineeships for the graduate training of professional nurses and professional public-health personnel. The provisions of this title are patterned after the existing authorization for traineeships in mental health, heart disease, cancer, and other health fields for which research institutes have been established in the Public Health Service. The training could be provided either in educational institutions, or in Public Health Service facilities. Traineeships could also be established and financed through grants to public and other nonprofit institutions. The money value of the individual traineeships would be established by the Surgeon General and would include a stipend and allowances for such expenses as travel and subsistence.

TITLE V.—PUBLIC-HEALTH SERVICES

The first major legislation authorizing Federal grants to States for public-health services was enacted in 1935. Additional grant authorizations have been added through subsequent enabling legislation and through the earmarking of annual appropriations. The Public Health Service now administers six separate State-grant programs—one grant for geenral public-health services and separate categorical grants for venereal-disease control, tuberculosis control, mental-health services, cancer control, and heart-disease control.

Each of these grant programs has had a salutary effect on the improvement of public-health services in our States and communities. We believe, however, that some modification of the structure is now desirable. Our objectives are to assure greater program flexibility and to provide greater assistance in the extension and improvement of existing programs. Title V would accomplish this desired modification.

The Public Health Service Act would be amended by this title to authorize a single, consolidated public-health grant to States in place of the present separate grants for general health and for the control of venereal disease, tuberculosis, cancer, and heart disease. Title VI, which is described below, would continue the separate grant for mental health for 5 more years.

The new consolidated grant would be allotted among the States on the basis of population, financial need, and the extent of health problems of the various States. On the basis of plans approved by the Surgeon General, States would be enttiled to receive a percentage of the cost of their public-health services. These Federal shares would vary in inverse proportion to the States per capita income—ranging from one-third to two-thirds.

To encourage the extension and improvement of public-health services, the Surgeon General would be authorized to provide that a portion—not to exceed 20 percent—of the allotments of the States may be used by them only for extending and improving their services. States would be entitled to receive 75 percent Federal participation in the costs of an extension and improvement project for the first 2 years of the project and 50 percent participation for the third and fourth years.

In addition to this consolidated grant, which would be allotted among the States in accordance with a standard formula, title V would also authorize special project grants to be made on the basis of individual applications. These special project grants would be employed to meet two types of situations for which a State-by-State formula grant is not appropriate. First, they would be used to provide pinpoint Federal assistance in meeting local or regional problems which have some national significance but which are not common to most States or localities. Second, special project grants would be employed to help finance ex-

perimental or demonstration projects which offer promise of developing new or improved methods of meeting public-health problems.

TITLE VI—MENTAL HEALTH

The final title of the bill has as its objective the intensification of Federal activities relating to the problem of mental illness—which is in many respects the most urgent health problem facing the Nation today. There are an estimated 9 million persons in the United States with serious mental disorders, most of them untreated, and those who are receiving institutional care or treatment occupy nearly half of the Nation's hospital beds.

The provisions of the Mental Health Act of 1946 already provide a statutory foundation for Federal research and training activities, as well as for grants to the States for the support and improvement of community mental-health services. Title VI proposes two amendments to the basic act. The first would strengthen and clarify the existing authorization for State grants. The second would provide new authority for special project grants aimed at improving institutional care and treatment of the mentally ill.

The provisions relating to "Grants to States for Mental Health Services" would not materially modify the basic authority of the Public Health Service in this area. Rather, they would incorporate into the basic act the administrative pattern of the existing categorical grant. The only modifications would be those required to assure consistency with the pattern prescribed by title V for the consolidated public-health grant. The principal effect of these provisions is to assure that grants to the States for this purpose will be separately appropriated and allotted for the next 5 years.

The second objective of title VI is to provide authority for the Public Health Service to contribute, through special project grants, to improved care and treatment of patients in mental hospitals. These special project grants could be made to State agencies responsible for administering State mental-health institutions or to appropriate nonprofit agencies for the development of improved methods of treatment and institutional administration.

One of the most urgent of all mental health needs is that of reducing the average length of hospitalization. This is essential both to improve the prospects for returning patients to their homes and communities and to reduce the staggering financial burden on our State and local governments. Fortunately, recent developments in institutional care methods offer new hope for the recovery and rehabilitation of many patients who have heretofore been regarded as permanent inmates of our mental institutions. By providing financial backing for the acceleration of these new developments, the Federal Government can make a significant contribution to the solution of this critical problem.

Secretary HOBBY. This committee has already received testimony indicating the extent and the seriousness of mental illness, but I should like to review very briefly some of the facts which lead us to the conclusion that the mental health problem is in many respects the most urgent health problem facing the Nation today. Two intensive mental health surveys indicate that as much as 6 percent of our total population, or about 9 million people, have serious mental disorders. Unless something more is done to prevent and control mental illness, 1 out of every 12 children born today will spend part of his life in a mental hospital.

Few families have the resources to pay for the prolonged treatment required for serious mental illness. After the family resources have been exhausted, there remains a tremendous financial burden upon the taxpayers of the Nation. The direct dollar cost for care of the mentally ill in hospitals, and for benefits to veterans with mental disorders, is more than $1 billion a year. This cost is rising at the rate of $100 million a year.

Hospitalization for the mentally ill accounts for a major share of the cost of mental illness.

Half of the hospital beds in the United States are occupied by mental patients, and 98 percent of the beds they occupy are tax supported.

The human suffering of families and individuals as a result of mental illness is beyond calculation. Of greater concern than the dollars and the mathematics involved is the loss of human resources represented by the mentally ill—and the impact of this loss on our national well-being.

SOME SIGNS OF PROGRESS

Research and experience are creating new opportunities in the prevention and treatment of mental disorders. At the same time, there has been a change of attitude toward those who suffer from mental illness. In the light of this new knowledge and understanding, we are better able to assess the effectiveness of our national effort to combat mental illness and to press forward toward greater accomplishments.

Progress is being made on many fronts. For example, the experts tell us, half or more of the persons suffering from schizophrenia can be helped by modern treatment methods.

With use of shock therapy, we have greatly increased the recovery and discharge rates of patients suffering with certain types of psychosis.

A recent study in one State hospital indicated that by the use of new drugs and new therapeutic techniques, the chance of recovery for long-term mental patients can be tripled.

These advances benefit patients in mental hospitals. But not all mental patients require hospitalization. Increasingly, mental illness is being detected in psychiatrists' offices and in mental health clinics. This permits early treatment, and thus often avoids more serious illness.

THE NATIONAL EFFORT

Many groups, both governmental and private, are working effectively to increase knowledge of the prevention and treatment of mental illness, and to encourage the application of this knowledge. Regional, State, and local activities reflect the growing awareness of the American people that mental illness is a serious problem which must be attacked on all fronts.

Groups of States are working together on regional problems. The governors have met several times to consider a program of concerted action against mental illness. State appropriations for mental-health activities have increased significantly in some instances—and the States are concerning themselves not only with care and treatment, but with prevention and education as well. It is this kind of response which demonstrates the potential of the Federal-State-local partnership, and helps to clarify the proper role of the Federal Government.

As for the mental-health activities of the Federal Government, they are of three kinds, spread among several bureaus and agencies.

First, the Federal Government operates special services for the care of the mentally ill who are its beneficiaries or wards. The agencies which provide these services include the Veterans' Administration, the Armed Forces, St. Elizabeths Hospital, the Public Health Service, and the Federal prisons.

Second, the hospital survey and construction program of the Public Health Service provides financial assistance to States for building mental institutions.

Third, the Federal Government maintains and supports programs aimed at the prevention and control of mental illness. Several of these programs are centered in the Department of Health, Education, and Welfare. The Children's Bureau, the Office of Vocational Rehabilitation, and the Office of Education all have special reasons for being concerned with mental health. But the most extensive program is centered in the National Institute of Mental Health, a division of the Public Health Service.

THE NATIONAL INSTITUTE OF MENTAL HEALTH

The program of this Institute is known to many of you. This committee was instrumental in the passage of the National Mental Health Act in 1946. Since then we have had ample proof of the wisdom of this legislation.

A brief review of the current activities of the National Institute of Mental Health may be helpful in portraying the relationship of the proposals in title VI to the present mental-health program of the Public Health Service. In general, the Institute deals in research, in training, and in community services.

In the study of mental illness research ranges from studies of the central nervous system to exploration of factors which affect human behavior. The Institute conducts research in its own facilities and makes research grants to independent investigators in medical schools, universities, and other non-Federal research centers. The Institute also supports a number of research fellowships, permitting young scientists to obtain supervised research experience.

Under the training program of the Institute grants are made to professional schools to improve the quality of training and to increase the number of competent professional workers. There is a serious shortage of qualified personel in the mental-health field. Trained people are needed for clinical services, teaching, research, and administration.

The community-services program carries out those provisions of the National Mental Health Act which authorizes assistance to the States in the prevention, diagnosis, and treatment of psychiatric disorders. Grants are made to the States and Territories for mental-health programs conducted outside mental hospitals and other institutions. Money is allotted on the basis of population, financial need, and the extent of the problem in each State. Two Federal dollars must be matched by not less than one dollar of State or local funds expended for the same purposes. Although this is the required ratio, by 1953 the States as a whole were matching each Federal dollar with more than $5 of their own.

The National Institute of Mental Health works through the mental health authority in each State. It provides technical assistance and consultation, makes special surveys on request, sets up demonstrations, and assists in program planning.

I should like at this point to ask Dr. Robert H. Felix, Director of the National Institute of Mental Health since its beginning, to illustrate and describe briefly the current program of the Institute.

Chairman HILL. We will be glad to have Dr. Felix at this time.

Dr. FELIX. Mr. Chairman and gentlemen of the committee, as Secretary Hobby has stated, there are mental health programs carried on in a number of bureaus or departments of the Federal Government.

The Veterans' Administration provides care and treatment for mentally ill veterans in their own hospitals and outpatient clinics.

The Department of Defense provides diagnostic services and treatment services for mentally ill members of the Armed Forces.

The Bureau of Prisons in the Department of Justice gives care and treatment of the mentally ill in Federal prisons.

In the Department of Health, Education, and Welfare, in addition to St. Elizabeths Hospital, the Office of Vocational Rehabilitation, the Office of Education, and the Children's Bureau have programs which have strong mental health components contained in them.

There are several programs in the Public Health Service which have mental health implications, but the one in which the program of mental health is principally centered and the one charged with the obligation of carrying out the act, is the National Institute of Mental Health, and I should like to describe this in a little more detail, if I can.

In this, as in all other health fields, Mr. Chairman, research is the base from which developments come, and out of which progress is accomplished, as we have seen most dramatically in the last 48 hours.

The Institute has scientists working on clinical investigations and laboratory research at the Clinical Center in Bethesda, Md., which you have seen; at the Addiction Research Center in Lexington, Ky., and at the Mental Health Study Center in Prince Georges County, Md.

Research covers a wide range of subjects, from the analysis of severe emotional disturbances in children, evaluations of the effectiveness of psychotherapy, and the relation of disordered brain function to the major psychoses, all the way down to such basic research as the biochemistry and metabolism of the nervous system and the causes and mechanisms of drug addiction.

In addition, grants are made to non-Federal scientists working in universities and laboratories throughout the United States, after their applications have been reviewed by a technical panel of non-Federal scientists and by the National Advisory Mental Health Council.

The Surgeon General makes these grants on the recommendations of the Council, as provided by law.

In addition to this, research fellowships are granted to promising young scientists to encourage them to pursue careers in the mental health specialty fields.

In addition to this kind of work, the Institute carries on statistical studies of the incidence and prevalence of mental illnesses in all of its forms, working very closely with the States to develop a model system for the reporting of data in this area.

I am sure that you are all aware that data of this kind are an absolute necessity for the planning of programs in the future, including such things as capital investments, new buildings, and so forth.

Now, I should like to move to another element of the program, if I may.

The Institute is assisting along with other organizations in trying to decrease this great deficit of trained personnel. The Institute

makes training grants and traineeship grants to institutions of higher learning and assist in the training of professional personnel, such as psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, and public health officers.

In addition to this, the Institute sponsors special conferences designed to develop new types of programs of training and to orient professional people in other professions to mental health problems.

Currently, the Institute is assisting 229 graduate training programs. Since the beginning of the program about 3,000 trainees have received individual assistance, and we have assisted about 48 medical schools to develop better programs of psychiatric training at the undergraduate level for their medical students.

Now, all of this, of course, has had an impact on the deficit, but it is by no means meeting it, and we feel that much more attention must be paid to this element of the problem if we are going to get on top of this anywhere soon.

Finally, the Institute, through its grants-in-aid to the States' program, assists the States in developing their community services programs. These services, administered by the States, help to alleviate the emotional distress and prevent more serious mental disorders. This is the type of program which title VI of the act proposes to extend for an additional 5 years.

Now, in addition to the grants made to the State mental authorities, the Institute provides technical assistance and consultation to the State mental health authorities or request. This assistance is for the purpose of helping the mental health authorities with various aspects of their problems, bringing to the State information with regard to programs in other States which they may be able to use.

Now, the State mental authorities very frequently work closely with other State agencies, such as those concerned with vocational rehabilitation, welfare, public assistance, and so forth.

The actual handling of the services is through voluntary agencies, and the focal point is the mental-health clinic, which provides treatment and guidance for persons with emotional disturbances.

In addition, it works cooperatively with schools, welfare agencies, and the courts and other agencies at the local level, so that there is an integrated program for the counseling, early detection, diagnosis and treatment, and health education.

Now, Mr. Chairman and gentlemen of the committee, while this is really a three-pronged program trying to attack these problems, these are closely tied together and each depends on the other. We need research in order to get the knowledge, and we need more trained people in order to deliver the services.

Thank you.

Chairman HILL. Any questions?

Senator LEHMAN. Madam Secretary, nobody is more interested in research and the whole question of mental health, the treatment of mental illness than I am.

I think that it offers the greatest field for the Government than any of the other great branches of medicine.

I wonder, however, whether the existing mental-health programs do not already give broad authority. If that is the case, is it not a fact that really what is needed is that the administration request more

funds for the carrying out of research and the services under the existing Mental Health Act?

Secretary HOBBY. Senator Lehman, there are two items there.

Now, as to the authority in the act, I would prefer to let Dr. Scheele answer that because he is more competent than I am to answer that.

Chairman HILL. Dr. Scheele.

Dr. SCHEELE. Senator Lehman, I do not believe that the authority in the present act is very clear on this subject of the special project grants of the type Mrs. Hobby is testifying to here, and we believe that a point of order might be raised if we would have funds under the present act. That is why we ask for additional authority.

However, in other areas in the mental-health field, we have asked for increases over last year. For example, for mental-health programs in the States, our level this year, 1955, is $2,325,000, and in the present request for 1956, we have asked for $3 million.

In training, we have stepped up the request from this year's $4,310,000 to $5,810,000 for next year.

Senator LEHMAN. What were those last figures?

Dr. SCHEELE. This year, $4,310,000, and the request pending before the Congress for 1956 is for $5,810,000, a $1,500,000 increase for training, or a 37-percent increase.

So, taken together, these things represent a rounded-out program including legislation, and we would propose to ask for $1,250,000 additional under the new authority in addition to the other increases that have been asked for under existing authority.

Senator LEHMAN. May I ask whether the figures you have given are the President's figures, or the figures the Institute recommended?

Dr. SCHEELE. These are the President's budget.

Senator LEHMAN. I wonder whether you would mind telling us what the Institute asks for as a minimum, to satisfy the minimum needs.

Dr. SCHEELE. I do not believe we have those figures with us. On the other hand, I think the figures are very close. We can supply that for the record.

Dr. FELIX. As a matter of fact, Senator Lehman, the Budget Bureau allowed all we asked for, and in one category, they allowed a little more than we asked for.

Senator LEHMAN. The Secretary has testified in her statement that approximately 9 million people are suffereing from some form of nervous disorder or mental illness. I believe that in the State hospitals alone there are 750,000 patients under custodial or medical care, and in my own State, New York, we have 130,000 right now. There is no one field of medicine, in my opinion, that is entitled to fuller support than this field of mental illness.

Now, I wonder whether the Secretary will agree with me that in view of the very small increases to which the Surgeon General has testified—increases of from $2,500,000 to $3 million, and from $4,500,000 to $5 million—that in view of the scope of this problem and the urgency of this problem—I want to emphasize that I believe no problem is more important—these figures that have been asked for seem to me to be very meager, indeed.

I believe the Congress would give very considerably more in order to relieve, at least to some slight degree, the great needs in this area which are increasing, not decreasing.

Secretary HOBBY. I am certainly glad to hear the Senator express that opinion because, as I testified, it is one grave problem.

But, Senator, money does not always solve everything. These people I have with me are much more competent to testify in this field than I, but I may say this:

We are far behind on the mental health program. This is very obvious; and we should have been about this years ago. Had we been, then we would not have the present shortage in personnel that we have.

But I would like for both Dr. Scheele and Dr. Felix to tell this committee what actually happens when you try to move too fast on a program. This problem has had the greatest thought and concern, along the very lines that you have asked about, Senator Lehman. It is not an unawareness of this problem, but a very thoughtful consideration of its scope.

Now, Dr. Scheele and Dr. Felix, both, I would like to have comment on this because we sat around the table and worried about the same problem that you raised.

Dr. SCHEELE. I would add this. We have to stay in phase. In the field of research, for example, we are finding in many instances in mental health that much of this research is research in the social sciences, and we are not probably as ready to move as rapidly and objectively as some of the natural sciences. Gradually, as some of the doors open toward understanding of the organic background of some mental illnesses, we will in future be able to move more rapidly, and Dr. Felix' program is taking advantage of these breakthroughs which are coming in our knowledge of mental illness.

So, we feel that the amounts that we are asking for, matched against the number of requests we have, represents adequate Federal support in that area for next year.

In the training area, we have not only the problem of wanting more people trained by also the problem of having facilities in which to train them. And certainly large sums of money will not provide facilities to train; money alone will not take care of that, as Mrs. Hobby said.

Senator BENDER. Doctor, do you think what you have asked for is an adequate approach, in view of the situation on training personnel?

Dr. SCHEELE. We think it represents an adequate Federal approach to the problem, and in a few moments Secretary Hobby is going to describe the title of the omnibus health bill which we think will give us—I do not want to get ahead of her statement here—but she is going to describe a program which we think will do many of the things Senator Lehman would like to have done.

We think this approach is going to do something about this ever mounting cost, both in terms of need for manpower and need for more institutions to take care of these people as custodial patients. As the story unfolds, I think you will, I hope you will, gain the impression that there is a means, a way to make a big impact on this problem of institutional care. This is one of the major problems in the whole field.

Senator LEHMAN. Doctor, I do not want anything I say construed as a criticism of the Institute of Mental Health. I admire the work you are doing down there, and I have had the privilege of visiting with you just 2 weeks ago.

Now, we had this same situation exactly when we had the bill for helping the physically handicapped, when I pointed out that although I thought that what we were doing is extremely important, that we should do far more, that we were not even making a dent in that great category of the physically handicapped, and that that class, the physically handicapped population, is increasing and not decreasing.

Now we are confronted with exactly the same situation here in this matter of the treatment of mental health; it is certainly not improving. I cannot speak for every State, but it is my opinion that probably the experience in my State can be and has been duplicated in many of the other States, that is, that the population of the mentally ill is increasing and not decreasing.

Therefore, I believe that we should proceed much more rapidly than we are.

May I ask you this question, and I am not at all certain that my facts are correct:

I have been told that the Advisory Council of the Institute of Mental Health reported that $30 million was needed this year, and yet that the budget has asked for only $17,500,000. Am I correct in that?

Dr. SCHEELE. Yes, sir; you are correct.

Senator LEHMAN. Well, now, why should the recommendation of the Advisory Council have been disregarded?

Dr. SCHEELE. Dr. Felix reminds me that a part of that request was for construction, and we did not feel at the present time that in the light of all of the needs in the Public Health Service and in the light of matching of needs in the Public Health to all the needs for Federal funds in the Department, and the Government as a whole, that we could go more rapidly than we are proposing in the $17,500,000 request. There, obviously, is a question always regarding the proper amount to ask for.

We think that more effort should be made in our States, and we think that our States are beginning to show evidence, in an increasing number of instances, of doing something about these problems themselves. That is, they are doing something more about the problem than just hospitalizing the patients and building more State mental institutions.

We have been very much pleased by the regional conferences of governors that have been held in several areas, particularly the Southern governors' conferences, where the States for the first time are recognizing training needs more adequately. Dr. Felix can describe that in detail.

The States are pooling, for instance, to operate on a regional basis. They have made arrangements to send men and women from one State, a State that does not have training facilities, to another State for training.

We believe that more development of this kind of spontaneous program and effort at local and State levels is the thing that is going to make us catch up with this problem, without necessarily doing it through greatly increased Federal appropriations each year. In other words, we feel that we are going to have a team approach, one that will not destroy State and local initiative.

Senor LEHMAN. Well, you might say that the States are not doing enough, but would you not agree with me that at least the State of

New York—and I am sure it is true of the other States—is carrying a tremendously heavy burden, when I tell you that in my own State of New York approximately one-third of the total State budget, exclusive of State aid to education, is for the care and treatment of the mentally ill.

Now, that is pretty substantial proof that the State is doing its very full share and doing a remarkably big job.

Dr. SCHEELE. It is a staggering sum of money that is being spent in New York State and other States for the care of mental patients, and particularly custodial care in the institutions.

Senator BENDER. In which field of mental health do you think there is the primary need; is it for training of personnel, or more buildings and facilities?

Secretary HOBBY. I can answer that in two or three ways, Senator Bender, but may I comment on the point Senator Lehman has raised? The terrific burden in your State in custodial care for the mentally ill, Senator Lehman, cannot be met unless we develop techniques through research to keep people out of mental hospitals—that is where we need to do much work. Many people go to mental hospitals and are committed, without, as you know, ever having had any care which might have kept them out of the hospital.

The second point, which I think bears particularly on the tremendous problem of custodial care of people in institutions, is that in most hospitals we do not have enough trained personnel to give patients proper attention. Now, I do not want to get ahead of the testimony, Senator Bender, but there is an important point to be made relative to what one can accomplish during the first year of occupancy in a mental hospital if one has enough trained personnel.

I would say, Senator Bender, there is not any one simple answer. One has to take it in all of the several parts, trying to approach the solution.

Senator BENDER. Well, if you had to make a choice, would you put more funds for personnel and training, or would it be for more buildings and physical facilities?

Secretary HOBBY. Well, Senator, that is an awful choice to make, when we need beds for people who are now mentally ill.

I think some way we must find the balance to take care of these people who are now mentally ill, and to try to keep people from becoming mentally ill and keep them from coming into the mental institution. It is a balance one has to achieve.

Senator BENDER. Senator Lehman, of course, is an expert on New York, and I have no reason to question any statement he makes regarding mental care of the people in New York and the money appropriated there.

However, I would say about my own State of Ohio that the most unattractive jobs in the whole State are these menial jobs of the people at these various mental institutions and the miserable wages that are paid and the lack of proper care, on the basis of the people who actually come in contact with these mental patients.

I think that is not an unfair statement. I think it is an observation that applies quite generally throughout the country—and I am excepting the State of Alabama and the State of New York. [Laughter.]

But I am wondering if we are concerning ourselves with that, if there is an effort being made to survey what the wages are that are paid to these people and the conditions under which they work.

Secretary HOBBY. Senator, we have no authority to make such a survey. I think there are some private figures.

I will, if I may, in commenting upon the Senator's remarks, say that the heartening thing is—and I mentioned this in my testimony—the growing awareness of the mental health problem of this country and the growing awareness that something can be done about the mentally ill.

It has not been so long since people thought that nothing could be done about a person committed to a mental institution. Now we know that that is not true. And there is not the same sense of shame, not the same stigma attached to mental illness that there has been. Now that we are beginning to have that kind of climate growing in this country, some of the ills that you mentioned with respect to mental institutions are going to be taken care of because public opinion, the searchlight of public opinion, is going to be focused on it.

Senator BENDER. I would like to ask you to reply or make a comment on a recent article that appeared, carried by the Associated Press and other press services, in which this is stated, and this was carried all over the country:

> A mental health specialist criticized the Eisenhower administration yesterday for sharply cutting the budget recommendations recommended for National Institute of Mental Health. He was Mike Gorman, executive director of the National Mental Health Committee, a private group working closely with the States, in testimony prepared for the House Commerce Subcommittee holding hearing on administration measures designed as a new attack on mental illness. Gorman said the Advisory Committee of the National Institute of Mental Health had urged a budget of $30 million for the year beginning July 1, yet the administration ignored this recommendation and proposes only $17,500,000 instead.

Now, I am wondering if this administration is being niggardly in the matter of handling this problem, that is, dragging its feet; or is it better or worse than the previous administration in the matter of handling this problem?

Secretary HOBBY. Senator Bender, I have not seen the testimony to which you refer, but I would say that it is a matter of opinion. If it was Mr. Gorman you were quoting, he is entitled to say anything he pleases. That is a matter of opinion.

I do not believe that there is any such approach here. I know that the gentlemen of this committee, having been here a long time, know that there are a great many requests for funds made by all groups. And, when you add them up, like any other household budget that I know of in the world, so far as I am concerned—and the national budget is like a family budget—one cannot give each child everything that it wants at any one time. One must find a balance.

So I would say—and I think you probably agree—that if we had not a real interest in this we would not be here; but I do not desire to enter into any controversy with Mr. Gorman as to what his personal opinion is on what we have presented.

Senator LEHMAN. Mrs. Secretary, may I say a word in reply to that?

I realize that governmental budgets are very much like a family budget and must be carefully considered, but I think that there are three fields in which the Federal Government and the State govern-

ments, if you will, should go much further than they have gone, because I believe that the people are entitled to full recognition and consideration in regard to those activities. One is the health of the people. I do not think any cost is too high for the health of the people.

The second is the education of the people. I again want to say that I do not think any cost is too high to safeguard and to make possible the education of the people.

The third is the maintenance of civil rights and liberties.

I think that those three fields are in an entirely different category than others.

We hear about the Federal Government spending $21 billion, I believe, for good roads. I am not against good roads. I am for them; I always have been. But I do not think that the question of good roads, the necessity of good roads, is even within hailing distance of the needs of furthering the health of the people and the education of the people.

We are very niggardly in the observance of that rule. I think we fight against giving money which unquestionably, in my opinion, could protect and further the good health and the education of the people, purely on the ground of economy.

Secretary HOBBY. I must say that I have a great feeling of sympathy for you gentlemen who sit on this committee, and you gentlemen who sit on the Appropriations Committee, when you go to make up the budget, because I know that you listen to many pleas. I know that you are always aware of the necessity for balancing the budget.

There could be no difference between the Senator from New York and the Secretary of Health, Education, and Welfare, in what he has just said about the importance of these subjects.

Senator LEHMAN. Then I wish that you would put in a request for $30 million, instead of $17,500,000.

Secretary HOBBY. The Senator can write himself an interesting amendment.

Senator BENDER. Mr. Chairman, if I might call attention to the fact that you are not limiting yourself to $17,519,000.

Is it not a fact that you are proposing for later transmission to special projects, grants for improved institutional care, $1,250,000, which is all new money? And is it not a fact, too, in the second instance, that for mental health control grants to States for community preventive services you are asking for $3 million as compared with $2,325,000 for 1955, and $2,307,000 for 1954, a 30 percent increase?

And then in the third instance, is it not a fact that for intensified training, mental health personnel, as compared with $4,310,000 for 1955 you are asking for $5,810,000, an increase of $1,500,000 or nearly 40 percent increase?

Is that not a fact?

Secretary HOBBY. Those are the facts.

Chairman HILL. Will you proceed, please?

Secretary HOBBY. Thank you, Mr. Chairman and gentlemen of the committee.

Dr. Felix has shown how the program of the National Institute of Mental Health is being carried out on the broad legislative base provided by the National Mental Health Act. But changing conditions

often require adjustments of existing programs to keep pace with the times. This is especially true in a field that is relatively new.

We have found that there are three parts of the mental health program which are in particular need of emphasis.

TRAINING OF PERSONNEL

One of the essential needs is for the training of additional mental health specialists.

There are many budgeted positions in mental institutions which cannot be filled because the trained personnel is not available. This means inadequate care for patients in those hospitals. We also need more trained personnel for mental health clinics and community programs, for research, for teaching the many skills and disciplines involved in the study of mental illness, and for care of the mentally ill.

As Dr. Felix has indicated, one part of the National Institute of Mental Health program consists of providing training grants and traineeships. We have reviewed our legislative authority in this field very carefully, and we have concluded that it is adequate. However, we propose to expand our program of training specialized personnel, and we have requested an increase of nearly 40 percent in the Mental Health Institute's 1956 training budget, from the present level of $4 million to $5½ million.

GRANTS TO STATES FOR PREVENTIVE SERVICES

A second area to be strengthened is the authorization of grants to States for mental health services.

Title V of S. 886 proposes consolidation of all categorical grants to States for public health services except the grant for mental health services. The statutory provisions for continuing this mental health categorical grant for another 5 years are contained in title VI.

Chairman HILL. That statutory provision required in the present Mental Health Act of 1946 is not limited, is it?

The authority in the Mental Health Act of 1946 continues, does it not?

Secretary HOBBY. Senator Hill, this title V that I referred to here would propose a consolidation of the grants into a block grant, except the mental health grant.

Chairman HILL. For 5 years?

Secretary HOBBY. Yes.

The National Mental Health Act of 1946 did not establish a categorical grant in the basic statute. In annual appropriations since 1947, however, grant funds for mental health services have been separately earmarked so as to provide, in effect, a categorical grant for this purpose. Title VI would convert this appropriations category into a category in the basic act for the next 5 years. This proposal does not include any new program authority, but it will give the program additional emphasis and assurance of continuity. The limitation of the extension to a 5-year period reflects our belief that any categorical grant authorization should provide for periodic congressional review to see if there is still need for a separate grant.

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Except for the matching provisions, the new statutory language would make no change in present grant formulas or procedures. The matching provisions would be modified slightly to assure consistency with the provisions in title V for the consolidated public health grant. The present law requires State matching funds, but leaves the exact matching ratio to be specified in administrative regulations. As I indicated earlier, the present regulations require 1 State dollar for every 2 Federal grant dollars. Under the provisions of title VI there would be a statutory matching ratio varying from one-third to two-thirds Federal participation, based on the per capita incomes of the several States.

SPECIAL PROJECT GRANTS FOR IMPROVED INSTITUTIONAL CARE

The third area requiring emphasis is improved care and treatment of patients in mental hospitals. This area of mental health has received very little systematic study and development in the United States, and there is a conspicuous need for pilot studies and demonstrations to stimulate further improvements. Title VI would authorize special project grants for this purpose.

These special project grants would be administered by the Surgeon General, with the assistance of the National Advisory Mental Health Council. Grants would be made on the basis of applications submitted by State agencies responsible for administering institutions for the care of the mentally ill or by other public or nonprofit agencies.

This provision of title VI is focused on the 725,000 patients in mental institutions, and on the many more who may some day need hospitalization for mental disorders. The pilot studies to be financed under this program would concentrate on institutional care. New techniques of management and therapy developed by these studies would be widely disseminated among mental hospitals and institutions.

To indicate why improved methods of care and treatment are needed, a few additional facts should be considered.

One involves the length of stay of the mentally ill in hospitals and institutions. More than half of the patients have been under treatment 8 years or more, and the proportion of those chronic patients is increasing. While some progress is being made, the fact remains that our mental institutions are still largely custodial.

Another fact is that about half of the patients admitted to a mental institution are released during the first year of hospitalization. But the prospects for release fall off sharply after the first year. It is therefore essential that we develop improved techniques of treatment and management of mental illness during those first crucial months.

We were to have with us this morning Dr. Winfred Overholser, Superintendent of St. Elizabeths Hospital, which this year is celebrating its centennial of service to the mentally ill, to discuss and illustrate the nature of these studies and their potential meaning to mental hospitals and clinics, Dr. Overholser was taken ill last evening and cannot be here.

Mr. Chairman, may Dr. Felix substitute for Dr. Overholser?

Chairman HILL. Yes. We will be delighted to hear from Dr. Felix.

Dr. FELIX. Mr. Chairman and gentlemen: This chart, and the one that follows it, are directed primarily toward the second provision of title VI in the omnibus health bill.

(The chart referred to, entitled, "Our Mental Institutions," appears in the prepared statement at p. 127.)

Dr. FELIX. One of the great problems we have in this country with regard to the mentally ill is the extreme length of stay of the patients in hospitals. This chart shows that in a graphic way.

Of some five-hundred-odd-thousand patients in State mental hospitals alone, not considering private hospitals, Federal hospitals, nursing homes, but only the State mental hospitals alone, 75 percent of these patients have been in the hospital for 2 years or more; 50 percent of them have been in for over 8 years; and a quarter of these have been in for more than 15 years. Only about 14 percent of these patients have been in for a year or less.

This, in itself, of course, is a tragic thing, but let me point out something else which I think makes this even more important.

A review of the statistics from the hospitals in the country over the last several years shows that the chances of a person getting out of a hospital alive during his first year of hospitalization is about 50–50. By the time the patient has been in the hospital for 2 years, his chances of getting out alive are about, that is, his chances against getting out alive I should say, are about 16 to 1. By the time the patient has been in the hospital for 8 years, his chances against getting out alive are poorer than 99 to 1.

It does not matter how much we treat this favorable group. They will get out with adequate treatment, but what can we do for this ever-increasing backlog of patients, which is filling our hospitals and which is growing, as I think it was you, Senator Lehman, mentioned, year by year.

(The chart referred to, entitled "Special Project Grant," appears in the prepared statement at p. 128.)

Dr. FELIX. The proposal in title VI of the bill attempts to meet this. There is research going on in the country today, of course, through grants from the Institute on Mental Health, and from private foundations, et cetera. These research projects are of the more formal type of research, they are very necessary, and we could not do without—we could use much more basic research, as I mentioned a minute ago, into studies of the brain and the metabolism of the brain, clinical studies, et cetera, but the other thing which is not being done in any amount at all is that about 6 percent of our total effort is to find new and different ways of dealing with and helping those patients with the personnel we now have on duty in our hospitals.

There are several things that could be done. These we call pilot studies, because they would point the way for States to carry on further, and also would be studies which the States can carry forward with some assistance through the grants, if allowed in this bill, and adding to that the money they are now spending for care of the patient.

Such procedures as improved methods and management of their hospital administration could be carried forward.

I believe it was Senator Bender who mentioned a bit ago the large turnover. What can they do about the some-400 percent turnover a year ago which we find in certain categories of personnel in the year? What different methods of management and administration of the institution? New and different methods of care and therapy of patients in the hospital. There are a number of these. For instance,

in California recently they have carried on a study in what they call the "total push" method, in which a variety of efforts are directed toward the patients at the same time. And they have found that among the chronic deteriorated patients they could increase by almost three times the number of patients who would be released from the hospital. These are the chronic deteriorated patients.

Then, in addition to this, there are alternate long-term care facilities which can be used, which will assist the patient to get out in some cases; in others, will at least relieve the congestion in the hospital where the more acute types of therapy can be carried on.

There is the cottage plan which is being used in some places, and which should be experimented with further.

There are special types of residential types of institutions, particularly for the aged, who do not, it seems to me, need to be in the mental hospitals as they are now constituted.

There are day-care hospitals in which the patient goes home at night and is with his family and comes in during the day for treatment, for rehabilitation services, et cetera.

And conversely, there are night-care hospitals in which the patient stays home during the day with his family, and comes in at night, because this is the time when he is most in need of attention and care.

All of these things can be done with what we know now, if we can get a little stimulus, so that the States can go forward.

I can testify becouse of the fact that I have, as a part of my duty, to get around the country all of the time, that States are now anxious to move in this direction if there was just some little stimulus to get them started.

I believe that this portion of title VI of the omnibus health bill will facilitate this and will pay great dividends.

Senator LEHMAN. I have a very strong feeling that the key to this whole thing is not so much in the internal administration of the hospitals, but in the very vigorous increase in basic research, clinical studies, and pilot studies and demonstrations which will, in the first place, hopefully, find some preventive medicine which would make it unnecessary to admit these poor people into the hospitals and, in the second place, some better methods of treatment, medical or therapeutic.

It is my strong feeling that very little improvement has come out, either in medical or clinical treatment, or even in methods—although there has been some improvement in methods—of the State hospitals themselves. All of the medical discoveries which the Secretary has already alluded to, and a great many witnesses who appeared before this committee have strongly testified to, have come out of medical schools, out of the Institute of Mental Health, if you will, out of research laboratories. Very little, I believe has come out of the great State hospitals.

I think that is due to a very simple thing. The people who are running these hospitals are so overwhelmed by the administrative duties that are necessarily imposed on them when they run a hospital of five or six or sometimes as many as eight or ten thousand patients—they just do not have the time or the opportunity to give to research and to study, to clinical observation, that is necessary. And that is why I am pleading for more money for research, for clinical studies, and for pilot studies, if you want to call it that.

I think that is the great hope we have. I think until we get that, unless we get that, we are losing time and a great opportunity.

It seemed impossible to develop a vaccine against poliomyelitis—I listened, as I said before, to the report last night and heard these three men, Dr. Salk and Dr. Francis and Dr. Gregg, state that the next great field would be the attack of mental illness.

They also agreed that it interposed the greatest difficulties, but were strongly in favor of using every possible means to carry on medical and chemical research. That is what I am pleading for.

I am not pleading for more buildings, more custodial care. We have beautiful buildings in New York State, and I am sure that they have in other States. We give good custodial care.

I do not think that anything of a scientific nature that is very important has come out of any of our hospitals, so far as my experience has taught me. And that goes back for 25 years.

Dr. FELIX. What you say is from the historical point of view quite true, with some notable exceptions. If I may respectfully differ with you in one thing, I do not believe it necessarily has to be true in the future.

What you say about the terrible burdens on these administrators and on the staff is very true. I know from my own personal experience.

I do not know under the conditions that we see in many hospitals today if there is money enough to woo me into one of them, if I were available for a job at the present time. This is partly because of the situations which arise within the State, and because of certain policies which are applicable in the States. This is not all of it.

I agree with you thoroughly we need much more research in laboratories and in clinics, and much of this particularly of the basic kind that I mentioned here, the clinical and basic studies that will come from the medical schools, from the laboratories. However, Senator, we have thousands of patients in these hospitals and they are clinical material themselves. It does not mean that they will be used as guinea pigs, but there are many things that we can do to try to improve their care and treatment which can only be done by using these patients. In addition to this there have been State institutions which have done outstanding work in the field of research.

I can mention three. And it is not because Senator Bender is here that I mention one, which is in his State, but because it is 1 of 3 that comes to mind at the moment. That is at Columbus State Hospital, Senator Bender, which has done some very outstanding research work that is well known over the country. This is basic research work that had to do with certain functions of the brain, and so forth.

The Worcester State Hospital in Massachusetts has been a bright spot for a generation or more because of the work they have done in the field of schizophrenia.

Stockton State Hospital in California has done some very outstanding work in fundamental research as well as in clinical research.

What I am trying to say is that I do not want to throw any possibilities out.

A bit ago the question was asked what would be the most important thing to do? It reminded me of some years ago that there was a

foundation which was trying to take the most brilliant young minds in the country, to give them a lot of special training. They gave them quite an examination. Among other questions was one that went something like this: If there are 7 men in a boat out at sea and you only have food enough for 6 of them to get to shore alive, what would you do?

I was glad I was not in the Secretary's position and had to answer that question, because I would simply say this: I would rather see all of the people go on short rations than to throw one to the sharks.

We cannot slight any of these areas. We must hit them all and as hard as we can, but remember that we have to develop these as we go along. Some of these areas cannot use great sums of money yet because they are not ready, but as they move along they will be ready.

I would hope, with the Secretary's permission, that if I come back in 2 or 3 years or less or more, as the case may be, and the need is ready, I would say, "Gentlemen, I need one-third more," or "one-half more," or "twice as much as I am getting now," and can document it, because these places are now ready to use it, you would say, "Well and good. Now you can have it."

That is my plea.

Senator LEHMAN. I would say right now.

Senator BENDER. Mr. Chairman, if you would not mind, I would like to make an observation.

Earlier in your testimony, Secretary Hobby, you pointed out the fact that 98 percent of the beds occupied by mental patients are tax supported. Senator Lehman properly called attention to the fact that so much of New York State's tax money—and this is equally true in all other States—goes to the support of the State hospitals.

Obviously, within the last 24 hours this fight on polio has received public attention. Of course, that was done principally by private research, or was it done by publicly financed research? I think it was done by private research, was it not?

Secretary HOBBY. It was private funds, mostly, as I think you know, that came from the National Foundation for Infantile Paralysis.

Senator BENDER. I want to come to my original thought here. I say there are vast programs that are under way to conquer some of man's other diseases, such as cancer, heart disease, arthritis, and a number of others. The Federal Government is putting funds into these fights.

Would you care to comment on what the prospects are for success in conquering these various diseases?

Secretary HOBBY. I would very much appreciate the compliment that is implied in your question, but may I respectfully refer your question to Dr. Scheele?

Dr. SCHEELE. I should say I agree with the things that the Secretary said. It is very difficult to predict when successes will come along in our fight against these many diseases. I think we have to be content at the moment to say that the increased public, congressional, and other interests in having research on an expanded scale is adding daily to the stockpile of fundamental and other information on many of these disease problems.

It is likely that we are "warm" and on the threshold of breaking through the barrier on some of them, but we cannot predict with certainty that it will be tomorrow or in 1 week or in 1 year.

We can say with certainty there now lies out on the table as public information a vast array of important basic discoveries. And we can be sure that scientists will operate as they have in the past, and that some of these men will add end to end some of these things, and with their hypotheses then move us forward into a real and better understanding of diagnosis and treatment of some of our diseases.

Senator BENDER. Do you not think as a result of calling the public's attention to these diseases through voluntary contributions and through Federal funds being provided for research, and so forth, that it has helped in bringing the matter to the attention of the public, in making them more conscious of the fact that there is a way of treating this, that is, these diseases, and possibly arresting them?

Dr. SCHEELE. Yes, sir; it has. I should like to underscore several times your comment as applying in the field of cancer. While we have not found dramatic new cures or dramatic new diagnostic tools on a broad front, we have some very dramatic tools, such as radioactive materials, for the detection and treatment of cancer of the thyroid gland. We are today curing much more cancer with old methods for the simple reason that people are beginning to understand it, to lose some of their former fear of the disease, and to seek earlier diagnosis and treatment. And this is coming about in large measure because of the American Cancer Society whose campaign is partly to teach people that something can be done for them.

So it is true that this increased awareness is bringing people opportunities for health and for continued life that somehow were not available to them 5 or 10 or 15 years ago.

Senator BENDER. I had a reason for asking these questions. I was coming now to this matter of mental health and the actual problem of saving millions and millions of dollars annually that is being appropriated through various tax units, through other public subdivisions, such as the States and communities.

Is it not a desirable thing for the Federal Government to initiate a campaign, to make people more aware of the cost of this problem and the need for greater attention to be paid to it? Is that being exploited enough? Is that being promoted enough, I should say.

Dr. SCHEELE. We do not promote that in the sense of a huge publicity campaign, but we do exploit this from the Public Health Service through our giving of technical assistance and guidance to the States along with many of the programs that we are able to give them financial help on or partial help on. We are also able to give them the part-time services of experts who know the field and can go in and help train others and stimulate others to carry on for themselves.

There is one program in Senator Lehman's State which is very outstanding. This program will in the next 5, 10, or 15 years make a major impact on the incidence of serious mental illness in that State. That is a recent bill passed by the New York State Legislature, a year or two ago, which provides that the State will match the funds that communities put up for so-called community-service programs.

We have had a stimulatory program in this field in the Public Health Service giving States some funds to set up some of the com-

munity clinics which are designed to work on the front end of the problem, the early diagnosis and early treatment and especially directed at children, so that the teachers in schools and the principals can send disturbed children to these clinics. We can then give them early treatment instead of waiting until they have far advanced disease and require long-term hospitalization.

Now, in New York State we have a situation in which, as soon as a community recognizes the opportunities it has and will put up a program, some program, the State will step in on a statewide basis and match that money in order to carry forward the preventive program.

This is really enlightenment in the overall approach to the mental-health problem, one that will, in New York State makes a real impact just by itself on that problem of continued need for building brick and mortar and hospitals to put these people in.

Senator LEHMAN. The cost of veterans' hospitals is, of course, recognition of the debt we owe to our veterans. That, of course, is another appropriation matter. But, can you tell me roughly the amount of money that was appropriated in 1955 to the Public Health Service?

Dr. SCHEELE. You mean for the entire United States Public Health Service, or do you mean for the States?

Senator LEHMAN. The research work, the Institutes, for all of the collateral health services, in other words, the entire Public Health Service appropriations.

Dr. SCHEELE. We do not have that figure with us, but we can supply that for the record.

Senator LEHMAN. I have just been informed—I will not vouch for the accuracy of it—that in 1955 they amounted, including the cost of the Institutes at Bethesda, to $277 million. That would be a little less than one-half of 1 percent of our total budget.

If we increase that, say, to one-half, a little less than one-half, or three-quarters of 1 percent, maybe we would not have to throw that one extra man to the sharks, as Dr. Felix stated.

Do you know whether my figures are reasonably accurate?

Dr. SCHEELE. I think that figure is reasonably accurate. We can supply an exact figure for the record. This would not include Walter Reed Hospital, which is part of the Army. This would be the United States Public Health appropriation.

(The information above referred to is as follows:)

Appropriations for 1955

Public Health Service	$251,310,000
Office of Vocational Rehabilitation	28,735,000
Children's Bureau	31,600,000
Food and Drug Administration	[1] 6,261,000
Total	317,906,000

[1] Includes $1,161,000 in an indefinite appropriation derived from payment of fees by applicants for certification or inspection of certain products.

Senator LEHMAN. For the Public Health Service.

Dr. SCHEELE. Possibly you are interested in other appropriations in the department which are related to health, because some are not covered in our Public Health Service budget, the Children's Bureau, for example.

Senator LEHMAN. I want the whole picture.

Secretary HOBBY. That will be supplied.

Senator BENDER. You are a professional man, as I understand it. You were here before President Eisenhower was elected. I know of your service. You have been with the department for some time. Is that correct?

Dr. SCHEELE. Yes, sir; I have been a career officer in the Public Health Service for over 20 years.

Senator BENDER. How many years?

Dr. SCHEELE. Twenty-one years.

Senator BENDER. Have you noticed any difference in the matter of the treatment or the handling of this problem? Is there any less vigilance or less interest or less care on the part of the Secretary or the present administration than there had been previously?

Dr. SCHEELE. No, sir. I have not. We do not approach our budget from a political standpoint.

I must say that our Secretary has been very generous. I think she has given us almost everything we have asked for.

Senator BENDER. I appreciate the observation.

Chairman HILL. You may proceed with your statement.

Secretary HOBBY. Thank you, sir.

Before concluding our testimony on title VI, there are two lesser points which should be brought to your attention.

First, section 603 of the bill contains a technical amendment to the provisions of the Public Health Service Act pertaining to traineeships in mental health. It would simply make clear that the authority of the Surgeon General to establish and maintain traineeships—section 433 of the act—applies to the field of mental health.

Second, it should be noted that title VI at a number of points is closely related to certain provisions of title V of the bill and incorporates, by reference, certain of the provisions of this preceding title. A number of technical amendments would therefore be required if title VI were to be considered as an independent measure.

In summary, Mr. Chairman, the mental health proposals of S. 886 would permit us to extend the provisions of the National Mental Health Act in two significant directions, as shown in the last chart:

(1) *Prevention*—to improve community mental health services through extension of mental health grants; and

(2) *Institutional care*—to develop improved methods of treatment and rehabilitation through special project grants.

We believe these represent needs that must be met if we are to accept our Federal share of the responsibility for continuing progress against mental illness.

We have appreciated this opportunity to discuss our mental health program with your committee, and will be very happy to answer any questions you may have.

(Chart VI Mental Health Proposal appears in the prepared statement at p. 129.)

Chairman HILL. Mrs. Secretary, you filed a statement on S. J. Res. 46, that is, the mental health study. Would you briefly summarize your position on that resolution?

Secretary HOBBY. I think I have a summary here.

Chairman HILL. We will be glad to have it.

Secretary HOBBY. Mr. Chairman, as you were aware, there were two proposals on mental health, S. 724, which provides for a Presi-

dent's commission on mental health to conduct a thorough inquiry.

Chairman HILL. That is right. That is correct.

Secretary HOBBY. And S. J. 46, which would authorize Federal participation in the conduct of a comprehensive mental health survey by means of a grant or grants to nongovernmental groups or agencies.

Mr. Chairman, to highlight the report, I would say that the Department is in accord with the objective of initiating a thorough baseline inquiry into all aspects of the national mental health problem.

The extent of the current problem, and the cost of administering preventive and treatment programs clearly indicates the need for a reappraisal of the problem and of present approaches to its solution.

I would like to do whatever the chairman and the committee likes me to do, to read further, or to read sections that I have underlined. Which would you like?

Chairman HILL. I think that if you would just read the sections you have underlined, then the whole thing will be in the record, of course.

Secretary HOBBY. Thank you. I think our conclusion, in summary, is that we favor Federal participation in the cost of a basic study of the mental-health problems facing the Nation, and we believe that subject to the reservations and amendments indicated above, either S. 724 or Senate Joint Resolution 46 would provide an acceptable means of achieving the desired objectives.

Chairman HILL. Do you have any preference between the two?

Secretary HOBBY. Well, Senator, I am sure you have read our reports. We pointed out improvements that we thought could be made to each one and the particular differences between them.

The commission in this instance would require a rather long survey afterward. We thought that was questionable.

In Senate Joint Resolution 46, we pointed out several changes that we thought might be helpful.

(The statement of the Department of Health, Education, and Welfare in its entirety is as follows:)

STATEMENT BY OVETA CULP HOBBY, SECRETARY OF HEALTH, EDUCATION, AND WELFARE IN SUPPORT OF TITLE VI OF S. 886

Secretary HOBBY. Mr. Chairman and members of the committee, we are pleased to have this opportunity to present the views of the Department of Health, Education, and Welfare on the several health bills under consideration by this committee. Our prepared statement is addressed solely to the mental-health provisions of S. 886. Our written reports on the other bills—S. 724, S. 848, S. 849, and Senate Joint Resolution 46—have been transmitted to your committee. We have no additional comments to offer on these bills, but we will be glad to answer any questions you may have regarding the views expressed in our reports.

S. 886 is the omnibus health bill introduced to implement certain of the health proposals recommended by the President in his special health message to the Congress on January 31. It contains six titles, aimed generally at improving methods of prepaying for the costs of medical care, stimulating construction of health facilities, helping to alleviate personnel shortages, and strengthening our public-health and mental-health programs. The objectives and provisions of all titles of the bill are summarized in a supplementary statement submitted herewith.

THE MENTAL-HEALTH PROBLEM TODAY

This committee has already received testimony indicating the extent and the seriousness of mental illness, but I should like to review very briefly some of the facts which lead us to the conclusion that the mental-health problem is in many respects the most urgent health problem facing the Nation today. Two intensive mental-health surveys indicate that as much as 6 percent of our total

population, or about 9 million people, have serious mental disorders. Unless something more is done to prevent and control mental illness, 1 out of every 12 children born today will spend part of his life in a mental hospital.

Few families have the resources to pay for the prolonged treatment required for serious mental illness. After the family resources have been exhausted, there remains a tremendous financial burden upon the taxpayers of the Nation. The direct dollar cost for care of the mentally ill in hospitals, and for benefits to veterans with mental disorders, is more than $1 billion a year. This cost is rising at the rate of $100 million a year.

Hospitalization of the mentally ill accounts for a major share of the cost of mental illness.

Half of the hospital beds in the United States are occupied by mental patients, and 98 percent of the beds they occupy are tax-supported.

The human suffering of families and individuals as a result of mental illness is beyond calculation. Of greater concern than the dollars and the mathematics involved is the loss of human resources represented by the mentally ill—and the impact of this loss on our national well-being.

SOME SIGNS OF PROGRESS

Research and experience are creating new opportunities in the prevention and treatment of mental disorders. At the same time, there has been a change of attitude toward those who suffer from the illness. In the light of this new knowledge and understanding, we are better able to assess the effectiveness of our national effort to combat mental illness and to press forward toward greater accomplishments.

Progress is being made on many fronts. For example, the experts tell us, half or more of the persons suffering from schizophrenia can be helped by modern treatment methods.

With use of shock therapy, we have greatly increased the recovery and discharge rates of patients suffering with certain types of psychosis.

A recent study in one State hospital indicated that by the use of new drugs and new therapeutic techniques, the chance of recovery for long-term mental patients can be tripled.

These advances benefit patients in mental hospitals. But not all mental patients require hospitalization. Increasingly, mental illness is being detected in psychiatrists' offices and in mental-health clinics. This permits early treatment, and thus often avoids more serious illness.

THE NATIONAL EFFORT

Many groups, both governmental and private, are working effectively to increase knowledge of the prevention and treatment of mental illness, and to encourage the application of this knowledge. Regional, State and local activities reflect the growing awareness of the American people that mental illness is a serious problem which must be attacked on all fronts.

Groups of States are working together on regional problems. The governors have met several times to consider a program of concerted action against mental illness. State appropriations for mental-health activities have increased significantly in some instances—and the States are concerning themselves not only with care and treatment, but with prevention and education as well. It is this kind of response which demonstrates the potential of the Federal-State-local partnership, and helps to clarify the proper role of the Federal Government.

As for the mental-health activities of the Federal Government, they are of three kinds, spread among several bureaus and agencies.

First, the Federal Government operates special services for the care of the mentally ill who are its beneficiaries or wards. The agencies which provide these services include the Veterans' Administration, the Armed Forces, St. Elizabeths Hospital, the Public Health Service, and the Federal prisons.

Second, the hospital survey and construction program of the Public Health Service provides financial assistance to States for building mental institutions.

Third, the Federal Government maintains and supports programs aimed at the prevention and control of mental illness. Several of these programs are centered in the Department of Health, Education, and Welfare. The Children's Bureau, the Office of Vocational Rehabilitation, and the Office of Education all have special reasons for being concerned with mental health. But the most extensive

program is centered in the National Institute of Mental Health, a division of the Public Health Service.

THE NATIONAL INSTITUTE OF MENTAL HEALTH

The program of this Institute is known to many of you. This committee was instrumental in the passage of the National Mental Health Act in 1946. Since then, we have had ample proof of the wisdom of this legislation.

A brief review of the current activities of the National Institute of Mental Health may be helpful in portraying the relationship of the proposals in title VI to the present mental-health program of the Public Health Service. In general, the Institute deals in research, in training, and in community services.

In the study of mental illness, research ranges from studies of the central nervous system to exploration of factors which affect human behavior. The Institute conducts research in its own facilities and makes research grants to independent investigators in medical schools, universities, and other non-Federal research centers. The Institute also supports a number of research fellowships, permitting young scientists to obtain supervised research experience.

Under the training program of the Institute, grants are made to professional schools to improve the quality of training and to increase the number of competent professional workers. There is a serious shortage of qualified personnel in the mental-health field. Trained people are needed for clinical services, teaching, research, and administration.

The community-services program carries out those provisions of the National Mental Health Act which authorize assistance to the States in the prevention, diagnosis, and treatment of psychiatric disorders. Grants are made to the States and Territories for mental-health programs conducted outside mental hospitals and other institutions. Money is allotted on the basis of population, financial need, and the extent of the problem in each State. Two Federal dollars must be matched by not less than $1 of State or local funds expended for the same purposes. Although this is the required ratio, by 1953 the States as a whole were matching each Federal dollar with more than $5 of their own.

The National Institute of Mental Health works through the mental-health authority in each State. It provides technical assistance and consultation, makes special surveys on request, sets up demonstrations, and assists in program planning.

I should like at this point to ask Dr. Robert H. Felix, Director of the National Institute of Mental Health since its beginning, to illustrate and describe briefly the current program of the Institute.

Dr. Felix.

Chart 1.—Federal Interest and Participation

Dr. FELIX. The first chart indicates the broad range of Federal participation in mental health programs.

The Veterans' Administration operates a number of psychiatric hospitals, general hospitals with psychiatric services, and outpatient mental hygiene clinics. The Armed Forces have developed services for early recognition and prompt treatment of mental and emotional disorders in order to maintain the mental health of the Armed Forces at the maximum level. The Federal Bureau of Prisons provides hospital care and treatment for prisoners who are mentally ill.

In the Department of Health, Education, and Welfare, in addition to St. Elizabeths Hospital, other constituents are contributing to better mental health. The Children's Bureau is concerned with the growth and development of the child and the special needs of handicapped children. The Office of Education has an interest in the educational needs of these children and in the mental health problems of schoolchildren generally. The Office of Vocational Rehabilitation assists those who have been mentally ill and those whose physical handicaps may raise psychological barriers to satisfactory rehabilitation.

In the Public Health Service, there are several programs which have mental-health components; but the principal unit, one in which the National mental health program is focused, is the National Institute of Mental Health.

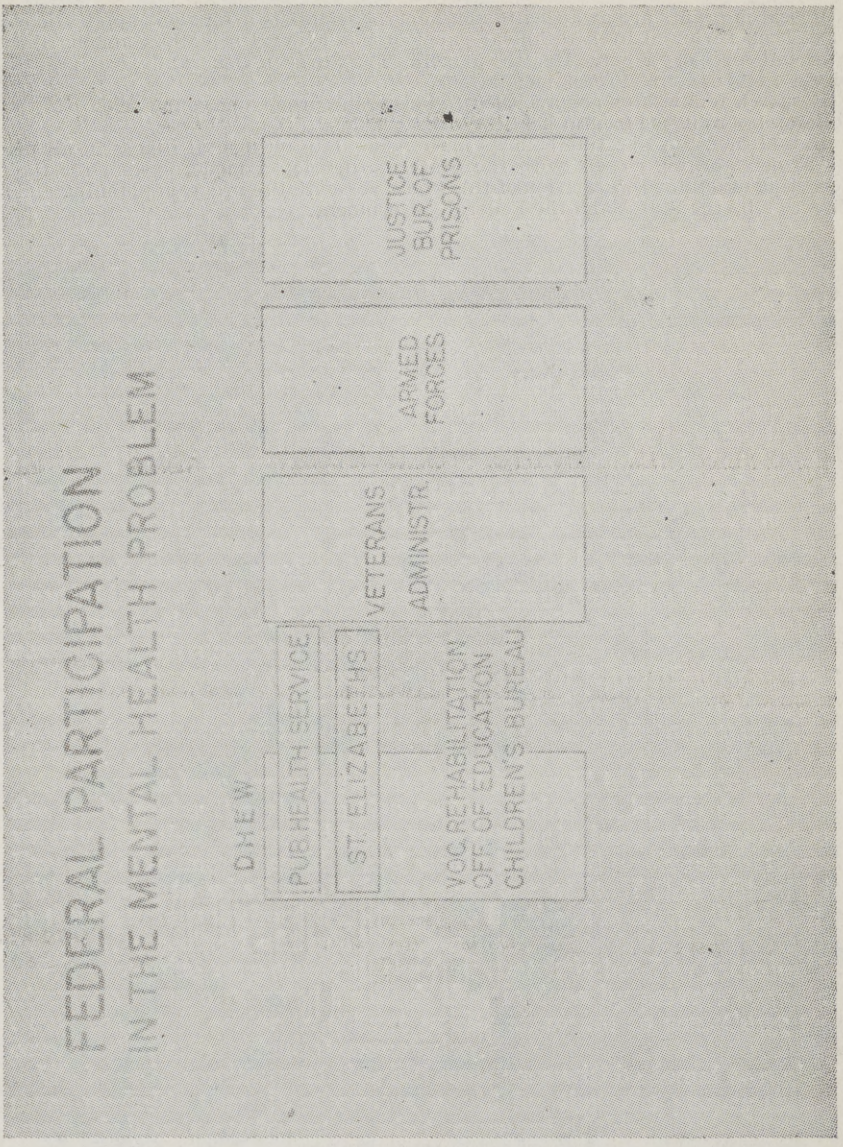


Chart 2.—Research at the National Institute of Mental Health

In this, as in all health fields, research is the base for most of the new developments leading to progress.

Scientists are conducting clinical and laboratory investigations at the Clinical Center in Bethesda; at the Addition Research Center in Lexington, Ky.; and at the Mental Health Study Center in Prince Georges County, Md. Studies range from the analysis of severe emotional disturbances in children, evaluations of the effectiveness of psychotherapy, and the relation of disordered brain function to the major psychoses, all the way to such fundamental research as the biochemistry and metabolism of the nervous system and the causes and mechanisms of drug addiction.

Research grants are awarded to non-Federal scientists after their applications have been reviewed by a technical panel of non-Federal scientists and by the National Advisory Mental Health Council. The Surgeon General awards grants on the basis of council recommendations.

Research fellowships are awarded to encourage promising young scientists to follow careers in the mental health specialty fields.

In addition, the Institute collects nationwide data on mental illness in all of its forms, working closely with the States to develop a model system for the reporting of data. Information of this kind is essential to program planning and direction by the States and the Federal Government.

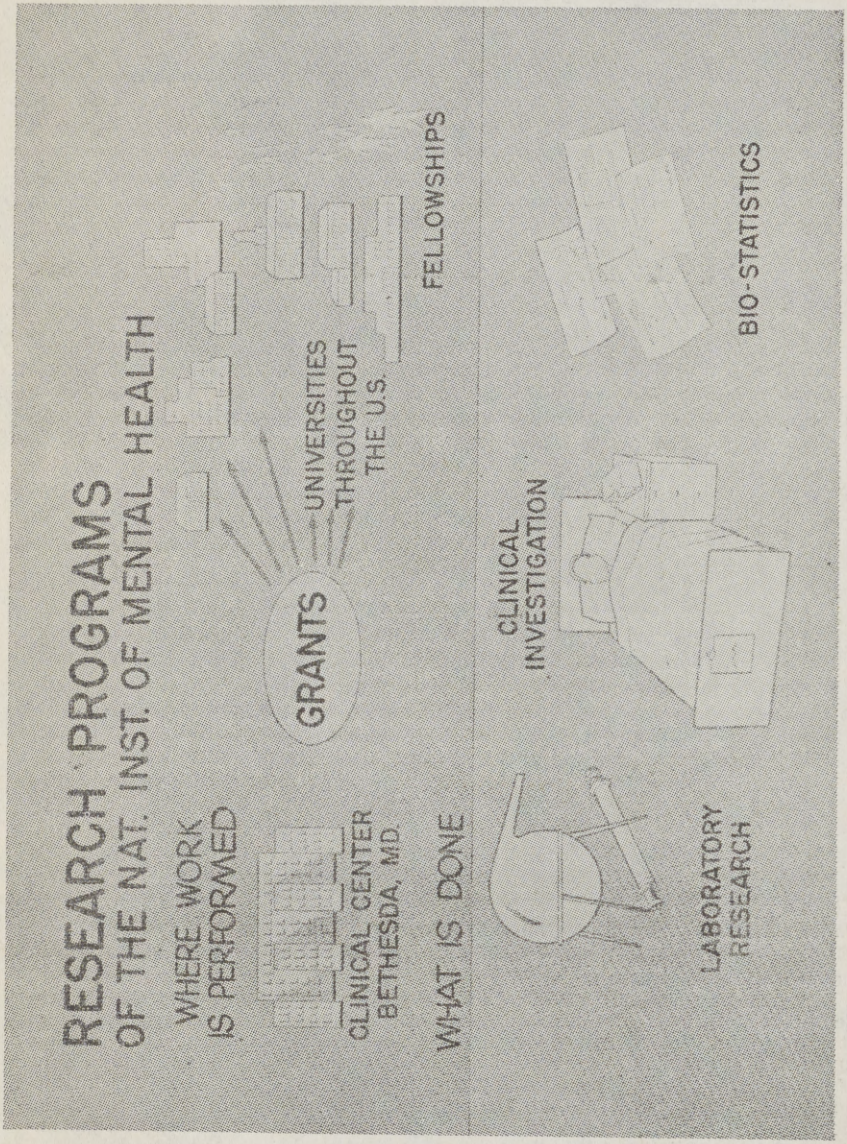


Chart 3.—The Mental Health Training Program

The National Institute of Mental Health maintains a training program to help meet the acute needs for personnel in the various mental health professions. Teaching grants and grants for traineeships are made to centers of higher learning. Assistance is given for training in psychiatry, psychology, psychiatric social work, psychiatric nursing and public health. In addition, the Institute sponsors a number of conferences for the development of new training programs or for the orientation of persons in other professions to problems of mental health.

National Institute of Mental Health grants currently sponsor 229 graduate programs. More than 3,000 trainees have received individual support since the program started. Approximately 48 medical schools have been aided in the undergraduate teaching of psychiatry. This effort has helped alleviate the manpower shortage, but the shortage is still acute and there is need for additional emphasis on the training program of the Institute.

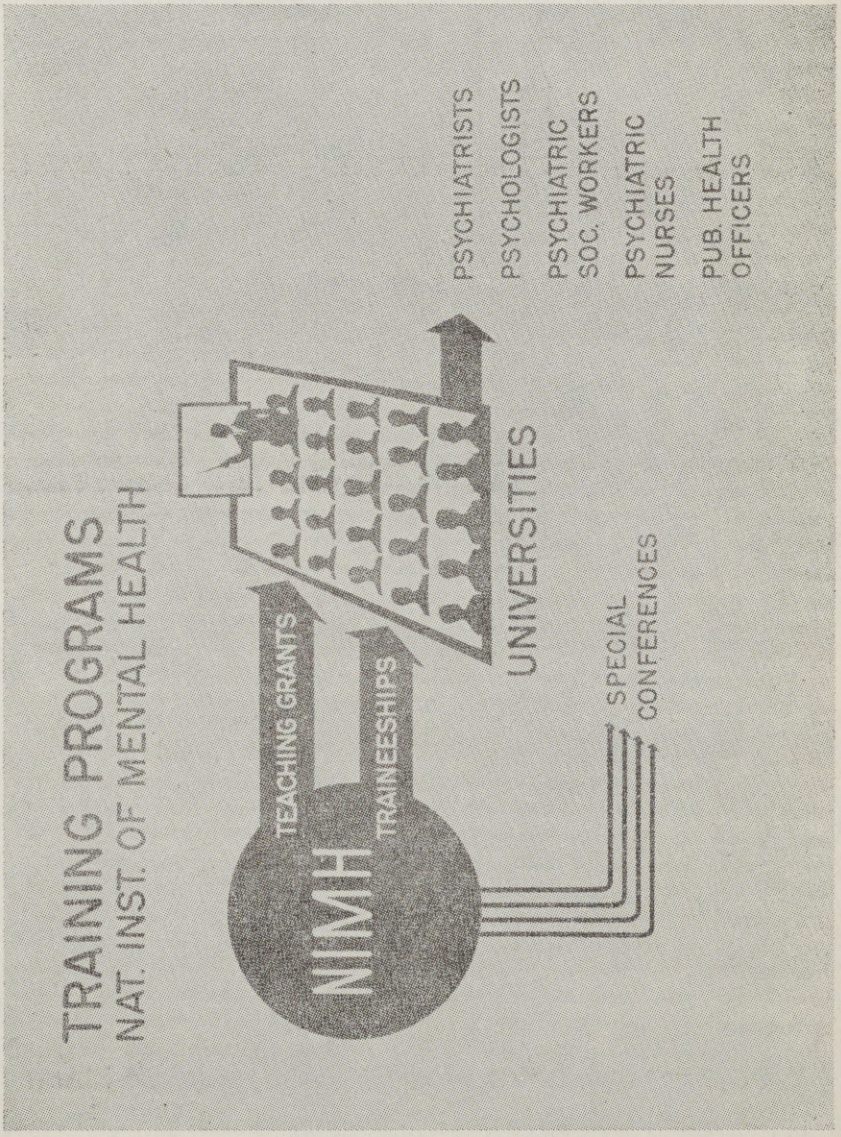
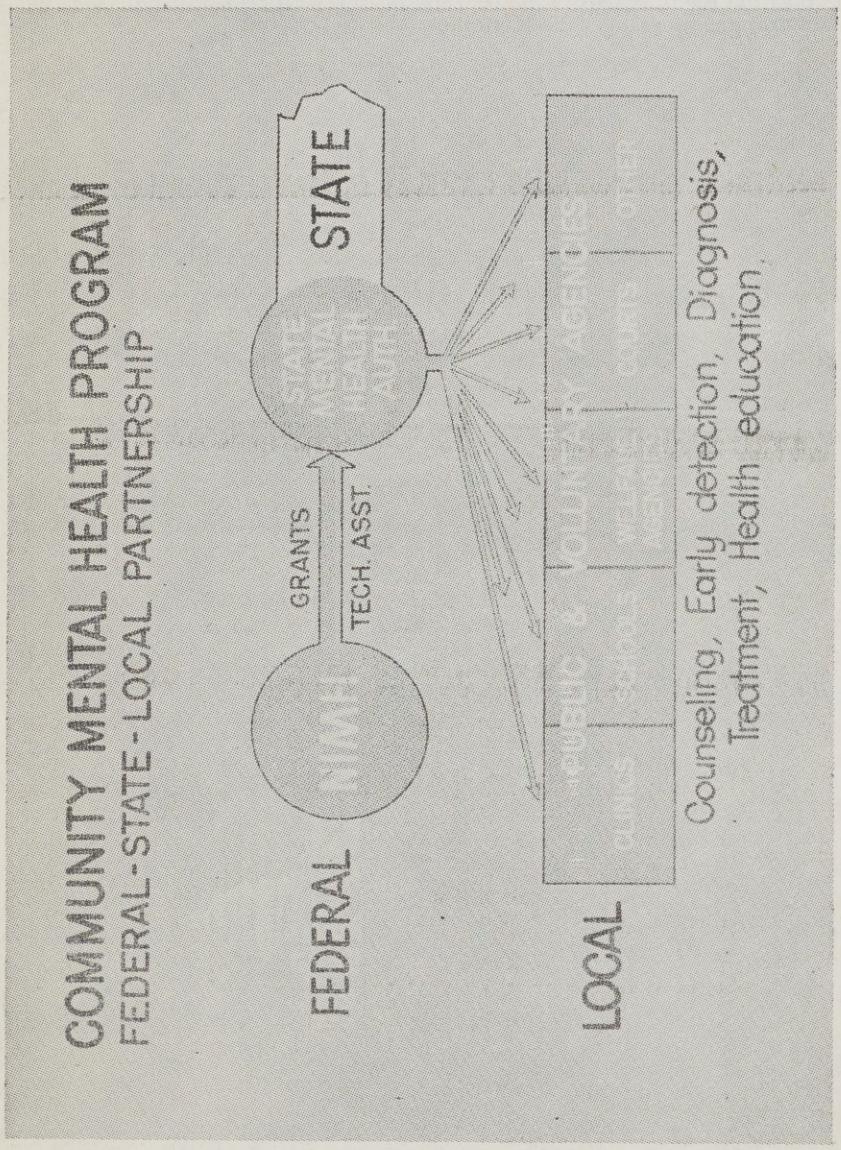


Chart 4.—Community Mental Health Services

The grant-in-aid program in mental health, which title VI proposes to continue for another 5 years, assists States in the development of community mental health services. These services help alleviate emotional distress and prevent more serious mental disorders.

In addition to assistance in the form of grants, the National Institute of Mental Health provides technical assistance and consultation. Grants are made through the State mental health authorities. Upon request, mental health consultants assist the State authorities in heir own programs, which vary from State to State according to need.

Cooperative programs are frequently developed with other State agencies, such as those concerned with vocational rehabilitation and public assistance.



The mental health services themselves are applied through local community programs. The mental health clinic is frequently the focal point for these services. It provides treatment and guidance for persons with emotional disturbances. It also provides consultation and assistance on mental health problems to other agencies, such as schools and courts. There is close cooperation with State and local voluntary agencies in all of these activities.

Dr. Felix has shown how the program of the National Institute of Mental Health is being carried out on the broad legislative base provided by the National Mental Health Act. But changing conditions often require adjustments of existing programs to keep pace with the times. This is especially true in a field that is relatively new.

We have found that there are three parts of the mental health program which are in particular need of emphasis.

TRAINING OF PERSONNEL

One of the essential needs is for the training of additional mental health specialists.

There are many budgeted positions in mental institutions which cannot be filled because the trained personnel is not available. This means inadequate care for patients in those hospitals. We also need more trained personnel for mental health clinics and community programs, for research, for teaching the many skills and disciplines involved in the study of mental illness, and for care of the mentally ill.

As Dr. Felix has indicated, one part of the National Institute of Mental Health program consists of providing training grants and traineeships. We have reviewed our legislative authority in this field very carefully, and we have concluded that it is adequate. However, we propose to expand our program of training specialized personnel, and we have requested an increase of nearly 40 percent in the Mental Health Institute's 1956 training budget, from the present level of $4 million to $5½ million.

GRANTS TO STATES FOR PREVENTIVE SERVICES

A second area to be strengthened is the authorization of grants to States for mental health services.

Title V of S. 886 proposes consolidation of all categorical grants to States for public health services except the grant for mental health services. The statutory provisions for continuing this mental health categorical grant for another 5 years are contained in title VI.

The National Mental Health Act of 1946 did not establish a categorical grant in the basic statute. In annual appropriations since 1947, however, grant funds for mental health services have been separately earmarked so as to provide, in effect, a categorical grant for this purpose. Title VI would convert this appropriations category into a category in the basic act for the next 5 years. This proposal does not include any new program authority, but it will give the program additional emphasis and assurance of continuity. The limitation of the extension to a 5-year period reflects our belief that any categorical grant authorization should provide for periodic congressional review to see if there is still need for a separate grant.

Except for the matching provisions, the new statutory language would make no change in present grant formulas or procedures. The matching provisions would be modified slightly to assure consistency with the provisions in title V for the consolidated public health grant. The present law requires State matching funds, but leaves the exact matching ratio to be specified in administrative regulations. As I indicated earlier, the present regulations require 1 State dollar for every 2 Federal grant dollars. Under the provisions of title VI there would be a statutory matching ratio varying from one-third to two-thirds Federal participation, based on the per capita incomes of the several States.

SPECIAL PROJECT GRANTS FOR IMPROVED INSTITUTIONAL CARE

The third area requiring emphasis is improved care and treatment of patients in mental hospitals. This area of mental health has received very little systematic study and development in the United States, and there is a conspicuous need for pilot studies and demonstrations to stimulate further improvements. Title VI would authorize special project grants for this purpose.

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These special project grants would be administered by the Surgeon General, with the assistance of the National Advisory Mental Health Council. Grants would be made on the basis of applications submitted by State agencies responsible for administering institutions for the care of the mentally ill or by other public or nonprofit agencies.

This provision of title VI is focused on the 725,000 patients in mental institutions, and on the many more who may someday need hospitalization for mental disorders. The pilot studies to be financed under this program would concentrate on institutional care. New techniques of management and therapy developed by these studies would be widely disseminated among mental hospitals and institutions.

To indicate why improved methods of care and treatment are needed, a few additional facts should be considered.

One involves the length of stay of the mentally ill in hospitals and institutions. More than half of the patients have been under treatment 8 years or more, and the proportion of these chronic patients is increasing. While some progress is being made, the fact remains that our mental institutions are still largely custodial.

Another fact is that about half of the patients admitted to a mental institution are released during the first year of hospitalizaiton. But the prospects for release fall off sharply after the first year. It is therefore essential that we develop improved techniques of treatment and management of mental illness during those first crucial months.

I should like to ask Dr. Winfred Overholser, Superintendent of St. Elizabeths Hospital, which this year is celebrating its centennial of service to the mentally ill, to discuss and illustrate the nature of these studies and their potential meaning to mental hospitals and clinics.

Dr. Overholser.

Chart 5. Mental Institutions Are Still Mainly Custodial

Dr. OVERHOLSER. These remarks and the charts on which they are based are relevant to the second of the proposals in title VI—pilot studies of the care, treatment, and rehabilitation of the mentally ill.

Certainly one of the major problems of mental illness is the extreme length of stay of the mentally ill in our hospitals and institutions. Of the more than 500,000 resident patients in our State mental hospitals, one-quarter have been hospitalized for more than 16 years, one-half for more than 8 years, and three-fourths for more than 2 years. This resident population consists largely of a slowly accumulated core of schizophrenic patients who are admitted during youth or early maturity and stay, in many cases, for the rest of their lives.

The probability of being released alive from a mental hospital decreases rapidly after the first year of hospitalization. During the first year there is now about a 50–50 chance of getting out alive. After 2 years the odds against being released rise to 16 to 1. By the time a patient has been hospitalized for 8 years, these odds are more than 99 to 1.

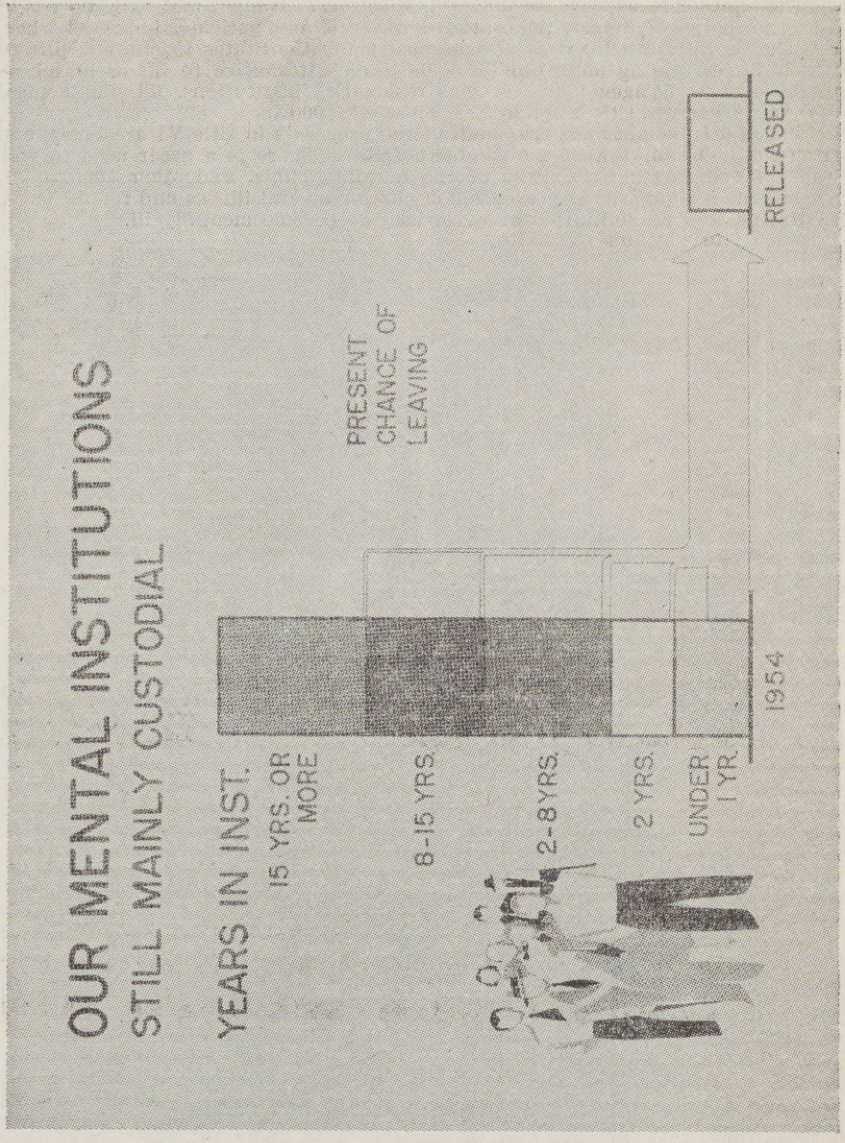


Chart 6.—Research Programs, Recent and Proposed

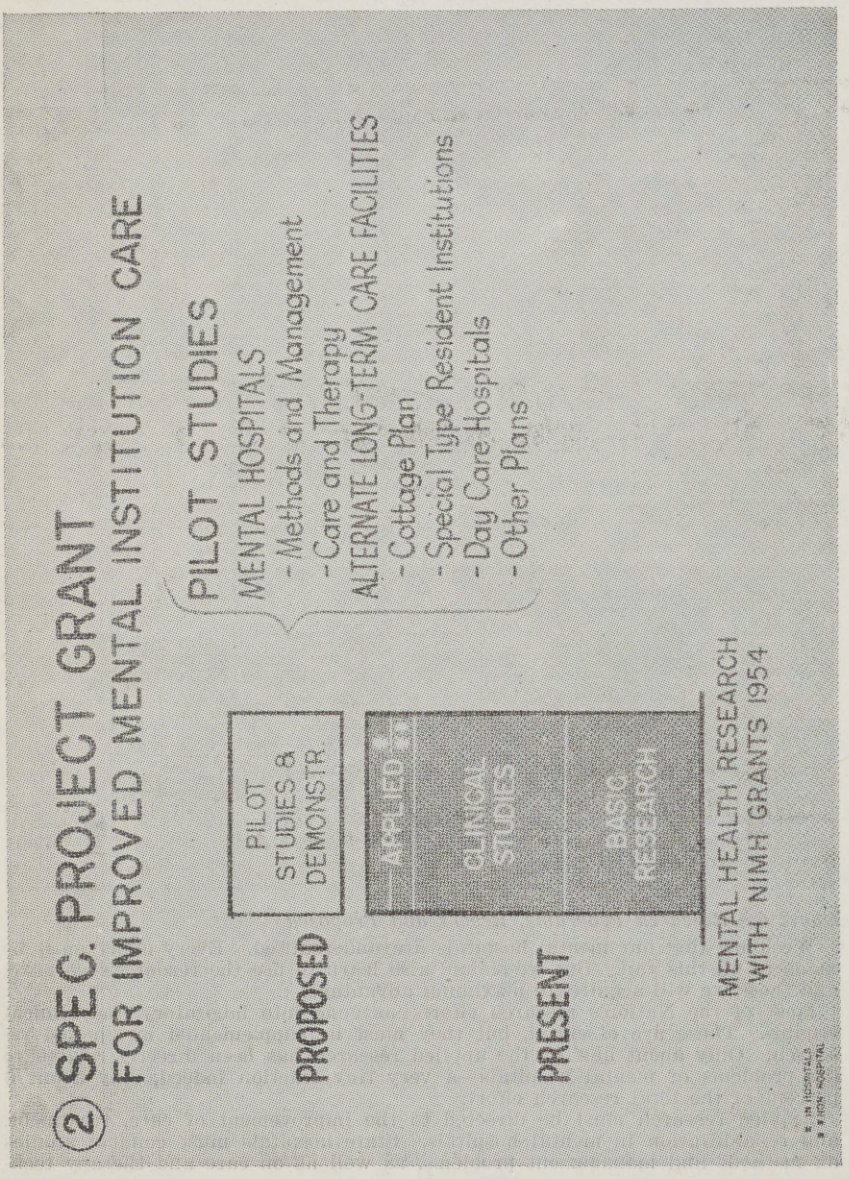
We know that our mental hospitals are understaffed. Every effort must be made to fill this gap. But we should also learn to use the resources we have, and those we will acquire, to maximum advantage.

Most of the Nation's research effort has gone into laboratory and clinical studies. These are essential, but they must be supplemented by applied research. Only about half of the applied research has been directly related to the problems of mental hospitals—a very tiny fraction indeed, only about 6 percent of the total research effort.

Applied research must be directed to the improvement of care, treatment, and rehabilitation in mental hospitals. State hospitals must conduct studies on methods and management problems, as well as on care and therapy tech-

niques, in order to improve as clinical institutions. I might add that the whole esprit de corps of a mental hospital, both staff and patients, improves when research is introduced. It is also necessary for the States to study facilities which for certain patients provide a desirable alternative to the mental hospital—such as cottage plans, special residential institutions, nursing homes, and "day" and "night" hospitals.

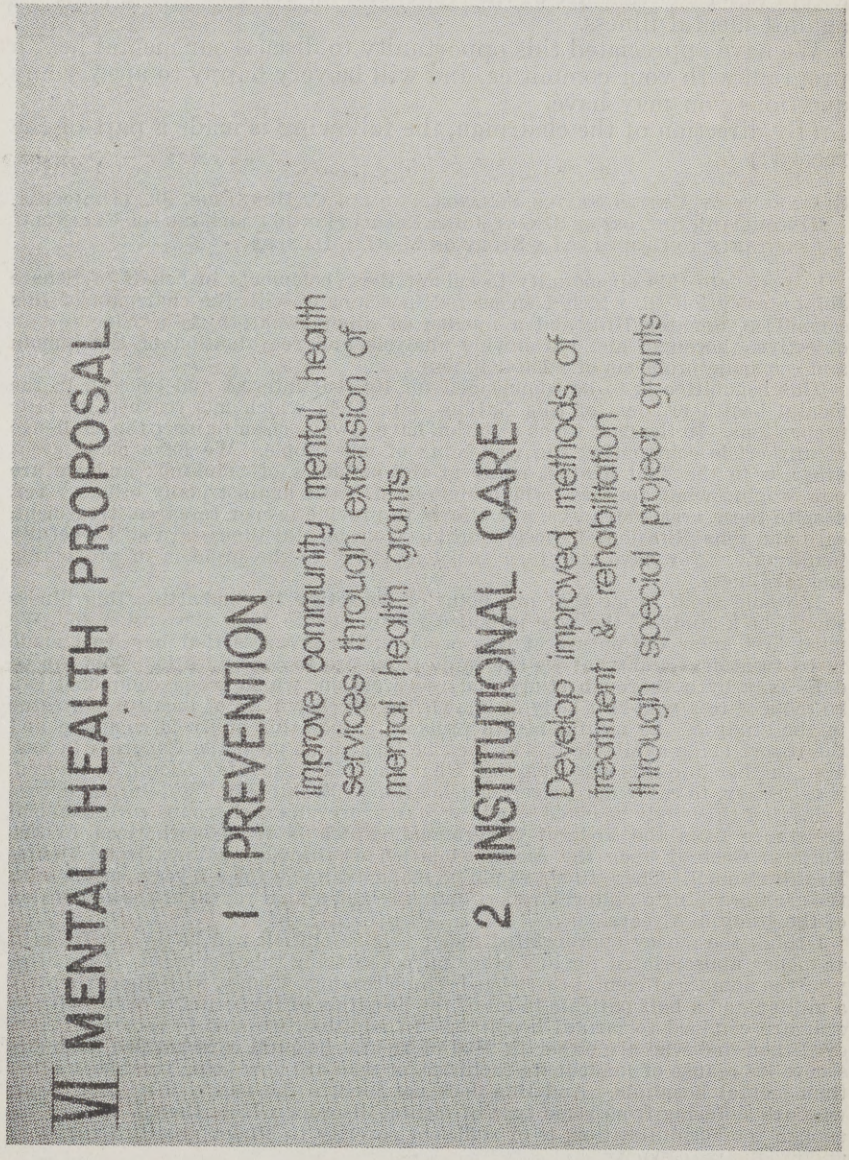
It should be emphasized that both of the proposals in title VI are important from the point of view of the mental hospital. There is a great need to find ways of coordinating resources of the hospital, clinic, and other community agencies as a team for the prevention of chronic mental illness and for the care, treatment, and rehabilitation of those who do become mentally ill.



Secretary HOBBY. Before concluding our testimony on title VI, there are two lesser points which should be brought to your attention.

First, section 603 of the bill contains a technical amendment to the provisions of the Public Health Service Act pertaining to traineeships in mental health. It would simply make clear that the authority of the Surgeon General to establish and maintain traineeships (sec. 431 of the act) applies to the field of mental health.

Second, it should be noted that title VI at a number of points is closely related to certain provisions of title V of the bill and incorporates, by reference, certain of the provisions of this preceding title.



A number of technical amendments would therefore be required if title VI were to be considered as an independent measure.

In summary, Mr. Chairman, the mental health proposals of S. 886 would permit us to extend the provisions of the National Mental Health Act in two significant directions, as shown in the last chart:

(1) *Prevention.*—To improve community mental health services through extension of mental health grants; and

(2) *Institutional care.*—To develop improved methods of treatment and rehabilitation through special project grants.

We believe these represent needs that must be met if we are to accept our Federal share of the responsibility for continuing progress against mental illness.

We have appreciated this opportunity to discuss our mental health program with your committee, and will be very happy to answer any questions you may have.

(By direction of the chairman, the following is made a part of the record:)

STATEMENT BY UNITED STATES SENATOR THOMAS C. HENNINGS, JR. (DEMOCRAT, MISSOURI) IN SUPPORT OF SENATE JOINT RESOLUTION 46 PROVIDING FOR FINANCIAL ASSISTANCE TO GROUPS FOR A STUDY ON MENTAL ILLNESS

I appreciate this opportunity to submit these comments in behalf of Senate Joint Resolution 46, which I sponsored in company with the chairman of this committee, Senator Hill, and a number of other Senators, to provide for an objective, thorough, and nationwide analysis and reevaluation of the human and economic problems of mental illness.

This committee is to be commended for its real interest and concern in the mental health problem of this Nation—a problem which has reached gigantic proportions. In the past we as a Nation have always risen to meet the challenge of any crisis confronting the well-being of our people. We have made great progress in the fight against many of the maladies of mankind; and we are now waging what appears to be a successful battle against many others. Yet, despite these great advances, our efforts to provide proper research, treatment, care and rehabilitation of those suffering from mental illness are still woefully inadequate. Nor have we given sufficient study to the problem of preventing mental illness.

It would seem to me that our point of departure in combatting this illness should be a study of the type provided for by Senate Joint Resolution 46. We must first know the nature of this problem, the progress that has been made in its treatment and what we are to do if we are to cope with it. This can be done only by a thorough study and reevaluation, which when completed can be reduced to a well-knit body of knowledge which will be of incalculable value in the study of the mental health problem. Once this study is complete and the report made available it will then be incumbent upon the Congress to look even further into this subject to see what financial assistance should be offered, if necessary, to carry out its recommendations. Senate Joint Resolution 46 provides that this study be made by qualified nongovernmental groups with financial assistance from the Federal Government, which is to be authorized by the Surgeon General upon the recommendation of the National Advisory Mental Health Council. These funds would be made available for a 3-year period, with the grantees filing an interim report annually and a final report at the conclusion of the study in 3 years.

I think the money appropriated under this resolution will be as wisely spent as money appropriated for any other purpose during this Congress. Year after year the number of mental cases has been increasing. Today, with approximately a million and a half patients in all of the hospitals of this country nearly 50 percent are confined to mental hospitals. In addition, we also have several hundred thousand who are either in need of mental hospital care but are unable to secure it because of inadequate facilities, or who are now being treated in other than mental hospitals. And this does not include the nearly 9 million people who are suffering from some type of mental disorder which, though not serious enough for hospitalization, is of sufficient severity to hinder greatly their work and productive capacity.

It is estimated that treatment of mental patients is costing us $1 billion per year. In addition to this amount the loss in income taxpaying capacity, we have American industry losing about $3 billion; and another $2 million loss is being sustained in earning and buying power; all of which can be attributed to mental illness.

Of course, losses cannot be measured merely in monetary terms. No segment of American life is immune from the detrimental effects of mental illness. Directly related to this illness are family disorders, divorce, juvenile delinquency, accidents, suicides, absenteeism, alcoholism, narcotic addiction, and many kinds of criminal activity.

In view of my membership on the Senate Subcommittee to Investigate Juvenile Delinquency, I would like to make particular mention of the effects these disorders have on juvenile delinquency. The recent interim report of the Subcommittee on Juvenile Delinquency contained the following statement:

"* * * mental health services are so scanty that a family member with a serious emotional problem may disrupt the whole fabric of family life for want of specialized treatment * * * utterly no services exist in the average community which are designed to identify and provide early remedial treatment for the child exhibiting unusual problems at home, in the school, or elsewhere in the community."

Considerable testimony was received by the Juvenile Delinquency Committee from psychiatrists and competent social workers pointing out the necessity and value of mental health clinics in preventing juvenile delinquency. It is estimated that from 10 to 20 percent of the young people who will appear before a juvenile court this year—and it is estimated there will be four to five hundred thousand of them—will be in need of residential care under the supervision of a psychiatrist. I earnestly hope that this study will look into this field to determine what effects the mental health question is having on the ever increasing rate of juvenile offenders.

The crime bill of our Nation, according to the testimony of J. Edgar Hoover last year, runs in the neighborhood of $20 billion a year, and unless effectively checked will continue to grow even larger. I do not profess to be an expert either in criminology or in juvenile delinquency. Yet, I have had an opportunity to learn a great deal about both of these fields both through my experience as a former prosecutor and district attorney and through my membership on the Senate Subcommittee on Federal Penitentiaries and Juvenile Delinquency. While there are, of course, a multitude of causative factors for both adult crime and juvenile delinquency, I nevertheless feel that there is considerable correlation between mental illness and these costly social problems. I earnestly hope that the study proposed by this bill will deal with the effects of our national mental health problem on the ever increasing rate of crime and delinquency. The funds proposed for this study of mental illness are paltry indeed in comparison to the staggering cost of crime and delinquency, not only in dollars and cents, but in the waste of human resources. This study could well save us many times the sums that we put into it.

In conclusion, I would like to pay tribute to the America Medical Association and the American Psychiatric Association whose interest in this problem is long standing. These organizations have shown a keen awareness of the mental health problems of this country and support the type of study and reevaluation which Senate Joint Resolution 46 will provide. These two organizations have formed a joint commission on mental illness and health to make a nationwide survey of this problem and to formulate a program for the improvement of the methods and facilities for diagnosing and treating the mentally ill. I am sure that with the work of this commission to supplement the study made under authority of Senate Joint Resolution 46 we will receive a report which will make a substantial and urgently needed contribution to our knowledge and understanding of mental illness and to the improvement of our method and procedures for dealing intelligently and effectively with the serious problem.

I earnestly hope that this committee and the Senate will see fit to act upon this resolution promptly and favorably.

STATEMENT OF ARTHUR J. GROSS, LL. B., OF BOSTON, MASS.

I have been a member of the bar of the Supreme Judicial Court of Massachusetts since 1917. I was admitted to the practice of law in the United States District Court for the District of Massachusetts in 1926 and the Supreme Court Court of the United States in 1928.

For over 25 years I have been active in the courts, before congressional committees, and before legislative committees and legislative-recess commissions in Massachusetts in the field of mental health, psychiatric jurisprudence, commitment to mental hospitals of the mentally and emotionally sick, their discharge, and in the appointment of guardians for the incompetent mentally sick person. This work came as the result of an investigation of an illegal commitment of a famous lawyer to mental institutions in 1901. He was confined a number of years in both private and State mental hospitals. A petition for a writ of habeas corpus was presented by me in behalf of this lawyer to the late Associate Justice of the Supreme Court of the United States, Oliver Wendell Holmes, in 1928. Justice Holmes issued a writ of habeas corpus on May 22, 1928. A photostatic copy of the petition and order of Justice Holmes is appended to this statement which set forth the allegations. This is done in the interest of the care and treatment for the mentally sick who are confined in mental institutions. In the course of the investigation over a period of 2 years it was found that in addition to the illegal commitment this lawyer's estate was mishandled by a member of his family, who had herself appointed his guardian without legal notice to him as required by law. No account was filed with the probate court by the guardian for several years until forced to do so, when the mishandling of the estate was discovered.

The above case is only one of many throughout the country where innocent people have been deprived of their liberty and property without due process of law when committed to a mental hospital, all in violation of the United States Constitution and the constitution of the several States where the victim may be confined.

This statement is made as a supplement to the report made to Senators William A. Purtell and Lister Hill by way of a letter dated March 6, 1955, on the above bills.

Since under the above bills it is intended that a thorough study be made of the problem of mental health including the care and treatment of the mentally and emotionally ill who are confined in mental hospitals throughout the country, it is felt that the subject of commitments, discharge, and appointment of guardians be included in the study by the Commission created under the above bills. Such a study is important from the standpoint of the victims of mental and emotional illness, their families and friends, and the taxpaper who must support the Federal and State mental hospitals, support the victims and their families through welfare funds appropriated by Congress and the several State legislatures. This phase of the problem of mental illness has been neglected in the past. Efforts have been made in the past 5 years to remedy this by the Federal Security Agency (now the Department of Health, Education, and Welfare), American Psychiatric Association through its committee on legal aspects, the American Bar Association, some of the State and local bar associations, and public-spirited citizens. However, nothing has been accomplished as yet.

In Massachusetts remedial legislation has been filed for the past 5 years to revise the laws on commitments to mental hospitals. Recess commissions under these bills have filed reports. The last of these recess commissions filed a resolve in 1955 to have the commission extended. From reliable sources it has been learned that this commission will file its report in the near future with proposed legislation to revise the laws on commitments and discharges from State hospitals. This resolve reads, "Resolve further continuing the special commission to study the methods of committing persons to mental hospitals, and their rights, care, treatment, and release or discharge of persons so committed."

It has been recognized by authorities both medical and legal that the commitment laws as they exist throughout the country are antiquated, inhuman, and without due process of law in most States. This has resulted in numerous people being committed to mental hospitals who do not belong there, causing an overcrowded condition in mental hospitals. It should be remembered that it is the intent of the law to commit persons to mental hospitals who are suffering from a mental illness and that they are dangerous to themselves or to society. A large group who have been committed to mental hospitals that do not belong there are the aged. The hospitals are filled with them. In most cases these unfortunate people have been dumped into mental hospitals by cities and towns in order to avoid old-age assistance payments, placing the burden on the State to support them in mental hospitals. Children also are to blame in having their aged parent committed in order to avoid the support of the parent. They also are placing the burden on the State. It will be found that only a small amount

is collected for the board of these aged people from those responsible for their support. There has been a cry by public spirited citizens and organizations interested in the welfare of these aged patients in the past 5 years. Some States have passed legislation recently to remedy these conditions by having the aged removed from mental hospitals who are not psychotic or suffering from mental illness.

AMERICAN BAR ASSOCIATION ACTION

During the American Bar Association convention held in Boston in August 1952 I introduced a resolution on the subject of commitments. This was amended by the committee on resolutions and given a broader scope reads:

"Whereas the American Bar Association has heretofore authorized the creation of, and for many years there has existed, a special committee on the rights of the mentally ill, which was again continued at this session; and

"Whereas this special committee has made no report to the house of delegates for many years; and

"Whereas the members of the American Bar Association are aware of the serious and pressing problems existing in many sections of the country, due to inadequacies existing in their substantive and procedural law, whereby the personal and property rights of individuals suffering from mental illness as well as persons under suspicion of being mentally ill, fail to receive and are not accorded the full protection to which they are entitled under proper concept of due process of law; and

"Whereas the protection and safeguarding of the personal and property rights of the mentally ill persons and of persons suspected of being mentally ill is and should remain the function of the judiciary, and the American Bar Association as well as the State and local associations of the several States should ever be alert to resist the encroachment upon or usurpation of the judicial functions or any part thereof by lay agencies: Now, therefore, be it

"*Resolved*, That the special committee on the rights of the mentally ill be and it hereby is charged with the responsibility of reporting to the house of delegates, not later than 1954 annual meeting of the American Bar Association on the results of its studies together with its recommendations of legislation that will better safeguard the rights of mentally ill persons and of persons under suspicion of mental illness, as well as maintaining the jurisdiction and powers of the several State courts charged with protection of such rights."

In many States the courts have frowned upon the illegality of some commitments to mental hospitals. During a court proceeding in October 1952 in the Superior Court in Boston, Judge Frank J. Donahue said: "A criminal can come into court and get relief but these unfortunates (mental patients) unless they have friends on the outside are doomed to spend their whole life in mental hospitals."

In cases where petitions are filed for the commitment of persons to a mental hospital, it is rare that a notice of the pending proceeding is given to the victim or his relative; proceedings are ex parte; all in violation of constitutional rights of the individual and without due process of law. In these cases the judge does not see the victim. He merely takes the written statements of one or two doctors who certify that the person should be committed to a mental hospital. The doctors' certificate is made after a brief examination of the victim, which in most cases does not last more than 5 minutes. These doctors are paid for these supposed examinations, which the law requires to be thorough, by the county. In many cases the doctors making the examinations are not qualified as experts in mental sickness.

I want to cite a few cases decided by our courts on the subject of illegal commitments to mental hospitals.

In *Barry* v. *Hall* (98 Fed (2d) 222), Judge Stephens of the Court of Appeals for the District of Columbia said in his opinion:

"The appellant's confinement in St. Elizabeths Hospital * * * was illegal. Insanity is not a crime and therefore the constitutional guaranty of jury trial is not applicable; nevertheless, confinement in a mental hospital is as full and effective a deprivement of personal liberty as is confinement in jail. The fifth amendment is applicable in the District of Columbia and it guarantees that no person shall be deprived of liberty without due process of law. Due process of law does not necessarily mean a judicial proceeding * * * the proceeding may be adapted to the nature of the case * * * but it does necessitate an opportunity for a hearing and defense."

The following cases are cited in the opinion:

Ballard v. *Hunter* (204 U. S. 241, 245)
Simon v. *Craft* (182 U. S. 427, 437)
Allgor v. *New Jersey State Hospital* (80 N. J. Eq. 386)
In re Wellman (3 Kan. App. 100, 45 P. 726)
In re Allen (82 Vt. 365 73 A. 1078)

Judge Stephens further said "Independently of statutes, every person is entitled to the right to be heard before he is condemned. No mere ex parte proceeding can effect either personal or property rights. Were the legislature to attempt to enact a law authorizing judicial proceedings, the object of which was to effect the person or property of a citizen, without notice or opportunity to be heard such legislation would be rejected and repudiated in advance as an intolerable outrage upon the rights of the citizen. It would not only be a serious infringement of natural rights, but would be a flagrant violation of the constitutional guaranty that no person shall be deprived of his liberty or property without due process of law."

Numerous other cases can be given to you as to illegal commitments and the rights of the mentally ill.

Another serious situation exists in many States who have a defective delinquent law, commitments of juveniles who are mentally defective or retarded. These cases arise in the criminal courts. The victim if sentenced as a defective delinquent will find that he or she is sentenced for life in a penal institution with little hope of ever getting out. Such a situation existed in Massachusetts until 1949 when the Supreme Court in the case of John O'Leary, petitioner (325 Mass. 179) discharged the boy. It said "An order of commitment of a boy 12 years of age as a defective delinquent was void where it appeared that it was issued upon an application of which no notice was given to the boy or anyone in his behalf, and neither he nor his mother, who was his only companion in court, understood the nature or scope of the proceeding."

As the result of this decision about half of the inmates at the defective delinquent department of the Bridgewater State Farm (a penal institution) were discharged upon petitions for writs of habeas corpus by the courts. A special session of the court was held in Brockton, Mass., on these cases.

The newspapers carried news stories and editorials on the subject. Here are a few headlines:

"Judge Raps Life Jailing in Car Theft"
"Veteran Asks Release From State Hospital"
"He Lost 25 Years of Life for Nothing"
"Innocent Rot in Jail, Says Prison Head"
"Innocents Freed After Long Years"
"Defective Delinquent Freed After Serving 10 Years: Is Now 76"
"Judge Releases Woman, 7 Men"
"Crimeless Prisoner 31 Years, Free Now"
"155 Defectives Freed Since 1950 Ruling"

EXPERT MEDICAL TESTIMONY AND PSYCHIATRISTS

The public, many courts, and even medical societies frown upon the conduct of some psychiatrists both as to their private practice and as experts in court cases. We have seen too many cases where we have a battle of experts on both sides of a case giving opposite opinions on the same set of facts and the same individual.

The Journal of the Indiana State Medical Association in an editorial said:

"At the present time expert medical testimony is thought by the public to be worthless through the conflict of opinions that seemingly are biased as a direct result of the fees or salaries paid by those who employ the witness. We hope that some plan may be worked out by the American Medical Association and the American Bar Association whereby unbiased expert testimony can be produced by the court."

Judge George T. McDermott, of Topeka, Kans., speaking of expert medical testimony said:

"I have heard much discussion of the constitutional and procedural problems of expert testimony. I have tried my hand in an honest way at the problem. When there is to be medical evidence, I say to the lawyers: 'Put in all the evidence that you want to, spend all the time you want to, but there will be one doctor selected by me who will make an examination, come into the courtroom and be questioned by me.' I turn him over to counsel. But since the jury knows

that the court's doctor is absolutely neutral, I tell you, my friends, they don't cross-examine him much and they don't call other doctors."

The Medical Legal Journal, volume 49, page 11:

Expert medical testimony by J. J. O'Connor, M. D., president of Lackawanna County Medical Society, said:

"I think it best to limit my adverse criticism to one topic I have chosen for unfavorable criticism is expert medical testimony."

Alfred W. Herzog in his Medical Jurisprudence says:

"Medical societies ought to pay careful attention to expert testimony given by members of the medical profession and to draw attention of the courts to such testimony if it is at variance with facts in the possession of the medical science.

"During the past year, certain expert medical testimony given by local physicians in judicial proceedings has been called to my attention as being stultifying to those giving it in some instances, and detrimental to the profession and the society on account of its mendacious nature."

I do not want to burden your committee with any further information; you no doubt are personally familiar with many cases yourself.

But since you will recommend legislation for a thorough study of the national problem of mental health, I urge upon you that such legislation should include a study of the legal problems of the mentally sick, their rights, and their care. The laws relating to commitments should be studied with the view of preventing illegal commitments to mental hospitals of people who do not require hospitalization. Since the commitment is a judicial matter, it should comply with all constitutional provisions. By keeping people from being sent to mental hospitals who do not require hospitalization and not mentally sick, an overcrowded condition will be eliminated. Most important of all is that a tremendous burden will be lifted from the taxpayer who must pay Federal and State taxes to maintain the mental hospitals, construct new hospitals, support families of the victims in mental hospitals through welfare funds.

Another important study should be made. This is the proper rehabilitation of patients in mental hospitals, vocational guidance and placing former patients in suitable employment in the community after they have been discharged from a mental hospital. Because of ignorance and prejudice as to mental illness, these victims of mental and emotional illness find it difficult in getting their old job back or finding a new job because they have at one time been a patient in a mental hospital. Patients leaving a mental hospital do not want charity. All they want is an opportunity to find work, support themselves and family. More effort should be made to give the victims of mental and emotional illness the benefits to which they are entitled under the Vocational Rehabilitation Act.

[Appendix J to Task Force Report on Federal Medical Services]

(Prepared for the Commission on Organization of the Executive Branch of the Government, December 1954)

MENTAL HEALTH

Although important advances have been made in the field of mental health since the publication of the report of the first Commission, mental disease still remains the greatest single problem in the Nation's health picture today. More than half of the Nation's hospital beds are still devoted to the care of the mentally ill and this year some 250,000 patients will have their first admission to mental hospitals. A number of these individuals will be young, many of them of superior intelligence, and some of them destined for chronic illness and prolonged hopsital stay. At the present rate of illness 1 out of every 12 children born will spend some time in a mental hospital. Were these statements true of any other illness, the situation would be regarded as a national emergency but in the case of mental illness the problem seemingly in large part is regarded with sympathetic apathy.

The great bulk of mental hospital care is provided in publicly supported institutions. Mental patients constitute the largest group of Federal and State patients and modest estimates place the cost of mental disease to the taxpayer at about $1 billion per year. The cost in terms of suffering and in loss of manpower is incalculable.

EXTENT OF ILLNESS

The number of patients in institutions for the care of the mentally ill is increasing steadily at the rate of approximately 10,000 per year as is shown in table 1. This increase results not so much from an upsurge in the rate of mental

illness (this is only apparent in the older age groups) but rather from the growth of the whole population and the larger number and proportion of older people. Although considerable strides have been made in the improvement of the rate at which patients are discharged from mental hospitals, this has been offset by the higher number of admissions and the fact that patients with mental illness now live longer.

The increased number of older resident patients in mental hospitals becomes strikingly apparent when we review the changes in the age distribution of present-day State hospital patients. In 1950 25 precent of the 89,700 resident patients in 6 selected States were 65 and over as compared to only 14 percent in this age group in 1939 as shown in table 2.

When we speak of the number of patients receiving care in mental hospitals, we must realize that this is only one measure of the incidence of mental disease and emotional disturbance in the United States. This figure does not include the number of people who are suffering with mental disorders who are kept at home, or who are in sanitaria, nursing homes, and general hospitals and thus are not included in psychiatric hospital statistics.

Although any estimate of the number of noninstitutionalized [1] cases would of necessity be imperfect, two widely quoted surveys suggest that as many as 9 million people, almost 6 percent of the total population, suffier from some form of mental disorder. Only about 10 percent of them are in need of hospital care.

TABLE 1.—*Number of patients in hospitals for long-term psychiatric care, by type of hospital control, United States, selected years, 1903–52*

Year	Number of resident patients at end of year					Rate per 100,000 population [1]	
	All hospitals	State hospitals	Veterans' hospitals [2]	County and city hospitals [3]	Private hospitals [3]	All hospitals	State hospitals
1903	150,151	128,312	----------	16,341	5,498	186.2	159.1
1909	187,791	159,096	----------	21,146	7,549	207.5	175.8
1922	267,617	229,837	1,703	26,846	9,231	243.2	208.8
1933	389,500	332,517	13,946	32,936	10,101	310.2	264.8
1934	403,519	341,485	17,894	33,839	10,301	319.3	270.2
1935	416,926	353,305	18,276	34,703	10,642	327.6	277.6
1936	432,131	364,403	21,960	34,743	11,025	337.5	284.6
1937	445,031	374,043	24,483	34,829	11,676	345.5	290.4
1938	457,983	384,573	26,599	35,980	10,831	352.8	296.2
1939	472,385	400,017	28,653	32,463	11,252	360.9	305.6
1940	480,637	410,427	29,951	29,581	10,678	364.2	311.7
1941	490,506	417,315	30,443	31,812	10,936	368.2	317.2
1942	497,938	432,550	32,348	21,256	11,784	369.8	330.5
1943	500,564	430,958	35,953	21,297	12,356	366.7	338.2
1944	506,346	434,209	38,623	21,259	12,255	366.7	343.2
1945	518,018	438,864	42,204	23,850	13,100	371.1	344.3
1946	529,247	445,561	48,235	23,150	12,301	382.4	321.9
1947	540,987	452,464	52,505	23,643	12,375	379.2	317.2
1948	554,454	469,500	52,619	19,240	13,095	381.6	323.1
1949	564,160	478,003	52,380	19,859	13,918	382.5	324.0
1950	577,246	489,930	51,553	21,687	14,076	384.3	326.2
1951	584,455	497,013	50,624	22,525	14,293	386.8	329.0
1952	[4] 595,519	[4] 507,765	[4] 51,221	[4] 23,187	[4] 13,346	[4] 388.3	[4] 331.1

[1] Rate for all hospitals 1946–50 and State hospitals 1940–50 based on estimates of civilian population.

[2] Veterans' hospital data for 1922–45 referred primarily to patients in VA neuropsychiatric hospitals. In 1946 and 1947 the data included neuropsychiatric patients in all types of VA hospitals and in other Federal hospitals. Starting in 1948, coverage was reduced somewhat to eliminate duplicate counting by excluding VA patients in "other Federal hospitals." The bulk of these patients were in St. Elizabeths Hospital, Washington, D. C., and are, therefore, included in data for State hospitals.

[3] The coverage for county, city, and private hospitals has never been entirely complete. A special study covering the years 1940 to 1945 indicates, in terms of psychotic 1st admissions, an estimated coverage of between 90 and 95 percent.

[4] Unpublished provisional data secured in the 1952 annual census of patients in mental institutions.

Sources: Public Health Service, Mental Hygiene Statistics, Series MH–549, No. 1 (Washington, D. C., Feb. 1, 1949).

National Institute of Mental Health, Patients in Mental Institutions 1949, p. 14, table C. Public Health Service Publication No. 233 (Washington, D. C., 1952) and recent figures from National Institute of Mental Health.

NOTE.—This table does not include data on patients in the 2 neuropsychiatric hospitals operated by the Public Health Service, Department of Health, Education, and Welfare, primarily for narcotics addicts.

[1] Cited by Dr. Felix in statement noted in footnote 1.

TABLE 2.—*Age distribution of patients in State hospitals for mental disease at end of years, selected States, 1939 and 1950*

	Total resident patients	Percent distribution by age				
		Total	Under 25	25 to 44	45 to 64	65 and over
Total of 6 States:						
1939	71,317	100.0	5.9	39.3	41.0	13.8
1950	89,716	100.0	3.5	29.0	42.3	25.2
Arkansas:						
1939	4,323	100.0	10.3	39.7	36.0	14.1
1950	4,947	100.0	7.2	34.1	37.0	21.7
California:						
1939	22,608	100.0	3.1	34.0	45.8	17.1
1950	31,544	100.0	3.4	29.2	41.2	26.2
Louisiana:						
1939	6,194	100.0	5.4	42.1	40.1	12.5
1950	7,311	100.0	4.7	36.6	41.6	17.1
Michigan:						
1939	15,377	100.0	12.9	51.4	28.6	7.2
1950	18,738	100.0	2.9	27.9	42.7	26.5
Nebraska:						
1939	4,003	100.0	2.5	29.5	46.9	21.1
1950	4,590	100.0	3.0	24.5	43.4	29.1
Ohio:						
1939	18,812	100.0	3.2	37.4	45.4	14.0
1950	22,586	100.0	3.0	26.7	44.8	25.5

Source: Patients in Mental Institutions 1939, U. S. Department of Commerce, Bureau of the Census Washington, D. C., and unpublished data collected for the 1950 census of mental patients.

The statistical reports of the Selective Service System and the Armed Forces in World War II regarding the rejection and discharge of men from the services for neuropsychiatric conditions are too well known to discuss them here. Suffice it to say more draft registrants were rejected and more military men discharged for psychiatric reasons than for any other cause.[2] As an index of the effect this had upon the manpower situation in the country at a time of need General Cooke's dramatic statement bears repetition. Speaking of the consternation of the General Staff when the size of this problem became apparent to them in 1943, he said: "Nearly as many men were being discharged from the Army as were entering through induction stations. The number of these discharges was enough to alarm even the most complacent because it was well up to six figures. In fact over a given period of time more men were getting out of the Army than were being sent across the Pacific to fight the Japs. It is small wonder then that the Chief of Staff wanted to be informed immediately how such a thing could come about."[3] This material is recalled in this report in order to point out the seriousness of this problem in time of war.

NEED FOR PERSONNEL

The most serious bottleneck in the provision of proper care for the mentally ill is the lack of trained personnel, physicians, nurses, and other properly equipped professional and auxiliary workers. Although this situation has improved somewhat in recent years, shortages of trained personnel continue not only to hamper efforts to improve general conditions, but also to restrict efforts to discover new methods of treatment and even to prevent the wide application of known therapeutic procedures.

The National Institute of Mental Health, using standards established by the American Psychiatric Association, has made a statistical survey and pointed up the dearth of physicians, nurses, social workers, and attendants in the various State hospitals. Table 3 indicates that in 1950 the need for full-time physicians was only about half met with 1 State having no psychiatrists at all. In the same year the hospitals had less than 24 percent of the required number of graduate nurses, 23 percent of psychiatric social workers, and under 74 percent of the attendants required.

[2] Statement by Robert H. Felix, M. D., director, National Institute of Mental Health, before House Committee on Interstate and Foreign Commerce, October 8, p. 1084.

[3] E. D. Cooke, All But Me and Thee. Psychiatry at the Foxhole Level, Infantry Journal Press, Washington, D. C., 1946, p. 11.

It is only within the past 25 years that an appreciable number of psychiatrists have engaged in private practice. Prior to that time mental patients could only receive specialized care in an institution. Due to a variety of factors, private practice is the magnet which draws many psychiatrists today and Dr. Daniel Blain, the medical director of the American Psychiatric Association, recently reported that more than 4,000 psychiatrists are now in private practice. Today the main need for psychiatrists in private practice exists in cities of less than 100,000 population.

TABLE 3.—*Staff needs in State mental hospitals, by type of personnel, showing range among States, 1950*

Type of personnel	Required	Available	Percent of need met		
			United States	High State	Low State
Physicians	3,836	1,987	51.8	112.2	0
Graduate nurses	19,188	4,574	23.8	98.5	0
Social workers	[1] 3,167	729	23.0	77.3	0
Attendants	79,952	58,844	73.6	114.5	37.5

[1] Includes requirements for patients in extramural care.

NOTE.—Estimated requirements are based on the following American Psychiatric Association standards: Physicians—1 physician per 100 admissions (excluding transfers) and 1 physician per 200 resident patients at end of year. Graduate nurses—1 nurse to every 25 average daily resident patients. Psychiatric social workers—1 worker for every 80 annual admissions and 1 worker for every 60 in convalescent status or family care. Attendants—1 attendant for every 6 average daily resident patients.

Source: Data supplied by Public Health Service.

There are many reasons for the great shortages of qualified personnel in the mental health field today. Lengthy and expensive training provides only a part of the explanation. Physicians now must serve 2 years in the armed services and the addition of 5 years of training and experience for psychiatric practice to his already long preparation delays his advent into practice until he is in his middle thirties. In most institutions the workload is extremely heavy for overcrowding is the rule. The pay is usually inadequate, the job location frequently in an isolated area, and the whole picture overwhelming. These factors stand in the way of the proper recruitment and retention of staff. Although it is evident that conditions are bad now, as far as the personnel situation is concerned, they have been kept from becoming even more serious by reason of the farsighted training program of the Veterans' Administration and the training stipends made possible under the National Mental Health Act. These programs will be commented upon when these agencies are considered later in this report.

NEED FOR RESEARCH

It is apparent that the alleviation and, if possible, the solution of the problem of mental disease must be found through research. As the population increases and as the life span and life expectancy increases the problem will grow. As the problem grows the costs will become greater and it is obvious that the only way to meet it will be through constant widespread scientific reesarch into causes and treatment methods. In the past 5 years research in the mental health field has commanded increasing interest and support but the surface of the problem has scarcely been scratched. Stevenson [4] pointedly asks: "Where else in medicine would we find such promising leads passed by or given so little recognition? What other disease of major magnitude offers so much promise of recovery?" It is obvious that research in this important field must be broad and thorough; it encompasses extremely complicated problems.

In spite of the enormity of the problem the picture is not altogether dark; appreciable strides have already been made through the medium of basic and clinical research. Paresis, an organic disease of the brain due to syphilis, has ceased to be the sizable problem that it was a decade ago. Formerly 10 percent

[4] Statement by George S. Stevenson on behalf of National Association for Mental Health at hearings before House Committee on Interstate and Foreign Commerce, October 8, 1953, p. 1069.

of all individuals who acquired syphilis became a victim of paresis. Now, due to the advent of new therapeutic methods less than 3 percent of patients who are treated adequately will develop this illness. It is not unlikely that the disease can be wiped out in this generation.

The same situation holds with pellagra. It has been estimated that 10 percent of patients in mental hospitals in the southern part of the country were there because of pellagra. With the finding in 1927 by Goldberger and Sebrell that this was a deficiency disease caused by a lack of vitamin, nicotinic acid in the diet, the disease became responsive to treatment and today it is readily preventable.

In the same vein other diseases have responded—less dramatically, it is true, but equally encouraging—for any inroads which can be made upon the illness contribute to the commonweal. The agitated depressions of middle life have responded dramatically to electric shock therapy, as have depressive illnesses in general. Schizophrenia in the third decade of this century had a spontaneous recovery rate of only 15 to 20 percent, whereas today 40 to 60 percent of the persons suffering with this illness can be helped by modern treatment. Epilepsy, which contributed a number of patients to mental hospitals several decades ago, is now being brought under control by modern treatment methods. Recent studies in one of the State hospitals in California demonstrated conclusively what psychiatrists have known for a long time, namely that by means of intensive treatment physicians could triple the recovery rates of the patients heretofore considered chronically ill and could return them to a useful status in the community. Despite all of our deficiencies and the lacunae in our knowledge, nearly two-thirds of present-day mental hospital admissions are discharged within a year.

There is an urgent need for research in the prevention and treatment of the mental diseases of the older age groups. It avails us little if the miracles of modern medicine spare the population for a longer life span if we are to end ingloriously with senile psychoses. It is becoming increasingly evident that the psychoses of the older age groups have psychological and social components which may be of as much or even more importance than the physiological and pathological. Loss of status and position, economic and emotional dependence, lack of useful occupation, and a feeling of being no longer worth while, all take their toll in persons who are dependent in later years. Research directed at these various components of the illness and treatment aimed at the alleviation of distressing conditions will not only bear fruit from a humanitarian standpoint but will salvage a number of people who would otherwise become wards of the Government.

In addition to advances in the treatment and prevention of frank mental disease, research has aided in the rapid developments in the field of psychosomatic medicine. Medical science now clearly recognizes the importance of emotional factors in many diseases hitherto considered to be of obscure origin. Gastric and duodenal ulcers, hypertension, asthma, colitis, and some other illnesses are now recognized as having emotional components which require recognition and treatment if the illness is to be properly managed. This field is of the greatest importance, for it is estimated that between 50 and 70 percent of the illnesses treated in the offices of physicians have important emotional components in their causation.

It is only by means of continued research that any one of these serious psychiatric problems will be met and research requires trained personnel and sufficient funds with which to accomplish it.

NEED FOR PREVENTIVE SERVICES IN THE COMMUNITY

Advances in treatment have made it possible to provide increased care for the mentally ill and the emotionally distressed outside of hospitals. Though hospitals continue to play the major role in frank mental illness, a variety of services in the community are in a position to make essential contributions, particularly in the early stages of the illness. Community health services have an especially important responsibility for the recognition of mental illness in its inception and by means of scientific vigilance to secure treatment for the patient before commitment is necessary or before tragedy occurs. Private practitioners of medicine, public health and school nurses, teachers, and religious leaders, all have important roles to play in preventive psychiatry, although it is axiomatic that meddlesome or amateur psychiatry is not to be engaged in.

It has become increasingly apparent that mental health clinics can be of the greatest assistance to patients whose illness, while distressing to them, does not require their hospitalization. Were it not for these clinics and their support and treatment, many additional patients would have to be added to hospital rolls. They also serve as a valuable center for the followup care of patients who have been hospitalized and have recovered sufficiently to return to their homes under professional supervision. One survey of a clinic in which children were treated indicated that in 1 year 66 children would have required hospitalization had their facilities not been available. The advantages of this arrangement are obvious.

For some patients a combination of hospital and outpatient care has proven efficacious. In the United States, Canada, and England, day hospitals have been established in order to offer the hospital and treatment facilities to patients able to return to their homes at night. In a similar vein night hospitals offer a haven for patients able to hold gainful occupation but unable to adjust to their home surroundings.

ROLE OF THE STATES

Since 1773 the States have in the largest part assumed responsibility for the care of the mentally ill who required hospitalization. Within the past decade all States have developed departments for the promotion of mental health and the prevention of mental illness. For more than half a century, as shown in table 4, about 85 percent of all patients in hospitals for the prolonged care of psychiatric patients have received care in State hospitals. Fifty years ago county and city hospitals provided most of the remaining care, with some help from private hospitals. Since World War I veterans' hospitals have taken on an increased percentage of the total load, and the role of the county, city, and private hospitals has tended to decline in relative importance.

TABLE 4.—*Proportion of resident patients in hospitals for the prolonged care of psychiatric patients receiving treatment in various types of hospitals, selected years 1923–50*

Year	Number of patients	State hospitals	Veterans hospitals	County and city hospitals	Private hospitals
		Percent [1]	*Percent* [1]	*Percent* [1]	*Percent* [1]
1903	150,151	85.5	----------	10.9	3.7
1922	267,617	85.9	0.6	10.0	3.4
1933	389,500	85.4	3.6	8.5	2.6
1938	457,983	84.0	5.8	7.9	2.4
1943	500,564	86.1	7.2	4.3	2.5
1948	554,454	84.7	9.5	3.5	2.4
1950	577,246	84.9	8.9	3.8	2.4
1952	595,519	85.3	8.6	3.9	2.2

[1] Percents may not add to 100 because of rounding.

NOTE.—Figures for State hospitals include patients in St. Elizabeths Hospital, the Federal mental hospital providing care primarily for residents of the District of Columbia. Not covered by this table are patients in the 2 neuropsychiatric hospitals operated by the Public Health Service, Department of Health, Education, and Welfare, primarily for narcotics addicts.

Source: Data supplied by Public Health Service.

Of $665 million in public funds spent for care of the mentally ill in 1952, State mental hospitals accounted for almost 70 percent, as shown in table 5. The Veterans' Administration spent the next largest share of the funds. It might be noted that the Veterans' Administration in addition to paying the $148 million for hospital care in 1952 distributed about $375 million in compensation and pensions to veterans disabled by mental illness or disorder.

Although there is no important difference among the States in the incidence of mental disorders, the ratio of mental hospital patients to population varies widely in different parts of the country—ranging from about 2 per 1,000 population in New Mexico to 6 per 1,000 in New York State.

TABLE 5.—*Public funds spent for care of the mentally ill, limited States, 1950–52*

[In thousands]

	1950		1951		1952	
	Amount	Percent of total	Amount	Percent of total	Amount	Percent of total
Total [1]	$534,202	100.0	$625,341	100.0	$665,175	100.0
Veterans' Administration, total	122,300	22.9	127,853	20.4	147,789	22.2
Inpatient care	121,000	22.6	126,600	20.2	146,565	22.0
Outpatient care	1,300	.3	1,253	.2	1,224	.2
Non-Federal public hospitals and activities, total	411,902	77.1	497,488	79.6	517,386	77.8
State mental hospitals	371,399	69.5	453,409	72.5	464,834	69.9
City and county mental hospitals	13,181	2.5	13,756	2.2	18,459	2.8
Psychopathic hospitals	3,789	.7	4,168	.7	5,035	.7
Other State and local mental activities	23,533.	4.4	26,155	4.2	29,058	4.4

[1] Does not include expenditures by the Public Health Service for 2 neuropsychiatric hospitals serving primarily narcotics addicts.

Source: Adapted from table prepared by Public Health Service, "Cost of taking care of the mentally ill with public funds, United States; 1950–52."

As of June 30, 1950, the distribution of States by the number of persons per 1,000 population resident in public mental hospitals (excluding VA) and institutions for mental defectives was as follows:

Resident patients per 1,000 population:	*States*
Less than 2	New Mexico.
2.0 to 2.9	Alabama, Arizona, Arkansas, Florida, Kentucky, Mississippi, Nevada, North Carolina, Tennessee, Texas, Utah, West Virginia.
3.0 to 3.9	California, Georgia, Idaho, Indiana, Kansas, Louisiana, Missouri, Oregon, South Carolina, South Dakota, Virginia, Wyoming.
4.0 to 4.9	Colorado, Iowa, Maine, Maryland, Michigan, Montana, Nebraska, Ohio, Oklahoma, Pennsylvania, Vermont, Washington, Wisconsin.
5.0 and over	Connecticut, Delaware, District of Columbia, Illinois, Massachusetts, Minnesota, New Hampshire, New Jersey, New York, North Dakota, Rhode Island.

INCREASING INTEREST OF THE STATES

Although even the admitted public obligation for the care of the mentally ill is far from being fulfilled, the States are assuming increased responsibility. Public concern about crowded conditions in State mental hospitals has resulted in larger appropriations for intensive treatment of the patient population in some States. The States also are expanding their preventive programs and increasing their support of research and training in the mental health field.

In February 1954 the first National Governor's Conference on Mental Health, sponsored by the governors of all of the 48 States and Puerto Rico, adopted a 10-point program advocating increased appropriations for intensive treatment, for additional qualified personnel, and for training and research. The governors and their representatives also called for State support of mental health, education in the schools, good relationships between hospitals and their surrounding communities, and expansion of community psychiatric services.

Several States have experimented widely with outpatient clinics for the treatment of mental disorders. The State of Michigan, for example, reports favorable experience with a system of child and adult psychiatric clinics. It has estimated the average cost of treating a patient in 1 of its 4 clinics for adults at $39, as compared with $1,124 for a patient in a State institution.

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New York and New Jersey are among the States that have inaugurated programs of research as part of their activities to identify, prevent, and treat mental illness. For 1954–55 alone New York has a research budget totaling $1,750,000 with trained research groups active at most of the State hospitals and schools.

Joint action by groups of States provides a means for pooling resources to promote mental health. Regional programs, such as the one now sponsored by the Southern Regional Education Board have stimulated training, research, and related activities. The Interstate Clearing House established through the Council of State Governments by request of the Governors' Conference will encourage interstate cooperation in the improvement of services for the mentally ill.

At the 1954 Governors' Conference, Governor Alfred E. Driscoll of New Jersey expressed confidence in the ability of the States to improve their care of the mentally ill:

"If I sound optimistic with respect to our ability to solve a pressing problem it is because I am aware of the vitality of our State governments, and also acutely aware of the present opportunity for a constructive partnership between our Government and private enterprise, which, in my judgment, offers the best avenue for success in any undertaking, and particularly in the present one."

PRESENT FEDERAL PROGRAMS

Although the States have taken the lead in promoting mental health and providing care for the mentally ill, the Federal Government also provides directly for care of certain Federal beneficiaries. In addition, it helps to support preventive services in the States, makes grants for research and training, and engages in research. The Veterans' Administration and the military services, among the Federal agencies, have the largest number of psychiatric patients in their hospitals at the present time. The United States Public Health Service maintains several hospitals and through the aegis of the National Institute of Mental Health leads efforts to promote the mental health of all the people through research, training, and preventive services.

VETERANS' ADMINISTRATION

The Veterans' Administration furnishes a variety of hospital and medical services for veterans disabled by mental illness. At the end of fiscal year 1953, the VA had 35 predominately psychiatric hospitals with 51,000 operating beds. In addition the general medical and surgical hospitals of the Veterans' Administration contained another 5,600 beds for psychiatric patients. To supplement its own hospital facilities the Veterans' Administration was hospitalizing more than 2,800 mentally-ill veterans in non-VA hospitals. For a considerable number of veterans with service-connected disabilities (hence eligible for outpatient care) the Veterans' Administration was also providing outpatient treatment through mental hygiene clinics and through private physicians paid on a fee basis. Just as mental disease in its various ramifications in the Nation's number one medical problem so also is it the Veterans' Administration number one medical problem and it merits the serious and continued attention of everyone in the administration in any way concerned.

Veterans' hospitals continue to have difficulty in recruiting and retaining sufficient staff, both professional and nonprofessional, and the situation has not been helped in the past by threatened cuts in budget and personnel cutbacks. At some hospitals the shortages of staff have caused substantial amounts of space and equipment to remain unused. The Veterans' Administration has made some progress in meeting its needs for psychiatrists and neurologists through a foresighted and well-conceived career program offering 3 years of formal residency training plus 2 years of clinical practice to full-time VA physicians; at the end of fiscal year 1954, 74 physicians were participating in this program.

In the next few years increasing number of veteran psychiatric patients will place new burdens on Veterans' Administration hospital and outpatient facilities. Already, although all veterans with service-connected disabilities are receiving care, VA hospitals have waiting lists of about 16,000 non-service-connected psychiatric cases, 14,000 of whom are psychotic. The Veterans' Administration estimates that in 1960 about 100,000 psychotic veterans will be receiving, or will be eligible to apply for, care in Veterans' Administration hospitals. Under present building plans, VA hospitals will not have more than 54,000 psychotic beds to care for these 100,000 veterans. To staff its hospital facilities for psychotic veterans and veterans with neurologic and nonpsychotic psychiatric disorders in 1960 the Veterans' Administration foresees the need for additional personnel.

In view of the expected increase in psychotic veterans eligible for admission to veterans' hospitals, the Veterans' Administration has worked out plans for reducing hospital stay. These plans include: (1) Expansion of existing and proven methods of treatment, such as individual psychotherapy, group therapy, group psychotherapy, shock therapy, psychosurgery, use of special services, and physical medicine and rehabilitation; (2) expansion of the foster-home program for certain psychotics on a trial visit status; (3) exploration of the plan for development of night hospitals for patients able to work in the community during the day; and (4) exploration of the possible development of day hospitals for patients who need access to hospital facilities, but who do not need hospital beds for purely dormitory purposes.

They also include: (5) Review of the possible development of intermediate hospitals as halfway houses between the regular hospital and the community; (6) expansion of VA mental hygiene clinics; (7) organization of special trial visit clinics; (8) cooperation with State hospitals in the more effective utilization of personnel and facilities; (9) continued promotion of basic research; (10) vigorous recruitment of psychiatric and other specialized personnel; (11) strengthening of the training and teaching program; and (12) increase in beds under contract.

In spite of their current staffing difficulties most veterans' hospitals at present provide a high level of psychiatric care. This task force has expressed the opinion that the Veterans' Administration might be able more effectively to combat chronic mental illness and reduce long-term hospitalization if it were able to provide outpatient treatment following hospitalization for veterans with non-service-connected psychiatric illness and thus cut down the length of hospital stay.

NATIONAL INSTITUTE OF MENTAL HEALTH

Legislation enacted by Congress in 1946 authorized the Public Health Service through the National Institute of Mental Health to make training grants, research grants, and grants to the States for the improvement of services for the public in the mental-health field. It also authorized certain direct research and training activities.

Of $14.1 million appropriated to the Public Health Service for mental-health activities during fiscal year 1955, more than half ($8.1 million) is earmarked for research and training grants, as shown in table 6. The next largest share of these funds is for research, training, and technical assistance and is to be administered directly by the National Institute of Mental Health. About one-sixth of the funds—$2.3 million—is for distribution to the States for the prevention and control programs.

In the past 5 years, the total appropriations for mental health have tended to increase. The 1955 appropriation exceeds the 1950 appropriation by about $2½ million, as is shown in table 6. This increase is not accounted for by rising grants to the States; in fact, Congress reduced these grants by 35 percent between 1950 and 1955. The additional funds have gone to support research and training and to expand the direct operations of the National Institute of Mental Health.

TABLE 6.—*Federal appropriations to the Public Health Service for research and training grants, grants to the States, and direct Federal operations in the field of mental health, fiscal years 1950–55*

[In thousands of dollars]

	1950	1951	1952	1953	1954	1955
Total appropriations	11,612	9,505	9,989	10,895	12,095	14,147
Grant allowances, total	7,294	8,250	9,019	8,675	9,275	10,409
Research project grants	794	1,146	1,663	1,649	2,587	3,587
Research fellowship grants	100	205	256	250	187	187
Teaching grants	1,950	2,299	4,000	3,676	4,176	4,310
Training grants	900	1,050				
Grants to States for prevention and control	3,550	3,550	3,100	3,100	2,325	2,325
Direct operations [1]	4,318	1,255	970	2,220	2,820	3,738

[1] Amounts appropriated for direct operations (including research, training, technical assistance, and miscellaneous administrative activities) are derived by subtracting grant allowances from total appropriations.

Source: Budget of the United States and data supplied by Public Health Service.

In the fiscal year 1953, the National Advisory Mental Health Council of the National Institute of Mental Health recommended 121 research project grants totaling about $1.6 million and additional research fellowships totaling a quarter million dollars. This Council also approved teaching and training grants totaling more than $3.6 million to 141 graduate institutions and medical schools and to 671 individuals for graduate professional work. In the same year the Institute spent more than half of its budget for direct operations on research and training programs.

The various States have used the Federal mental-health grants for (1) diagnostic and treatment clinics, for children and adults, (2) operation of medical, social, nursing, and psychological services for the mentally ill, (3) educational activities for professional personnel, teachers, social workers, nurses, and the general public, (4) special research studies, (5) maintaining a roster of community mental health facilities and of the mentally handicapped, and (6) training.

Prior to the passage of the National Mental Health Act in 1946, 24 States had a mental-health program other than in the hospitals. Today all of the States, the District of Columbia, and the Territories have such programs.

MILITARY SERVICES

The military services, in fiscal year 1953, had an average of 6,000 neuropsychiatric bed patients, almost all of them military personnel on active duty.

TABLE 7.—*Average daily patient load, neuropsychiatric cases, in military hospitals, 1953*

Service	Patient load		Rate per 1,000 troops
	Total	Active-duty personnel	
Total	5,996	5,652	
Army	3,166	2,899	1.9
Navy	1,989	1,930	1.9
Air Force	841	823	.9

A general policy has been developed under which the military services transfer patients with mental illness to VA hospitals, if return to active duty is contraindicated. A total of 1,430 military patients were so transferred in 1953 under the provisions of this policy.

The three services have quite different policies as to return of mentally ill patients to active duty. At present, due to the manpower shortage, the services are experimenting with the return of patients to duty who formerly would have been discharged. The Army returns over 20 percent of schizophrenics to active duty; the Air Force and the Navy, due to the exigencies of service in the air and afloat, return a very few or none at all.

Inasmuch as in our present society most of our young men will spend some time in the military services, it becomes incumbent upon them to take the opportunity during this period to detect and, if possible, prevent mental disorders in the inductees. Not only will this redound to the credit of the military services but it will also prevent the inductees from becoming psychiatric patients in veterans' hospitals. The military services wherever possible should provide facilities for the study and prevention of psychiatric illnesses in military personnel. To do this they will require sufficient funds and personnel to carry out this important function.

Another important aspect of the military psychiatry is the effect on the physicians taking part in the military services. In years to come a very large percentage of all newly graduating physicians will have a sojourn in their professional field in the military service. It is at this particular early period in their medical careers that proper training has its greatest influence on their future. It would appear, therefore, that a large part of the future of American psychiatry is in the hands of the military and during the young physician's sojourn in the military service every effort should be exerted to see that the specialty training of his choice is of the best caliber. In this manner not only would that military duty be profitable to the individual, but also to the service,

the community, and the people whom the psychiatrist will eventually serve. It is recognized that the mission of the military service is not to train psychiatrists but, as they are to supervise all young psychiatrists for at least 2 years of their lives, this form of integration of Government service will assist in meeting a serious problem which confronts the Nation.

In summary, we find that mental illness poses serious and responsible problems for the Federal Government. At present State governments bear the largest burden in providing care of mental illness. Increasing numbers of these governments are developing constructive programs to combat the problems arising out of the present heavy hospital loads. It is only reasonable that the States should continue to furnish major support for their ongoing service programs. However, the Federal Government has a clear obligation to improve the care of its own beneficiaries and also must assume some responsibility for assisting and stimulating the development of more effective State and community services.

It is our recommendation, therefore, that examination be made of means of establishing further cooperative planning among Federal agencies providing psychiatric care;

That the military services be assisted in every way in developing special facilities for the study and prevention of mental disorders among the young men who will serve a tour of duty under their aegis;

That the Veterans' Administration be encouraged to give greater emphasis to preventive psychiatric services; and

That the Federal Government, through the Public Health Service, continue to attack the serious problems of mental disease by:

(*a*) Increased grants to the States to help communities participate in the development of outpatient and child-health clinics for the prevention and treatment of mental illness;

(*b*) Increased research grants to universities and other research centers for continuing investigation of mental health and disease in all of its ramifications; and

(*c*) Continued and expanded grants for advanced training for psychiatrists and workers in allied fields, with emphasis on residences and fellowships for physicians.

NOTE.—Acknowledgment: Much of the background of the material in this report was drawn from publications of the National Institute of Mental Health, hearings before the Committee on Interstate and Foreign Commerce, House of Representatives, 83d Congress, part 4, October 7, 8, and 9, 1953, and a conference on Federal mental-health problems held under the auspices of the medical services task force in Chicago, Ill., on August 30, 1954, which was attended by Leo H. Bartemeier, M. D., American Medical Association; Daniel Blain, M. D., American Psychiatric Association; Capt. E. L. Caveny, United States Navy; Sarah H. Hardwicke, M. D., American Hospital Association; Maj. Edward J. Kollar, Jr., United States Air Force; Morton Kramer, Sc. D., National Institutes of Health; Col. Donald B. Peterson, United States Army; Richard J. Plunkett, M. D., American Medical Association; Curtis Southard, M. C., National Institute of Mental Health; Harvey J. Tompkins, M. D., Veterans' Administration; and for the medical services task force: Evarts A. Graham, M. D., Basil C. MacLean, M. D., Edwin L. Crosby, M. D., Mr. Chauncey McCormick, chairman.

STATEMENT SUBMITTED BY THE COUNCIL OF STATE GOVERNMENTS, CHICAGO, ILL.

Memorandum on State Activity in the Field of Mental Health Prepared by Sidney Spector, Director, Interstate Clearinghouse on Mental Health

The problems of mental health are being attacked by the States not only on an individual basis, but within recent years through joint action. In all sections of the country, States are devising and operating programs of national and regional cooperation for more effective efforts in treating and preventing mental illness.

Impetus for this increasing attention on interstate cooperation comes from the ever-growing responsibility of the States in the mental-health field. Two major developments have contributed to the interest and concern.

First has been a growing conviction that the purpose of a mental hospital is not primarily to provide custody for the mentally ill but to use all available scientific knowledge for effective medical treatment.

Second is an increasing awareness that emphasis also must be placed on prevention of mental illness and on efforts to achieve positive programs of mental health.

As a consequence the States are increasingly concerned with adequate staffing of mental hospitals, with training of new personnel, with research into the causes of mental illness, and with programs of prevention. Mental health has become a major element of State budgetary consideration.

The States are now spending more than half a billion dollars a year on the care and treatment of the mentally ill in State mental hospitals alone. They house approximately 500,000 patients in these hospitals; approximately 85 percent of all patients in mental hospitals. In just 9 years, from 1945 to 1953, expenditures for operating mental hospitals soared from around $166 million to $500 million; an increase of about 200 percent. During the same period, as staffs were enlarged and salaries increased, salary and wage expenditures rose from $89 million to $320 million, increasing almost fourfold. The steady annual increases in these costs have been as follows:

Year	*Salaries and wages (amount)*
1945	$89,415
1946	105,342
1947	129,969
1948	165,872
1949	195,816
1950	228,194
1951	249,213
1952	288,672
1953	320,020

Within some individual States, expenditures for salaries and wages were multiplied 6 or 7 times. Figures from a few States will illustrate the dramatic rise:

State	Amount expended for salaries and wages		Percent increase
	1945	1953	
Arkansas	$477,000	$2,345,000	391
Connecticut	1,744,000	8,443,000	384
Delaware	160,000	1,005,000	527
Kansas	556,000	3,958,000	610
North Carolina	913,000	4,983,000	445

Figures for daily per-patient costs for maintenance and operation underline the same story. The average for the United States increased from $1.06 in 1945 to $2.70 in 1953. Here, again, within numerous individual States the increases were spectacular:

State	Per patient per diem maintenance		Percent increase
	1945	1953	
Connecticut	$1.17	$3.74	211
Delaware	.97	3.09	218
Kansas	.70	3.87	450
Maryland	.81	2.98	268
Michigan	1.28	3.48	171
Nebraska	1.01	3.61	257
Wisconsin	1.54	5.13	233

Much of the rise resulted from an increase of some 50 percent in the general price level. But, as the figures show, the increase in mental hospital maintenance expenditures has been much greater. In part it reflects higher salary scales, but more particularly expansion in numbers of personnel. This was based primarily on belief that a heavy investment in staff would result in returning an increasing number of patients to their communities and to productive lives.

Thus, during the postwar period, the number of physicians in State mental hospitals went up from 1,458 in 1945 to 2,661 in 1953, an 82 percent increase. Similarly, the number of psychologists rose 574 percent, social workers 165 percent, graduate nurses 107 percent, and other nurses and attendants 112 percent.

As a consequence of this concentration on personnel, overall staff-patient ratios from 1945 to 1953 increased approximately 76 percent despite the fact that the number of residents in hospitals rose 16.7 percent during this period and the number of first admissions 39 percent.

The number of patients discharged from mental hospitals to active lives has risen markedly on an overall basis. In some hospitals, at least 80 percent of first admissions are returned to productive activity within a year. A return of at least 60 percent is becoming common.

Recently, for example, the Kansas Legislative Council assessed the results in that State of heavy investment in personnel for effective treatment of mental patients. It found that in the 7-year period 1947–53, the average patient population in Kansas State hospitals actually decreased 7.3 percent, as compared with an increase of 15.2 percent in the 15 hospitals comprising the model reporting area of the United States Public Health Service. The number of admissions in Kansas rose 21 percent, but the number of discharged patients 200 percent. The number discharged in 6 months rose from 84 in 1947 to 664 in 1953, about 700 percent. The council stated that "in consequence it seems logical to conclude that the investments in modern treatment over a 5-year period are now paying dividends, as revealed by the 1954 statistics, and that greater accomplishments may be expected from the program in the future."

Despite improvements of this magnitude, however, the States are facing ever-increasing obligations to house, treat, and rehabilitate mental patients. From 1945 to 1953 the average daily resident population in State mental hospitals rose an average of 9,000 per year. If this trend continues to 1963, there will be about 620,000 patients in State hospitals as compared with the present half million, and the present condition of aggravated overcrowding will become critical. The sums required for buildings alone assume almost prohibitive proportions.

Even with an 82 percent increase in the number of physicians from 1945 to 1953 there was only 1 psychiatrist for every 325 patients in State mental hospitals. And even though the number of phychologists climbed 574 percent, there still were only 465 in all State hospitals—an average of 1 to every 1,142 patients. A number of hospitals still do not have a single social worker; the average for the Nation was 1 to 488. The greatest shortage was among nurses; their average ratio was approximately 1 to 100 patients, an almost impossible nursing load.

INTERSTATE COOPERATION

Faced with shortages in personnel and with tremendous outlays for building programs, the States are joining forces for a more effective mutual attack on the problem.

Each of the last five governors' conferences has been concerned with this problem. In 1949, after an entire session on the subject, the governors' conference directed the Council of State Governments to undertake a comprehensive examination of the care and treatment of the mentally ill in the 48 States. The resulting council report, published in 1950, emphasized overcrowding in buildings and the need for providing adequate facilities. In 1951, the governors again discussed the whole problem. They underlined that it could not be solved without a program of prevention, research and training. Although well aware that care and treatment required the major share of a State's mental health resources, they recognized that ultimate reduction of mental hospital admissions could not be achieved by present methods alone. Hope for the future lay primarily in discovering better means of treatment and prevention—through research and through security enough adequately trained personnel.

This led the governors to adoption of a resolution directing the Council of State Governments to continue its work in the field, concentrating now on research, training, and prevention. A study on these aspects was completed in 1953 and adopted by the governors at their annual meeting in Seattle. At the same time the governors adopted a resolution to hold a national governors' conference devoted entirely to mental health, concentrating on training, research, and prevention.

GOVERNORS' CONFERENCE ON MENTAL HEALTH

Thus the first national governors' conference on mental health was held in Detroit, Mich., last February. Representatives of 46 States and the Commonwealth of Puerto Rico gathered for a meeting which Gov. G. Mennen Williams, of the host State, said "could well turn out to be one of the historic turning points in the ancient struggle of mankind against disease." Ten governors, many legislators, mental health and other State officials, and leaders of all relevant psychiatric professions joined together for the first time to discuss the means of attacking this great problem.

The meeting was an inspirational one, but by no means only that. The governors present adopted a concrete 10-point program on mental health which now has received the widest distribution among governors, legislators, budget officers, mental-health officials, and others. It has become a guide for action, and was cited in inaugural and legislative messages of many governors this year.

The 10-point program called for increased appropriations to secure additional, qualified mental-health personnel, including psychiatrists, psychologists, social workers, nurses, and others. It urged special appropriations, in addition to regular appropriations, to be used for training personnel and for research. It recommended that State institutions not now accredited as residencies or training centers for psychiatrists, clinical psychologists, social workers, nurses, and other professional groups should receive support to raise their levels of teaching and supervision and thereby to secure accreditation. It cited needs for stipends for graduate training, for higher salary scales, for educational leaves of absence. And it concluded by urging the encouragement and support of mental-health education in the schools and provision of adequate community psychiatric services.

The governors' conference as a whole, moreover, felt that specific steps should be taken on a cooperative basis among the States. They, therefore, directed the Council of State Governments to establish an interstate clearinghouse on mental health, to assist the States in organizing effective programs of interstate cooperation.

REGIONAL COOPERATION

One of the outstanding means by which the States are acting to solve mental-health problems is through programs of regional cooperation.

Regional cooperation permits each participating State to obtain maximum benefit from the total resources of the area, rather than relying only on facilities within its own limited geographical boundaries. If resources permitted, each State individually might choose to provide training centers for each of the mental-health specialities. But many States find it inadvisable or financially impossible to maintain all training facilities independently. The cost of buildings, laboratories and classrooms, and difficulties in securing first-rate staff, often make it prohibitive.

A prime example of interstate cooperation for mental health is the program of the Southern Regional Education Board to pool the mental-health resources of the Southern States for a more effective attack on this extremely expensive and urgent problem. The board was created by the southern governors' conference through an interstate compact of 14 States. The board enters into agreements with States, educational institutions, and other agencies to provide adequate services and facilities in graduate professional and technical education in various fields. Under its policies students move across State lines and participating States without educational facilities in one or more of the graduate and professional fields obtain the use of a $2 million or $3 million school for relatively small amounts annually. In return the participating universities have received about $1,350,000 a year to help strengthen and expand their programs.

Following a directive of the southern governors' conference, the activities of the Southern Regional Education Board now have been expanded to include the field of mental health. During 1954, committees on mental health were created in 16 Southern States, and a comprehensive survey was undertaken of training and research resources and needs. The southern governors' conference last November adopted the major recommendations of the survey groups—namely, to establish a Southern Regional Council on Mental Health Training and Research, with a highly qualified staff for consultation and advice to the States, to work out appropriate regional arrangements and to promote training and research activities in mental health. The regional council is to be financed by appropriations of $8,000 a year from each Southern State,

with the objective of improved care for the mentally ill and more effective prevention of mental disorders.

A similar survey of mental health training and research in the Midwest was undertaken in 1954, and it was climaxed by the Midwest governors' conference on mental health in Chicago on November 30. The survey grew out of the Detroit conference and a subsequent meeting at Indianapolis in June of mental-health officials from each of the Midwest States. Their governors appointed the State mental-health directors as chairmen of committees which undertook to inventory available resources in personnel, training, and research. Many of the States issued extensive reports outlining their resources and needs and submitted recommendations for bringing these into closer alinement.

The Midwest governors' conference which followed this survey was almost a duplicate, on a regional basis, of the national governors' conference on mental health. Governors, legislators, mental-health officials, representatives of mental-health associations, and the various professional disciplines participated. At the conclusion a series of concrete resolutions were adopted for implementation of the 10-point program.

The final recommendation—and perhaps the most important—calls for establishment of a Midwest Governors' Committee on Mental Health as a continuing body, to meet one or more times a year, for regular examination of Midwest mental health efforts and for cooperative action. This will include further exchange of experience, personnel, and facilities, permitting accelerated efforts in the most promising directions. The Interstate Clearing House on Mental Health is to serve as secretariat for this continuing committee.

In the Far West a movement for regional cooperation in mental health also is getting underway. On March 25 and 26 a western interstate conference on mental health is to be held in cooperation with the Western Interstate Commission for Higher Education. This conference is expected to lay the foundation for mental health surveys and for recommendations for a western governors' conference next fall.

In addition, the States in the Northeast are reexamining their previous conference activities and are thinking of the kind of regional cooperation that has been started in other parts of the country. A meeting of the Northeast State governments conference on mental health is to be held in Wilmington, Del., on April 28 and 29.

Such, in outline, is the unfolding pattern of interstate cooperation for mental health. For the first time in all regions of the Nation there is a continuing official impetus, with the highest executive and legislative support, for major strides in the treatment and prevention of mental illness and in the promotion of mental health.

STATEMENT BY DR. CHESTER D. SWOPE, CHAIRMAN, DEPARTMENT OF PUBLIC RELATIONS, AMERICAN OSTEOPATHIC ASSOCIATION

The American Osteopathic Association wishes to go on record as interested and ready to cooperate in achieving the goals projected in the pending measures (S. 724, S. 848, title VI of S. 886, S. J. Res. 46 and H. J. Res. 256), which include not only a comprehensive nationwide research into and reevaluation of our resources, methods and practices for diagnosing, treating, caring for, and rehabilitating the mentally ill, but also the devising of ways and means for better use and improvement of existing facilities and the development of new resources for combating the mental health problem.

The American College of Neuropsychiatrists (osteopathic) has long been cognizant of the need of increased clinical facilities and psychiatric personnel for the diagnosis and treatment of the mentally ill, according to Dr. Don C. Littlefield, secretary. Dr. Littlefield writes me that the college advocates such measures as are necessary and proper to increase the number of mental health clinics throughout the country; provide adequate qualified personnel (mental health) on a full- or part-time basis to the community with the object of early diagnosis and treatment of emotionally disturbed persons; and provide for research into causation of juvenile delinquency, adult crime, suicide, alcoholism and all other community problems motivated from individual and/or group maladjustment; and states that the pending bills are important steps in the proper direction.

The training and certifying of psychiatrists who are doctors of osteopathy have followed, to a great extent, the training and certifying of psychiatrists who are doctors of medicine. The speciality certifying board for doctors of medicine

was founded in 1934. In 1941 the American Osteopathic Board of Neurology and Psychiatry was officially approved by the board of trustees of the American Osteopathic Association. It was formed by members of the American College of Neuropsychiatrists (osteopathic) which had been organized in 1938. In order to qualify for certification the candidate must be a graduate of an approved college of osteopathy, complete an internship of at least 1 year in an approved intern-training hospital, evidence at least 3 years of approved residency or equivalent special training, then practice at least 2 years as a specialist devoting at least 80 percent of his practice in the specialty field, after which he must pass appropriate examinations conducted by the specialty board.

Organized psychiatric departments in all the colleges provide undergraduate training. However, facilities for graduate training are very limited. Commenting on this fact, Dr. Thomas J. Meyers, secretary of the American Osteopathic Board of Neurology and Psychiatry, has written me (in response to my inquiry for an expression from him regarding the bills now pending before the subcommittee) in part as follows:

"A positive program aimed at training a greater number of skilled professional and allied personnel is badly needed. We need more psychiatrists in our profession, but our training centers can take only a few candidates, and these are trained only because the trainers have been willing to sacrifice personal advantages without adequate compensation * * *.

"Many of the discoveries made in this field have been made by small institutions that escape notice or consideration, and which must work under the stimulus of dedicated individuals. These bills offer promise that some assistance will now be available to them so that their contributions will become more fully developed and more widely disseminated."

It is gratifying that the bill, H. R. 5046, which passed the House on March 21 and is now pending before the Senate Appropriations Committee increases the funds available to the Mental Health Institute, particularly for training programs which may enable the Institute to extend mental health teaching grants to more medical and to osteopathic colleges.

It is the policy of the osteopathic profession and institutions to cooperate with agencies, public and private, for advancing the public health.

AMERICAN HOSPITAL ASSOCIATION,
WASHINGTON SERVICE BUREAU,
Washington 6, D. C., April 1, 1955.

Hon. LISTER HILL,
Chairman, Committee on Labor and Public Welfare,
United States Senate, Washington 25, D. C.

DEAR SENATOR HILL: The American Hospital Association welcomes this opportunity to express its views on the mental-health bills before your committee. The association has long been aware of the magnitude and seriousness of the Nation's mental-health problem.

The American Hospital Association represents some 5,300 of the Nation's hospitals. This includes a substantial percentage of the mental beds and approximately 90 percent of the general hospital beds of the Nation.

The association believes that the mental-illness problem must be attacked by all levels of government and that the Federal Government has a recognized responsibility in assisting State and local governments in solving their problem of providing better mental-health care to their citizens.

We believe there are three broad areas where great need exists. These are need for better facilities, need for more and better trained health personnel, and need for more research.

Today, approximately 50 percent of the Veterans' Administration hospital beds are occupied by patients with mental disorders. The average per-patient-day costs to the Federal Government of rendering care to these patients in 1953 was $8.52. It is generally recognized that medical care in Veterans' Administration facilities is of high quality. The average per-patient-day cost of care in State and local mental institutions for the same year was $2.60. This comparison of expenditures reflects convincingly that far less is being spent per patient in our State and local mental institutions than is needed to provide high quality mental-health care.

Good health care for mental disorders is expensive. Few families have financial resources to withstand the burden of prolonged treatment for one of its members with serious mental illness. Beyond the limitation of private resources, there is an ever-increasing burden on the taxpayers of the Nation. The provision of good mental-health care often imposes a financial burden on the small local communities which is prohibitive. The Federal Government must necessarily render assistance to the State and local communities if the objective of sound mental-health programs is to be obtained.

Our most eminent authorities in the field of mental health have estimated that 6 percent of the Nation's population suffer from some mental disorder. Over one-half of the hospital beds in the United States are occupied by mental patients—98 percent of these are tax-supported. Lack of facilities and well-trained personnel in some of these hospitals make conditions deplorable. Greater emphasis must be put on the training and preparing of health personnel if this problem is ever to be solved.

We believe that the high patient load in our mental institutions could be reduced materially through better preventive mental-health programs, better diagnostic outpatient mental-health facilities, and more research into the methods of treating mental disorders. Last year, the American Hospital Association, in testifying before your committee on expansion of the Hospital Survey and construction program, urged that the diagnostic and treatment centers envisioned in the amendments to the law include community mental-health clinics. We believe the law as passed provides for these facilities.

The length of stay of the mentally ill in our mental institutions is shocking. This results from the fact that in many of these institutions, the care rendered is little better than custodial. Better methods of care and treament are vitally needed. This includes in- and outpatient care. Such a comprehensive program should, wherever feasible, and prior to institutionalizsd care, make provision for the early diagnosis and treatment of mental illness.

Many patients have been unnecessarily institutionalized for long terms because of the lack of proper mental facilities in our general hospitals and the lack of ambulatory treatment facilities. Persons with mental disorders should be given every possible chance of recovery before commitment to a mental hospital. Programs for the early diagnosis and treatment of persons suffering from such disorders are significantly related to the solution of the Nation's mental-health problems. We believe that good ambulatory facilities and mental units in our general hospitals could have provided the early treatment which would have prevented many patients now in our mental hospitals from being institutionalized. Mental-health clinics at the community level could provide the treatment and guidance necessary to prevent more serious disorders. Further, many such long-term patients in our institutions would have a much greater chance of recovery through new drugs and new therapeutic techniques used by well trained personnel.

Research into new methods of prevention and treatment of mental disorders is accomplishing much in combating mental illness. Yet greater progress could be made if financial and other assistance were available to States and communities for more and better facilities, personnel and research. We wish to reemphasize the tremendous need of assistance in these areas. We wish to go on record as supporting the Federal Government's participation in finding solutions to the Nation's pressing mental-health problems. We, therefore, will continue to support legislation which will accomplish these objectives in the manner we have outlined above.

Sincerely yours

KENNETH WILLIAMSON,
Associate Director, American Hospital Association.

AMERICAN PUBLIC WELFARE ASSOCIATION,
Washington, D. C., March 31, 1955.

Hon. LISTER HILL,
Chairman, Senate Committee on Labor and Public Welfare,
Room F–42, Capitol, Washington, D. C.

DEAR SENATOR HILL: The American Public Welfare Association is interested in bills pending before your committee which have for their purpose the strengthening and improvement of mental-health programs in this country and more specifically, Senate Joint Resolution 46.

This association is a nonpartisan organization composed of: (1) State and local departments of public welfare; (2) individuals engaged in public welfare at all levels of government; and (3) persons outside government who are interested in public-welfare programs. Affiliated with it are the National Council of State Public Assistance and Welfare Administrators and the National Council of Local Public Welfare Administrators.

The field of public welfare is concerned with mental-health legislation because a number of State public-welfare agencies are responsible for the administration of mental-health institutions and programs and because all local and State public-welfare departments, through their daily work, are aware of the need for broader preventive and treatment services in mental health.

In a nationwide study of the aid to dependent children program published by the American Public Welfare Association in 1952, it was determined that more than 4 percent of the parents whose incapacity cause the family to be financially dependent were in mental institutions. It is our belief that research and other methods of improving and extending mental-health services will result in a reduction in the number of persons becoming dependent upon public assistance because of the wage earner's mental illness.

Public-welfare agencies also have had extensive experience with the problems of older persons who are committed to or remain in mental institutions because there are no suitable resources in the community. As more and more of our population lives to an advanced age, there is greater need for studies of ways in which these problems can be reduced.

Furthermore, many public welfare agencies share with other communities services responsibility for prevention and treatment of juvenile delinquency. Effective action is frequently handicapped by the lack of sufficient child guidance clinics and other community mental health services.

The American Public Welfare Association has long recognized that no condition is as costly in terms of individual, social, and economic loss as ill health and disability. In dealing with problems resulting from ill health and disability, public welfare is largely dependent upon the advance of medical knowledge, the availability of health facilities and personnel, and the extension of health services. We believe that government must continue to assume some financial responsibility for programs improving and strengthening the prevention and treatment of mental illness.

We are pleased to note the activity of your committee in this field. We are especially interested in Senate Joint Resolution 46 because the provisions of this measure go farther and are more specific than other similar measures now pending.

We should like to have this communication made a matter of record in your hearings.

Sincerely yours,

MARIE D. LANE,
Mrs. Marie D. Lane.
Washington Representative.

STATEMENT BY THE AMERICAN NURSES' ASSOCIATION

The American Nurses' Association, an organization of registered professional nurses, with over 175,000 members in 53 constituent State and Territorial associations, submits this statement in support of title VI: Mental Health, of S. 886. This association supports the principle of consolidated Federal grants-in-aid to States for public health services. But we believe that categorical grants for mental health are justified at this time because the necessary programs are administered in varying patterns within the States, and because of the nature and scope of the health problem with which these programs must deal.

The enactment of this legislation would provide the means for granting to the States a portion of the money needed for research, for the expansion and improvement of programs of prevention and treatment, and for the training of mental health personnel.

There exists a critical shortage of nursing personnel prepared to meet the present and anticipated needs for nursing in both preventive mental health services and psychiatric treatment. Of the 25,286 nurses engaged in public health nursing, working with people in homes, schools, and clinics, only 36.8

percent have had 1 or more years of academic work in public health.[1] The preparation of many of these nurses has not been adequate to prepare them for their potential contribution to the mental health of the community.

Funds are needed to provide for the improvement of in-service education of present practitioners, and for additional academic work for these nurses, as well as to improve the preparation of public health nurses for the future.

Similar provisions are required for nursing personnel prepared for and employed in hospital nursing and in industry.

Turning to the institutional field, we find that a total of 12,692 nurses were working in hospitals for nervous and mental diseases in 1953. Considering the bed capacity of these institutions to be 749,393 beds, this would provide approximately 1 nurse for each 59 patients, if all of the nurses were directly engaged in patient care. However, 7,333 of the 12,692 nurses are engaged in teaching, supervision, and administration, leaving 5,359 nurses in positions designated as bedside nursing.[2] Among the basic reasons for failure in recruiting nurses to work in mental illness is the fact that there are too few institutions sufficiently developed to offer suitable learning experiences in psychiatric nursing as part of the basic nursing curriculum. Too few institutions offer conditions under which employed nurses can give adequate care to mentally ill patients. Projects designed to improve administrative and treatment practices in hospitals for the mentally ill are much needed.

Much of the nursing care of patients in mental hospitals in the hands of nonprofessional workers, approximately 100,000 in number, most of whom have had little or no training for the work they are doing. Experimentation with teaching programs for these workers is needed, in order to devise ways of producing workers in quantity and quality needed to perform elementary skills of psychiatric nursing.

Research projects in nursing are needed, not only to improve nursing practice in relation to the prevention and care of mental illness, but also to bring about better utilization of nursing personnel in their collaborative role in treatment.

The American Nurses' Association is not in a position to offer an official statement regarding Senate Joint Resolution 46 at this time. There does not seem to be any conflict of purposes between it and title VI and, therefore, Senate Joint Resolution 46 should be considered as a reasonable adjunct to, and not in competition with, title VI, S. 886.

The American Nurses' Association requests that this statement be considered by the committee in its deliberations on legislation relating to mental health, and that it be included in the report of the present hearings.

[From Edward P. Morgan's broadcast, March 8, 1955, American Broadcasting Co.]

There is nothing socially degrading about a broken arm. It is not fun, but once you survive the pain and the awful itch under the cast, there can be something dashing about the sling which invites ready sympathy, as if you had incurred your wound on some knightly errand, instead of by slipping on an icy back stoop. But what about a broken spirit, a compound fracture of the mind? These injuries are different. Visible bandages don't apply. We do crack jokes about seeing a psychiatrist, but the chances are we crack them nervously. Since civilization began, mental illness has been something "queer," to be ashamed about, to keep out of sight, a skeleton, often literally locked in the family closet.

When we built mental hospitals we hid them, sometimes so far back in the woods that doctors couldn't be induced to work in them. But the problem became too big to hide.

Day before yesterday, the Hoover Commission released a study prepared by Dr. Francis J. Braceland, a psychiatrist, and a professor at Yale. The study classified mental illness as the "greatest single problem in the Nation's health picture." More than half the country's 1,500,000 hospital beds are filled with mental cases, of one kind or another. Although there isn't room or proper care for them, about 250,000 new patients will enter hospitals this year because of mental illness. At this rate, 1 child out of every 12 born in the United States will spend some time in a mental institution.

This doesn't necessarily mean the atomic age is suddenly driving Americans mad. As shattering as statistics are, they reflect, in part, a growing aware-

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[1] U. S. Department of Health, Education, and Welfare, Public Health Service, Division of Public Health Nursing, 1953.

[2] Journal of the American Medical Association, May 15, 1954, p. 269.

ness of the condition, more cases of mental illness actually being reported that weren't reported before; and, of course, the increase is tied, too, to the immense growth of the American population.

But any way it's viewed, the problem is grave and growing graver. And it's a taxpayer's problem. Ninety-seven and seven-tenths percent of all mental patients are in public institutions, that is, State, county, city, or Veterans' Administration hospitals. The average length of stay of a mental patient in a State hospital is 8 years. Mental illness costs the country annually more than $2½ billion.

Yet radical, almost revolutionary, advances have been made in mental health. New drugs have emerged, new techniques, to head off emotional disorders at the start in some cases, to help the cure of others. A couple of years ago, with rare and remarkable daring, the American Medical Association coupled its council on mental health with the American Psychiatric Association to take a piercing new look at the "snake pit" situation. Governors of all but three States took their own more than agonizing reappraisals through the National Mental Health Committee. Some objectives: To find out why one institution can give better, quicker treatment than another; what are the best techniques and drugs; how to solve the shortage of trained personnel—the most serious bottleneck in proper care, according to the Hoover Commission's Dr. Braceland.

To speed and coordinate this reevaluation, Congress has before it a joint resolution sponsored by a bipartisan group, led by two Democrats, Alabama's Lister Hill in the Senate and Tennessee's J. Percy Priest in the House. It would provide a million and a quarter dollars to nongovernmental groups for their studies. Addicted as it is to studies of its own, the support of the Department of Health, Education, and Welfare was not counted on. But this morning Secretary Hobby warmly endorsed the resolution, to its backers' surprise. Before swooning with joy, some of them are waiting to see whether the administration follows through with the more tangible endorsement of the help for research and training that the administration's own experts say is required.

This is Edward Morgan, saying good night from Washington.

(Whereupon the hearing was adjourned.)

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