MENTAL HEALTH
(SUPPLEMENTAL)

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE HOUSE OF REPRESENTATIVES

EIGHTY-EIGHTH CONGRESS

FIRST SESSION

ON

S. 1576

AN ACT TO PROVIDE ASSISTANCE IN COMBATING MENTAL RETARDATION THROUGH GRANTS FOR CONSTRUCTION OF RESEARCH CENTERS AND GRANTS FOR FACILITIES FOR THE MENTALLY RETARDED AND ASSISTANCE IN IMPROVING MENTAL HEALTH THROUGH GRANTS FOR CONSTRUCTION AND INITIAL STAFFING OF COMMUNITY MENTAL HEALTH CENTERS, AND FOR OTHER PURPOSES

JULY 10 AND 11, 1963

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MENTAL HEALTH

(Supplemental)

WEDNESDAY, JULY 10, 1963

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON PUBLIC HEALTH
AND SAFETY OF THE COMMITTEE ON
INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to call, in room 1334, Longworth Building, Hon. Kenneth A. Roberts (chairman of the subcommittee) presiding.

Mr. ROBERTS. The subcommittee will please be in order.

The Subcommittee on Public Health and Safety is holding hearings this morning on the bill, S. 1576, as amended, which entitled "Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963."

S. 1576, as amended, represents, in large measure, a consolidation of the provisions of the two bills, H.R. 3688 and 3689, introduced by the chairman of our full committee, the distinguished gentleman from Arkansas, concerning which the Committee on Interstate and Foreign Commerce has already held hearings, and, in addition, certain new matter.

The subcommittee had earlier reported the bill favorably, with amendments, to the full committee. However, owing to certain questions, which in the opinion of the committee have not been sufficiently explored, the committee directed the subcommittee to hold hearings for the purpose of developing additional information.

(S. 1576 referred to and the report of the Department of Health, Education, and Welfare follow:)

[S. 1576, 88th Cong., 1st sess.]

AN ACT To provide assistance in combating mental retardation through grants for construction of research centers and grants for facilities for the mentally retarded and assistance in improving mental health through grants for construction and initial staffing of community mental health centers, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963".

TITLE I—CONSTRUCTION OF RESEARCH CENTERS AND FACILITIES FOR THE MENTALLY RETARDED

SHORT TITLE

SEC. 100. This title may be cited as the "Mental Retardation Facilities Construction Act".

PART A—GRANTS FOR CONSTRUCTION OF CENTERS FOR RESEARCH ON MENTAL RETARDATION AND RELATED ASPECTS OF HUMAN DEVELOPMENT

SEC. 101. Title VII of the Public Health Service Act is amended by inserting "AND MENTAL RETARDATION RESEARCH CENTERS" after "FACILITIES" in the heading thereof, by inserting immediately below such heading "PART A—GRANTS FOR CONSTRUCTION OF HEALTH RESEARCH FACILITIES" and by changing the words "this title" to "this part" wherever they appear, except in sections 702, 707, and 708, and by adding at the end of such title the following new part:

"PART B—CENTERS FOR RESEARCH ON MENTAL RETARDATION AND RELATED ASPECTS OF HUMAN DEVELOPMENT

"AUTHORIZATION OF APPROPRIATIONS

"SEC. 721. There are authorized to be appropriated $6,000,000 for the fiscal year ending June 30, 1964, $8,000,000 for the fiscal year ending June 30, 1965, and $6,000,000 each for the fiscal year ending June 30, 1966, and the fiscal year ending June 30, 1967, and $4,000,000 for the fiscal year ending June 30, 1968, for project grants to assist in meeting the costs of construction of facilities for research, or research and related purposes, relating to human development, whether biological, medical, social, or behavorial, which may assist in finding the causes, and means of prevention, of mental retardation, or in finding means of ameliorating the effects of mental retardation. Sums so appropriated shall remain available until expended for payments with respect to projects for which applications have been filed under this part below July 1, 1968, and approved by the Surgeon General thereunder before July 1, 1969.

"APPLICATIONS

"SEC. 722. (a) Applications for grants under this part with respect to any facility may be approved by the Surgeon General only if—

"(1) the applicant is a public or nonprofit institution which the Surgeon General determines is competent to engage in the type of research for which the facility is to be constructed; and

"(2) the application contains or is supported by reasonable assurances that (A) for not less than 10 years after completion of construction, the facility will be used for the research, or research and related purposes, for which it was constructed, (B) sufficient funds will be available for meeting the non-Federal share of the cost of constructing the facility, and (C) sufficient funds will be available, when the construction is completed, for effective use of the facility for the research, or research and related purposes, for which it was constructed; and (D) all laborers and mechanics employed by contractors or subcontractors in the performance of work on construction of the center will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Davis-Bacon Act, as amended (40 U.S.C. 276a–276a–5), and will receive compensation at rates not less than the rates determined in accordance with and subject to the provisions of the Contract Work Hours Standards Act (Public Law 87–581); and the Secretary of Labor shall have, with respect to the labor standards specified in this clause (D) the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. 133z–15), and section 2 of the Act of June 13, 1934, as amended (40 U.S.C. 276c).

"(b) In acting on applications for grants, the Surgeon General shall take into consideration the relative effectiveness of the proposed facilities in expanding the Nation's capacity for research and related purposes in the field of mental retardation and related aspects of human development, and such other factors as he, after consultation with the national advisory council or councils con-

cerned with the field or fields of research involved, may by regulation prescribe in order to assure that the facilities constructed with such grants, severally and together, will best serve the purpose of advancing scientific knowledge pertaining to mental retardation and related aspects of human development.

"AMOUNT OF GRANTS; PAYMENTS

"SEC. 723. (a) The total of the grants with respect to any project for the construction of a facility under this part may not exceed 75 per centum of the necessary cost of construction of the center as determined by the Surgeon General.

"(b) Payments of grants under this part shall be made in advance or by way of reimbursement, in such installments consistent with construction progress, and on such conditions as the Surgeon General may determine."

PART B—PROJECT GRANTS FOR CONSTRUCTION OF UNIVERSITY-AFFILIATED FACILITIES FOR THE MENTALLY RETARDED

AUTHORIZATION OF APPROPRIATIONS

SEC. 121. For the purpose of assisting in the construction of clinical facilities providing, as nearly as practicable, a full range of inpatient and outpatient services for the mentally retarded and facilities which will aid in demonstrating provision of specialized services for the diagnosis and treatment, education, training, or care of the mentally retarded or in the clinical training of physicians and other specialized personnel needed for research, diagnosis and treatment, education, training, or care of the mentally retarded, there are authorized to be appropriated $5,000,000 for the fiscal year ending June 30, 1964, $7,500,000 for the fiscal year ending June 30, 1965, and $10,000,000 each for the next 3 fiscal years. The sums so appropriated shall be used for project grants for construction of public and other nonprofit facilities for the mentally retarded which are associated with a college or university.

APPLICATIONS

SEC. 122. Applications for grants under this part with respect to any facility may be approved by the Secretary only if the application contains or is supported by reasonable assurances that—

(1) the facility will be associated, to the extent prescribed in regulations of the Secretary, with a college or university hospital (including affiliated hospitals), or with such other part of a college or university as the Secretary may find appropriate in the light of the purposes of this part;

(2) the plans and specifications are in accord with regulations prescribed by the Secretary under section 133(c);

(3) title to the site for the project is or will be vested in one or more of the agencies or institutions filing the application or in a public or other nonprofit agency or institution which is to operate the facility;

(4) adequate financial support will be available for construction of the project and for its maintenance and operation when completed; and

(5) all laborers and mechanics employed by contractors or subcontractors in the performance of construction of the project will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Davis-Bacon Act, as amended (40 U.S.C. 276a–276a–5), and shall receive overtime pay in accordance with and subject to the provisions of the Contract Work Hours Standards Act (Public Law 87–581); and the Secretary of Labor shall have with respect to the labor standards specified in this paragraph the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. 133z–15) and section 2 of the Act of June 13, 1934, as amended (40 U.S.C. 276c).

AMOUNT OF GRANTS; PAYMENTS

SEC. 123. (a) The total of the grants with respect to any project for the construction of a facility under this part may not exceed 75 per centum of the necessary cost of construction thereof as determined by the Secretary.

(b) Payments of grants under this part shall be made in advance or by way of reimbursement, in such installments consistent with construction progress, and on such conditions as the Secretary may determine.

RECOVERY

SEC. 124. If any facility with respect to which funds have been paid under this part shall, at any time within twenty years after the completion of construction—

(1) be sold or transferred to any person, agency, or organization which is not qualified to file an application under this part, or

(2) cease to be a public or other nonprofit facility for the mentally retarded, unless the Secretary determines, in accordance with regulations, that there is good cause for releasing the applicant or other owner from the obligation to continue as such a facility,

the United States shall be entitled to recover from either the transferor or the transferee (or, in the case of a facility which has ceased to be a public or other nonprofit facility for the mentally retarded, from the owners thereof) an amount bearing the same ratio to the then value (as determined by the agreement of the parties or by action brought in the district court of the United States for the district in which the facility is situated) of so much of the facility as constituted an approved project or projects, as the amount of the Federal participation bore to the cost of the construction of such project or projects.

PART C—GRANTS FOR CONSTRUCTION OF FACILITIES FOR THE MENTALLY RETARDED

AUTHORIZATION OF APPROPRIATIONS

SEC. 131. There are authorized to be appropriated, for grants for construction of public and other nonprofit facilities for the mentally retarded, $10,000,000 for the fiscal year ending June 30, 1965, $12,500,000 for the fiscal year ending June 30, 1966, $15,000,000 for the fiscal year ending June 30, 1967, and $30,000,000 for the fiscal year ending June 30, 1968.

ALLOTMENTS TO STATES

SEC. 132. (a) For each fiscal year, the Secretary shall, in accordance with regulations, make allotments from the sums appropriated under section 131 to the several States on the basis of (1) of the population, (2) the extent of the need for facilities for the mentally retarded, and (3) the financial need of the respective States; except that no such allotment to any State, other than the Virgin Islands, American Samoa, and Guam, for any fiscal year may be less than $100,000. Sums so allotted to a State for a fiscal year for construction and remaining unobligated at the end of such year shall remain available to such State for such purpose for the next fiscal year (and for such year only), in addition to the sums allotted to such State for such next fiscal year.

(b) In accordance with regulations of the Secretary, any State may file with him a request that a specified portion of its allotment under this part be added to the allotment of another State under this part for the purpose of meeting a portion of the Federal share of the cost of a project for the construction of a facility for the mentally retarded in such other State. If it is found by the Secretary that construction of the facility with respect to which the request is made would meet needs of the State making the request and that use of the specified portion of such State's allotment, as requested by it, would assist in carrying out the purposes of this part, such portion of such State's allotment shall be added to the allotment of the other State under this part, to be used for the purpose referred to above.

(c) Upon the request of any State that a specified portion of its allotment under this part be added to the allotment of such State under part A of title II, and upon (1) the simultaneous certification to the Secretary by the State agency designated as provided in the State plan approved under this part to the effect that it has afforded a reasonable opportunity to make applications for the portion so specified and there have been no approvable applications for such portion, or (2) a showing satisfactory to the Secretary that the need for the community mental health centers in such State is substantially greater than for the facilities for the mentally retarded, the Secretary shall, subject to such limitations as he may by regulation prescribe, promptly adjust the allotments of such

State in accordance with such request and shall notify such State agency and the State agency designated under the State plan approved under part A of title II, and thereafter the allotments as so adjusted shall be deemed the State's allotments for purposes of this part and part A of title II.

REGULATIONS

SEC. 133. Within six months after enactment of this Act, the Secretary shall, after consultation with the Federal Hospital Council (established by section 633 of the Public Health Service Act and hereinafter in this part referred to as the "Council"), by regulations prescribe—

(a) the kinds of services needed to provide adequate services for mentally retarded persons residing in a State;

(b) the general manner in which the State agency (designated as provided in the State plan approved under this part) shall determine the priority of projects based on the relative need of different areas, giving special consideration to facilities which will provide comprehensive services for a particular community or communities;

(c) general standards of construction and equipment for facilities of different classes and in different types of location; and

(d) that the State plan shall provide for adequate facilities for the mentally retarded for persons residing in the State, and shall provide for adequate facilities for the mentally retarded to furnish needed services for persons unable to pay therefor. Such regulations may require that before approval of an application for a facility or addition to a facility is recommended by a State agency, assurance shall be received by the State from the applicant that there will be made available in such facility or addition a reasonable volume of services to persons unable to pay therefor, but an exception shall be made if such a requirement is not feasible from a financial viewpoint.

STATE PLANS

SEC. 134. (a) After such regulations have been issued, any State desiring to take advantage of this part shall submit a State plan for carrying out its purposes. Such State plan must—

(1) designate a single State agency as the sole agency for the administration of the plan, or designate such agency as the sole agency for supervising the administration of the plan;

(2) contain satisfactory evidence that the State agency designated in accordance with paragraph (1) hereof will have authority to carry out such plan in conformity with this part;

(3) provide for the designation of a State advisory council which shall include representatives of State agencies concerned with planning, operation, or utilization of facilities for the mentally retarded and of nongovernment organizations or groups concerned with education, employment, rehabilitation, welfare, and health, and including representatives of consumers of the services provided by such facilities;

(4) set forth a program for construction of facilities for the mentally retarded (A) which is based on a Statewide inventory of existing facilities and survey of need; (B) which conforms with the regulations prescribed under section 133(a); and (C) which meets the requirements for furnishing needed services to persons unable to pay therefor, included in regulations prescribed under section 133(d);

(5) set forth the relative need, determined in accordance with the regulations prescribed under section 133(b), for the several projects included in such programs, and provide for the construction, insofar as financial resources available therefor and for maintenance and operation make possible, in the order of such relative need;

(6) provide such methods of administration of the State plan, including methods relating to the establishment and maintenance of personnel standards on a merit basis (except that the Secretary shall exercise no authority with respect to the selection, tenure of office, or compensation of any individ-

ual employed in accordance with such methods), as are found by the Secretary to be necessary for the proper and efficient operation of the plan;

(7) provide minimum standards (to be fixed in the discretion of the State) for the maintenance and operation of facilities which receive Federal aid under this part;

(8) provide for affording to every applicant for a construction project an opportunity for hearing before the State agency;

(9) provide that the State agency will make such reports in such form and containing such information as the Secretary may from time to time reasonably require, and will keep such records and afford such access thereto as the Secretary may find necessary to assure the correctness and verification of such reports; and

(10) provide that the State agency will from time to time, but not less often than annually, review its State plan and submit to the Secretary any modifications thereof which it considers necessary.

(b) The Secretary shall approve any State plan and any modification thereof which complies with the provisions of subsection (a). The Secretary shall not finally disapprove a State plan except after reasonable notice and opportunity for a hearing to the State.

APPROVAL OF PROJECTS

SEC. 135. (a) For each project for construction pursuant to a State plan approved under this part, there shall be submitted to the Secretary through the State agency an application by the State or a political subdivision thereof or by a public or other nonprofit agency. If two or more such agencies join in the construction of the project, the application may be filed by one or more of such agencies. Such application shall set forth—

(1) a description of the site for such project;

(2) plans and specification therefor in accordance with the regulations prescribed by the Secretary under section 133(c);

(3) reasonable assurance that title to such site is or will be vested in one or more of the agencies filing the application or in a public or other nonprofit agency which is to operate the facility;

(4) reasonable assurance that adequate financial support will be available for the construction of the project and for its maintenance and operation when completed;

(5) reasonable assurance that all laborers and mechanics employed by contractors or subcontractors in the performance of construction of the project will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Davis-Bacon Act, as amended (40 U.S.C. 276a—276a–5), and shall receive overtime pay in accordance with and subject to the provisions of the Contract Works Hours Standards Act (Public Law 87–581); and the Secretary of Labor shall have with respect to the labor standards specified in this paragraph the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. 133z–15) and section 2 of the Act of June 13, 1934, as amended (40 U.S.C. 276c); and

(6) a certification by the State agency of the Federal share for the project.

The Secretary shall approve such application if sufficient funds to pay the Federal share of the cost of construction of such project are available from the allotment to the State, and if the Secretary finds (A) that the application contains such reasonable assurance as to title, financial support, and payment of prevailing rates of wages; (B) that the plans and specifictions are in accord with the regulations prescribed pursuant to section 133; (C) that the application is in conformity with the State plan approved under section 134 and contains an assurance that in the operation of the facility there will be compliance with the applicable requirements of the State plan and of the regulations prescribed under section 133(d) for furnishing needed facilities for persons unable to pay therefor, and with State standards for operation and maintenance; and (D) that the application has been approved and recommended by the State agency and is entitled to priority over other projects within the State in accordance with the regulations prescribed pursuant to section 133(b). No application shall be disapproved by the Secretary until he has afforded the State agency an opportunity for a hearing.

(b) Amendment of any approved application shall be subject to approval in the same manner as an original application.

WITHHOLDING OF PAYMENTS

SEC. 136. Whenever the Secretary after reasonable notice and opportunity for hearing to the State agency designated as provided in section 134(a)(1), finds—

(1) that the State agency is not complying substantially with the provisions required by section 134 to be included in its State plan or with regulations under this part; or

(2) that any assurance required to be given in an application filed under section 135 is not being or cannot be carried out; or

(3) that there is a substantial failure to carry out plans and specifications approved by the Secretary under section 135; or

(4) that adequate State funds are not being provided annually for the direct administration of the State plan,

the Secretary may forthwith notify the State agency that—

(5) no further payments will be made to the State from allotments under this part; or

(6) no further payments will be made from allotments under this part for any project or projects designated by the Secretary as being affected by the action or inaction referred to in paragraph (1), (2), (3), or (4) of this section,

as the Secretary may determine to be appropriate under the circumstances; and, except with regard to any project for which the application has already been approved and which is not directly affected, further payments from such allotments may be withheld, in whole or in part, until there is no longer any failure to comply (or to carry out the assurance or plans and specifications or to provide adequate State funds, as the case may be) or, if such compliance (or other action) is impossible, until the State repays or arranges for the repayment of Federal moneys to which the recipient was not entitled.

TITLE II—CONSTRUCTION AND STAFFING OF MENTAL HEALTH CENTERS

SHORT TITLE

SEC. 200. This title may be cited as the "Community Mental Health Centers Act".

PART A—GRANTS FOR CONSTRUCTION OF COMMUNITY MENTAL HEALTH CENTERS

AUTHORIZATION OF APPROPRIATIONS

SEC. 201. There are authorized to be appropriated, for grants for construction of public and other nonprofit community mental health centers, $35,000,000 for the fiscal year ending June 30, 1965, $50,000,000 for the fiscal year ending June 30, 1966, $65,000,000 for the fiscal year ending June 30, 1967, and $80,000,000 for the fiscal year ending June 30, 1968.

ALLOTMENTS TO STATES

SEC. 202. (a) For each fiscal year, the Secretary shall, in accordance with regulations, make allotments from the sums appropriated under section 201 to the several States on the basis of (1) the population, (2) the extent of the need for community mental health centers, and (3) the financial need of the respective States; except that no such allotment to any State, other than the Virgin Islands, American Samoa, and Guam, for any fiscal year may be less than $100,000. Sums so allotted to a State for a fiscal year and remaining unobligated at the end of such year shall remain available to such State for such purpose for the next fiscal year (and for such year only), in addition to the sums allotted for such State for such next fiscal year.

(b) In accordance with regulations of the Secretary, any State may file with him a request that a specified portion of its allotment under this part be added to the allotment of another State under this part for the purpose of meeting a portion of the Federal share of the cost of a project for the construction of a community mental health center in such other State. If it is found by the Secretary that construction of the center with respect to which the request is made would meet needs of the State making the request and that use of the specified portion of such State's allotment, as requested by it, would assist in carrying out the purposes of this part, such portion of such State's allotment shall be

added to the allotment of the other State under this part, to be used for the purpose referred to above.

(c) Upon the request of any State that a specified portion of its allotment under this part be added to the allotment of such State under part C of title I and upon (1) the simultaneous certification to the Secretary by the State agency designated as provided in the State plan approved under this part to the effect that it has afforded a reasonable opportunity to make applications for the portion so specified and there have been no approvable applications for such portion or (2) a showing satisfactory to the Secretary that the need for facilities for the mentally retarded in such State is substantially greater than for community mental health centers, the Secretary shall, subject to such limitations as he may by regulation prescribe, promptly adjust the allotments of such State in accordance with such request and shall notify such State agency and the State agency designated under the State plan approved under part C of title I, and thereafter the allotments as so adjusted shall be deemed the State's allotments for purposes of this part and part C of title I.

REGULATIONS

SEC. 203. Within six months after enactment of this Act, the Secretary shall, after consulation with the Federal Hospital Council (established by section 633 of the Public Health Service Act), by regulations prescribe—

(a) the kinds of community mental health services needed to provide adequate mental health services for persons residing in a State;

(b) the general manner in which the State agency (designated as provided in the State plan approved under this part) shall determine the priority of projects based on the relative need of different areas, giving special consideration to projects on the basis of the extent to which the centers to be constructed thereby will, alone or in conjunction with other facilities owned or operated by the applicant or affiliated or associated with the applicant, provide comprehensive mental health services (as determined by the Secretary in accordance with regulations) for mentally ill persons in a particular community or communities or which will be part of or closely associated with a general hospital;

(c) general standards of construction and equipment for centers of different classes and in different types of location; and

(d) that the State plan shall provide for adequate community mental health centers for people residing in the State, and shall provide for adequate community mental health centers to furnish needed services for persons unable to pay therefor. Such regulations may require that before approval of an application for a center or addition to a center is recommended by a State agency, assurance shall be received by the State from the applicant that there will be made available in such center or addition a reasonable volume of services to persons unable to pay therefor, but an exception shall be made if such a requirement is not feasible from a financial viewpoint.

STATE PLANS

SEC. 204. (a) After such regulations have been issued, any State desiring to take advantage of this part shall submit a State plan for carrying out its purposes. Such State plan must—

(1) designate a single State agency as the sole agency for the administration of the plan, or designate such agency as the sole agency for supervising the administration of the plan;

(2) contain satisfactory evidence that the State agency designated in accordance with paragraph (1) hereof will have authority to carry out such plan in conformity with this part;

(3) provide for the designation of a State advisory council which shall include representatives of nongovernment organizations or groups, and of State agencies, concerned with planning, operation, or utilization of community mental health centers or other mental health facilities, including representatives of consumers of the services provided by such centers and facilities who are familiar with the need for such services, to consult with the State agency in carrying out such plan;

(4) set forth a program for construction of community mental health centers (A) which is based on a statewide inventory of existing facilities and survey of need; (B) which conforms with the regulations prescribed

by the Secretary under section 203(a); and (C) which meets the requirements for furnishing needed services to persons unable to pay therefor, included in regulations prescribed under section 203(d);

(5) set forth the relative need, determined in accordance with the regulations prescribed under section 203(b), for the several projects included in such programs, and provide for the construction, insofar as financial resources available therefor and for maintenance and operation make possible, in the order of such relative need;

(6) provide such methods of administration of the State plan, including methods relating to the establishment and maintenance of personnel standards on a merit basis (except that the Secretary shall exercise no authority with respect to the selection, tenure of office, or compensation of any individual employed in accordance with such methods), as are found by the Secretary to be necessary for the proper and efficient operation of the plan;

(7) provide minimum standards (to be fixed in the discretion of the State) for the maintenance and operation of centers which receive Federal aid under this part;

(8) provide for affording to every applicant for a construction project an opportunity for hearing before the State agency;

(9) provide that the State agency will make such reports in such form and containing such information as the Secretary may from time to time reasonably require, and will keep such records and afford such access thereto as the Secretary may find necessary to assure the correctness and verification of such reports; and

(10) provide that the State agency will from time to time, but not less often than annually, review its State plan and submit to the Secretary any modifications thereof which it considers necessary.

(b) The Secretary shall approve any State plan and any modification thereof which complies with the provisions of subsection (a). The Secretary shall not finally disapprove a State plan except after reasonable notice and opportunity for a hearing to the State.

APPROVAL OF PROJECTS

SEC. 205. (a) For each project for construction pursuant to a State plan approved under this part, there shall be submitted to the Secretary through the State agency an application by the State or a political subdivision thereof or by a public or other nonprofit agency. If two or more such agencies join in the construction of the project, the application may be filed by one or more of such agencies. Such application shall set forth—

(1) a description of the site for such project;

(2) plans and specifications therefor in accordance with the regulations prescribed by the Secretary under section 203(c);

(3) reasonable assurance that title to such site is or will be vested in one or more of the agencies filing the application or in a public or other nonprofit agency which is to operate the community mental health center;

(4) reasonable assurance that adequate financial support will be available for the construction of the project and for its maintenance and operation when completed;

(5) reasonable assurance that all laborers and mechanics employed by contractors or subcontractors in the performance of construction of the project will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Davis-Bacon Act, as amended (40 U.S.C. 276a—276a-5), and shall receive overtime pay in accordance with and subject to the provisions of the Contract Work Hours Standards Act (Public Law 87-581); and the Secretary of Labor shall have with respect to the labor standards specified in this paragraph the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. 133z-15) and section 2 of the Act of June 13, 1934, as amended (40 U.S.C 276c); and

(6) a certification by the State agency of the Federal share for the project.

The Secretary shall approve such application if sufficient funds to pay the Federal share of the cost of construction of such project are available from the allotment to the State, and if the Secretary finds (A) that the application contains such reasonable assurance as to title, financial support, and payment of prevailing rates of wages and overtime pay; (B) that the plans and specifica-

tions are in accord with the regulations prescribed pursuant to section 203; (C) that the application is in conformity with the State plan approved under section 204 and contains an assurance that in the operation of the center there will be compliance with the applicable requirements of the State plan and of regulations prescribed under section 203(d) for furnishing needed services for persons unable to pay therefor, and with State standards for operation and maintenance; (D) that the services to be provided by the center, alone or in conjunction with other facilities owned or operated by the applicant or affiliated or associated with the applicant, will be part of a program providing, principally for persons residing in a particular community or communities in or near which such center is to be situated, at least these essential elements of comprehensive mental health services for mentally ill persons which are prescribed by the Secretary in accordance with regulations; and (E) that the application has been approved and recommended by the State agency and is entitled to priority over other projects within the State in accordance with the regulations prescribed pursuant to section 203(b). No application shall be disapproved by the Secretary until he has afforded the State agency an opportunity for a hearing.

(b) Amendment of any approved application shall be subject to approval in the same manner as an original application.

WITHHOLDING OF PAYMENTS

SEC. 206. Whenever the Secretary, after reasonable notice and opportunity for hearing to the State agency designated as provided in section 204(a)(1), finds—

(1) that the State agency is not complying substantially with the provisions required by section 204 to be included in its State plan, or with regulations under this part; or

(2) that any assurance required to be given in an application filed under section 205 is not being or cannot be carried out; or

(3) that there is a substantial failure to carry out plans and specifications approved by the Secretary under section 205; or

(4) that adequate State funds are not being provided annually for the direct administration of the State plan,

the Secretary may forthwith notify the State agency that—

(5) no further payments will be made to the State from allotments under this part; or

(6) no further payments will be made from allotments under this part for any project or projects designated by the Secretary as being affected by the action or inaction referred to in paragraph (1), (2), (3), or (4) of this section,

as the Secretary may determine to be appropriate under the circumstances; and, except with regard to any project for which the application has already been approved and which is not directly affected, further payments from such allotments may be withheld, in whole or in part, until there is no longer any failure to comply (or to carry out the assurance or plans and specifications or to provide adequate State funds, as the case may be) or, if such compliance (or other action) is impossible, until the State repays or arranges for the repayment of Federal moneys to which the recipient was not entitled.

PART B—INITIAL STAFFING OF COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTERS

AUTHORIZATION OF APPROPRIATIONS

SEC. 221. For the purpose of assisting in the establishment and initial operation of comprehensive community mental health centers, there are authorized to be appropriated $10,000,000 for the fiscal year ending June 30, 1966, $34,000,000 for the fiscal year ending June 30, 1967, $62,000,000 for the fiscal year ending June 30, 1968, $93,000,000 for the fiscal year ending June 30, 1969, $99,000,000 for the fiscal year ending June 30, 1970, $69,000,000 for the fiscal year ending June 30, 1971, $42,000,000 for the fiscal year ending June 30, 1972, and $18,000,000 for the fiscal year ending June 30, 1973, for grants by the Secretary, in accordance with this part, to assist in meeting the cost of initial staffing of community mental health centers.

APPLICATIONS AND GRANTS

SEC. 222. Grants under this part with respect to any center may be made only upon application, and only if—

(1) the applicant is a public or nonprofit private agency or organization which owns or operates the center;

(2) a grant was made under part A of this title to assist in financing the construction of the center;

(3) the services to be provided by such center, alone or in conjunction with other facilities owned or operated by the applicant or affiliated or associated with the applicant, are part of a program which provides, principally for persons residing in a particular community or communities in or near which such center is situated, at least diagnostic services, inpatient care, outpatient care, and day care for mentally ill persons.

DURATION AND AMOUNT OF GRANTS

SEC. 223. Grants for staffing of any center under this part may be made only for the period beginning with the commencement of the operation of such center and ending with the close of four years and six months after the month in which such operation commenced. Such grants with respect to any center may not exceed 75 per centum of the cost of such staffing for the period ending with the close of the eighteenth month following the month in which such operation commenced, 60 per centum of such cost for the first year thereafter, 45 per centum of such cost for second year thereafter, and 30 per centum of such cost for the third year thereafter.

PAYMENTS

SEC. 224. Payment of grants under this part may be made (after necessary adjustment on account of previously made overpayments or underpayments) in advance or by way of reimbursement, and on such terms and conditions and in such installments, as the Secretary may determine.

REGULATIONS

SEC. 225. The Secretary shall, after consultation with the National Advisory Mental Health Council (appointed pursuant to the Public Health Service Act) prescribe general regulations concerning eligibility of centers and the terms and conditions for approving applications under this part.

TITLE III—TRAINING OF TEACHERS OF MENTALLY RETARDED AND OTHER HANDICAPPED CHILDREN

TRAINING OF TEACHERS OF HANDICAPPED CHILDREN

SEC. 31. (a)(1) The second sentence of the first section of the Act of September 6, 1958 (Public Law 85-926), is amended by striking out "Such grants" and inserting in lieu thereof "Grants under this section" and by striking out "fellowships" and inserting in lieu thereof "fellowships or traineeships".

(2) Such section is further amended by inserting before the second sentence thereof the following new sentence: "He is also authorized to make grants to public or other nonprofit institutions of higher learning to assist them in providing professional or advanced training for personnel engaged or preparing to engage in employment as teachers of handicapped children, as supervisors of such teachers, or as speech correctionists or other specialists providing special services for education of such children, or engaged or preparing to engage in research in fields related to education of such children."

(3) The first sentence of such section is amended by striking out "mentally retarded children" and inserting in lieu thereof "mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, emotionally disturbed or socially maladjusted, crippled, or other health impaired children (hereinafter in this Act referred to as 'handicapped children')". Section 2 of such Act is amended by striking out "mentally retarded children" and inserting in lieu thereof "handicapped children".

(4) The second sentence of section 3 of such Act is repealed. Section 7 of such Act is amended to read:

"SEC. 7. There are authorized to be appropriated for carrying out this Act—

"(1) $1,000,000 for any fiscal year ending prior to July 1, 1963; and

"(2) $11,500,000 for the fiscal year ending June 30, 1964, $14,500,000 for the fiscal year ending June 30, 1965, and $19,500,00 for the fiscal year ending June 3, 1966."

(5) The amendments made by this subsection shall apply in the case of fiscal years beginning after June 30, 1963, except that deaf children shall not be included as "handicapped children" for purposes of such amendments for the fiscal year ending June 30, 1964.

(b) Effective for fiscal years beginning after June 30, 1964, the first section of such Act is amended by adding at the end thereof the following new sentence: "The Commissioner is also authorized to make grants to public or other nonprofit institutions of higher learning to assist them in establishing and maintaining scholarships, with such stipends as may be determined by the Commissioner, for training personnel preparing to engage in employment as teachers of the deaf."

(c) Subsections (a) and (b) of section 6 of the Act of September 22, 1961 (Public Law 87-276, 20 U.S.C. 676), are each amended by striking out "June 30, 1963" and inserting in lieu thereof "June 30, 1964".

RESEARCH AND DEMONSTRATION PROJECTS IN EDUCATION OF HANDICAPPED CHILDREN

SEC. 302. (a) There is authorized to be appropriated for the fiscal year ending June 30, 1964, and each of the next two fiscal years, the sum of $2,000,000 to enable the Commissioner of Education to make grants to States, State or local educational agencies, public and nonprofit private institutions of higher learning, and other public or nonprofit private educational or research agencies and organizations for research or demonstration projects relating to education for mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, emotionally disturbed or socially maladjusted, crippled, or other health impaired children (hereinafter in this subsection referred to as "handicapped children"). Such grants shall be made in installments, in advance or by way of reimbursement, and on such conditions as the Commissioner of Education may determine.

(b) The Commissioner of Education is authorized to appoint such special or technical advisory committees as he may deem necessary to advise him on matters of general policy relating to particular fields of education of handicapped children or relating to special services necessary thereto or special problems involved therein.

(c) The Commissioner of Education shall also from time to time appoint panels of experts who are competent to evaluate various types of research or demonstration projects under this section, and shall secure the advice and recommendations of such a panel before making any such grant in the field in which such experts are competent.

(d) Members of any committee or panel appointed under this section who are not regular full-time employees of the United States shall, while serving on the business of such committee or panel, be entitled to receive compensation at rates fixed by the Secretary of Health, Education, and Welfare, but not exceeding $75 per day, including travel time; and, while so serving away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5 of the Administrative Expenses Act of 1946 (5 U.S.C. 73b-2) for persons in the Government service employed intermittently.

(e) The Commissioner of Education is authorized to delegate any of his functions under this section, except the promulgation of regulations, to any officer or employee of the Office of Education.

TITLE IV—GENERAL

DEFINITIONS

SEC. 401. For purposes of this Act—

(a) The term "State" includes Puerto Rico, Guam, American Samoa, the Virgin Islands, and the District of Columbia.

(b) The term "facility for the mentally retarded" means a facility specially designed for the diagnosis, treatment, education, training, or custodial care of the mentally retarded, including facilities for training specialists and sheltered

workshops for the mentally retarded, but only if such workshops are part of facilities which provide or will provide comprehensive services for the mentally retarded.

(c) The term "community mental health center" means a facility providing services for the prevention or diagnosis of mental illness, or care and treatment of mentally ill patients, or rehabilitation of such persons, which services are provided principally for persons residing in a particular community or communities in or near which the facility is situated; and such term may include facilities for provision of such services for narcotic addicts if such facilites are part of facilities providing services for other mentally ill persons.

(d) The terms "nonprofit facility for the mentally retarded", "nonprofit community mental health center", and "nonprofit private institution of higher learning" means, respectively, a facility for the mentally retarded, a community mental health center, and an institution of higher learning which is owned and operated by one or more nonprofit corporations or associations no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual; and the term "nonprofit private agency or organization" means an agency or organization which is such a corporation or association or which is owned and operated by one or more of such corporations or associations.

(e) The term "construction" includes construction of new buildings, expansion, remodeling, and alteration of existing buildings, and initial equipment of any such buildings (including medical transportation facilites); including architect's fees, but excluding the cost of off-site improvements and the cost of the acquisition of land.

(f) The term "cost of construction" means the amount found by the Secretary to be necessary for the construction of a project.

(g) The term "title", when used with reference to a site for a project, means a fee simple, or such other estate or interest (including a leasehold on which the rental does not exceed 4 per centum of the value of the land) as the Secretary finds sufficient to assure for a period of not less than fifty years undisturbed use and possession for the purposes of construction and operation of the project.

(h) The term "Federal share" with respect to any project means—

(1) if the State plan under which application for such project is filed contains, as of the date of approval of the project application, standards approved by the Secretary pursuant to section 402 the amount determined in accordance with such standards by the State agency designated under such plan; or

(2) if the State plan does not contain such standards, the amount (not less than 45 per centum and not more than either 75 per centum or the State's Federal percentage, whichever is the lower) established by such State agency for all projects in the State: *Provided*, That prior to the approval of the first such project in the State during any fiscal year such State agency shall give to the Secretary written notification of the Federal share established under this paragraph for such projects in such State to be approved by the Secretary during such fiscal year, and the Federal share for such projects in such State approved during such fiscal year shall not be changed after such approval.

(i) The Federal percentage for any State shall be 100 per centum less that percentage which bears the same ratio to 40 per centum as the per capita income of such State bears to the per capita income of the United States, except that the Federal percentage for Puerto Rico, Guam, American Samoa, and the Virgin Islands shall be 75 per centum.

(j)(1) The Federal percentages shall be promulgated by the Secretary between July 1 and August 31 of each even-numbered year, on the basis of the average of the per capita incomes of the States and of the United States for the three most recent consecutive years for which satisfactory data are available from the Department of Commerce. Such promulgation shall be conclusive for each of the two fiscal years in the period beginning July 1 next succeeding such promulgation; except that the Secretary shall promulgate such percentages as soon as possible after the enactment of this Act, which promulgation shall be conclusive for the fiscal year ending June 30, 1965.

(2) The term "United States" means (but only for purposes of this subsection and subsection (i)) the fifty States and the District of Columbia.

(k) The term "Secretary" means the Secretary of Health, Education, and Welfare.

STATE STANDARDS FOR VARIABLE FEDERAL SHARE

SEC. 402. The State plan approved under part C of title I or part A of title II may include standards for determination of the Federal share of the cost of projects approved in the State under such part. Such standards shall provide equitably (and, to the extent practicable, on the basis of objective criteria) for variations between projects or classes of projects on the basis of the economic status of areas and other relevant factors. No such standards shall provide for a Federal share of more than 75 per centum or less than 45 per centum of the cost of construction of any project. The Secretary shall approve any such standards and any modifications thereof which comply with the provisions of this subsection.

PAYMENTS FOR CONSTRUCTION

SEC. 403. (a) Upon certification to the Secretary by the State agency, designated as provided in section 134 in the case of a facility for the mentally retarded, or section 204 in the case of a community mental health center, based upon inspection by it, that work has been performed upon a project, or purchases have been made, in accordance with the approved plans and specifications, and that payment of an installment is due to the applicant, such installment shall be paid to the State, from the applicable allotment of such State, except that (1) if the State is not authorized by law to make payments to the applicant, the payment shall be made directly to the applicant, (2) if the Secretary, after investigation or otherwise, has reason to believe that any act (or failure to act) has occurred requiring action pursuant to section 136 or section 206, as the case may be, payment may, after he has given the State agency so designated notice of opportunity for hearing pursuant to such section, be withheld, in whole or in part, pending corrective action or action based on such hearing, and (3) the total of payments under this subsection with respect to such project may not exceed an amount equal to the Federal share of the cost of construction of such project.

(b) In case an amendment to an approved application is approved as provided in section 135 or 205 or the estimated cost of a project is revised upward, any additional payment with respect thereto may be made from the applicable allotment of the State for the fiscal year in which such amendment or revision is approved.

JUDICIAL REVIEW

SEC. 404. (a) If the Secretary refuses to approve any application for a project submitted under section 135 or 205, the State agency through which such application was submitted, or if any State is dissatisfied with his action under section 134(b) or 204(b) or section 136 or 206, such State, may appeal to the United States court of appeals for the circuit in which such State is located, by filing a petition with such court within sixty days after such action. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary, or any officer designated by him for that purpose. The Secretary thereupon shall file in the court the record of the proceedings on which he based his action, as provided in section 2112 of title 28, United States Code. Upon the filing of such petition, the court shall have jurisdiction to affirm the action of the Secretary or to set it aside, in whole or in part, temporarily or permanently, but until the filing of the record, the Secretary may modify or set aside his order. The findings of the Secretary as to the facts, if supported by substantial evidence, shall be conclusive, but the court, for good cause shown, may remand the case to the Secretary to take further evidence, and the Secretary may thereupon make new or modified findings of fact and may modify his previous action, and shall file in the court the record of the further proceedings. Such new or modified findings of facts shall likewise be conclusive if supported by substantial evidence. The judgment of the court affirming or setting aside, in whole or in part, any action of the Secretary shall be final, subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code. The commencement of proceedings under this subsection shall not, unless so specifically ordered by the court, operate as a stay of the Secretary's action.

RECOVERY

SEC. 405. If any facility or center with respect to which funds have been paid under section 403 shall, at any time within twenty years after the completion of construction—

(1) be sold or transferred to any person, agency, or organization (A) which is not qualified to file an application under section 135 or 205, or (B) which is not approved as a transferee by the State agency designated pursuant to section 134 (in the case of a facility for the mentally retarded) or section 204 (in the case of a community mental health center), or its successor; or

(2) cease to be a public or other nonprofit facility for the mentally retarded or community mental health center, as the case may be, unless the Secretary determines, in accordance with regulations, that there is good cause for releasing the applicant or other owner from the obligation to continue as such a center.

the United States shall be entitled to recover from either the transferor or the transferee (or, in the case of a facility or center which has ceased to be public or other nonprofit facility for the mentally retarded or community mental health center, from the owners thereof) an amount bearing the same ratio to the then value (as determined by the agreement of the parties or by action brought in the district court of the United States for the district in which the center is situated) of so much of such facility or center as constituted an approved project or projects, as the amount of the Federal participation bore to the cost of the construction of such project or projects. Such right of recovery shall not constitute a lien upon such facility or center prior to judgment.

STATE CONTROL OF OPERATIONS

SEC. 406. Except as otherwise specifically provided, nothing in this Act shall be construed as conferring on any Federal officer or employee the right to exercise any supervision or control over the administration, personnel, maintenance, or operation of any facility for the mentally retarded or community mental health center with respect to which any funds have been or may be expended under this Act.

CONFORMING AMENDMENT

SEC. 407. (a) The first sentence of section 633 (b) of the Public Health Service Act is amended by striking out "eight" and inserting in lieu thereof "twelve". The second sentence thereof is amended to read: "Six of the twelve appointed members shall be persons who are outstanding in fields pertaining to medical facility and health activities, and three of these six shall be authorities in matters relating to the operation of hospitals or other medical facilities, one of them shall be an authority in matters relating to the mentally retarded and one of them shall be an authority in matters relating to mental health, and the other six members shall be appointed to represent the consumers of services provided by such facilities and shall be persons familiar with the need for such services in urban or rural areas."

(b) The terms of office of the additional members of the Federal Hospital Council authorized by the amendment made by subsection (a) who first take office after enactment of this Act shall expire, as designated by the Secretary at the time of appointment, one at the end of the first year, one at the end of the second year, one at the end of the third year, and one at the end of the fourth year after the date of appointment.

Passed the Senate May 27, 1963.

Attest:

FELTON M. JOHNSTON,
Secretary.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, June 17, 1963.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This is in response to your request of June 6, 1963, for a report on S. 1576, a bill to provide assistance in combating mental retardation through grants for construction of research centers and grants for facilities for the mentally retarded and assistance in improving mental health through grants

for construction and initial staffing of community mental health centers, and for other purposes.

Title I of the bill contains three construction grant authorizations for facilities relating to mental retardation: Part A would authorize aggregate appropriations of $30 million over a 5-year period for project grants to assist in constructing special centers for research relating to mental retardation; part B would authorize appropriations of $42.5 million over a 5-year period for project grants for college or university associated facilities for the mentally retarded; and part C would authorize $67.5 million over a 4-year period for grants to the States to aid in constructing public or nonprofit facilities for the mentally retarded.

Title II includes two new grant authorizations relating to the establishment of community mental health centers. The first, contained in part A, would permit appropriations totaling $230 million over a 4-year period for grants to the States to help construct public and nonprofit facilities for such community centers. The second, contained in part B, relates to grants—totaling $427 million over an 8-year period—for the initial staffing of comprehensive centers constructed with grants pursuant to part A.

Title III of the bill would authorize appropriations of $47 million over a 3-year period to extend and strengthen existing programs for training teachers of mentally retarded children and deaf children and to expand these programs to include training for teachers of other handicapped children. In addition, this title would authorize the appropriation of $6 million over a 3-year period for grants for research or demonstration projects relating to the education of the handicapped.

Title IV of the bill includes a series of definitions and other general provisions relating to the several program authorizations in the preceding titles.

Except for the provisions of title III, which will be discussed later in this report, the provisions of S. 1576 represent a consolidation, with certain modifications, of proposals originally included in two separate bills to carry out certain legislative recommendations in the President's February 5, 1963, message to the Congress on mental illness and mental retardation. In the House of Representatives these proposals were embodied in H.R. 3688 and H.R. 3689, and several identical bills, on which your Subcommittee on Public Health and Safety held public hearings in March of this year.

Apart from the structural differences resulting from the consolidation per se, the substantive provisions of S. 1576 differ from those of H.R. 3688 and H.R. 3689 in several significant particulars:

1. S. 1576 includes (in part B of title I) a separate project grant authorization for construction grants for university associated facilities for the mentally retarded, whereas under the provisions of H.R. 3689 aid for the construction of such facilities would be provided through the earmarking of a portion of the appropriations authorized for grants to the States. After further consideration of these alternative approches to the same objective, we believe the project grant approach contained in S. 1576 lends itself more readily to the emphasis which the President indicated should be accorded to this category of facilities.

2. The program authorizations in S. 1576 for formula grants to the States for constructing mental retardation facilities (part C of title I) and for constructing community mental health centers (part A of title II) would each be limited to 4 years, whereas the corresponding authorizations in H.R. 3688 and H.R. 3689 are for 5-year periods. These changes would have the effect of providing a uniform terminal date for all of the new construction grant authorizations proposed, which might facilitate subsequent congressional review of these programs and of the merits of program extensions or modifications. We would therefore have no objection to these changes.

3. Specific annual appropriations ceilings are included in all of the new grant program authorizations in S. 1576, whereas the only corresponding authorization in the related House bills pertains to the grants for the construction of mental retardation research centers (included in H.R. 3689). In all cases, however, the ceilings included in S. 1576 parallel (with minor deviations resulting from substantive adjustments in the proposals) the cost projections developed in this Department for our original legislative proposals. Therefore, if the Congress should prefer the approach of specific annual authorizations to the more flexible authorizations which we originally proposed, the provisions of S. 1576 in this respect would be in accord with our estimates of program costs.

4. The provisions of S. 1576 (sec. 407) expanding the membership of the Federal Hospital Council differ from the corresponding provisions of H.R. 3688 and H.R. 3689 in that they would retain the present balance between profes-

sional and lay members of the Council rather than increase only the professional membership. We are in complete accord with this modified provision.

5. The definition of a "community mental health center" in sec. 401(c) of S. 1576 specifically provides that such centers may include facilities for the provision of services for narcotic addicts. While no corresponding provision is included in H.R. 3688, we believe that the provisions of the House bill could be so construed. We therefore believe that the language of S. 1576 is consistent with our original proposal in this respect.

As indicated above, the provisions of title III of S. 1576 have no counterpart in H.R. 3689. These provisions would carry out certain of the President's recommendations in the area of education of handicapped children. They are the same as the provisions in the administration's proposals on this subject included in H.R. 3000 and other identical bills.

These provisions of the Senate-passed bill include amendments to the Act of September 6, 1958 (Public Law 85-926) which now authorizes (1) grants to institutions of higher learning for training personnel who can, in turn, train teachers of mentally retarded children, and (2) grants to State educational agencies to assist them to provide training of teachers of mentally retarded children and supervisors of such teachers. The amendments would extend this legislation to all handicapped children, and the grants to the institutions would be expanded to include grants for training teachers (and supervisors of teachers) of handicapped children and other specialists and research personnel for work in this area.

Public Law 85-926 authorizes $1 million annually for training teachers of the mentally retarded; a similar program for training teachers of the deaf (Public Law 87-276) authorizes $1.5 million annually. The latter program, scheduled to expire June 30, 1963, would be extended 1 year as a transitional measure by S. 1576. In total, appropriations for training of teachers of the handicapped would be increased by S. 1576 from the current level of $2.5 million annually to $13 million in 1964, $14.5 million in 1965, and $19.5 million in 1966.

Finally, the Senate-passed bill authorizes appropriation of $2 million per year for the fiscal year ending June 30, 1964, and each of the next 2 years for grants for research and demonstration projects relating to education of handicapped children.

In summary, the provisions of S. 1576 are designed to carry out a number of legislative proposals relating to mental illness and mental retardation that have been recommended by the President. While its provisions deviate in some particulars from related proposals on which we have previously submitted supporting testimony to your committee, none of these deviations represents any conflict of program objectives or approaches, and in some instances we believe the provisions of S. 1576 represent legislative improvements. Therefore we would urge favorable consideration of S. 1576 at the earliest possible date.

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

Sincerely,

ANTHONY J. CELEBREZZE, *Secretary.*

Mr. ROBERTS. Our first witness today will be Mr. Boisfeuillet Jones, Special Assistant to the Secretary (Health and Medical Affairs), Department of Health, Education, and Welfare, and he is accompanied by Dr. Luther L. Terry, Surgeon General of the Public Health Service, and by Dr. Robert H. Felix, Assistant Surgeon General, National Institutes of Health.

I would like to also welcome to the subcommittee hearings several distinguished gentlemen from various States in the Union, and I am hoping that we can go along fast enough that we can hear all of these gentlemen who are here on this important legislation.

Mr. Jones?

STATEMENT OF BOISFEUILLET JONES, SPECIAL ASSISTANT TO THE SECRETARY (HEALTH AND MEDICAL AFFAIRS), DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY DR. LUTHER L. TERRY, SURGEON GENERAL, PUBLIC HEALTH SERVICE; AND DR. ROBERT H. FELIX, ASSISTANT SURGEON GENERAL, NATIONAL INSTITUTES OF HEALTH

Mr. JONES. Thank you, Mr. Chairman.

I have a statement, Mr. Chairman, which I would like to read at this time. The statement undertakes to answer some specific questions that have been raised previously on the staffing pattern, and the rationale for support of operating staff in the comprehensive community mental health centers.

This statement will be directed primarily to that point, but in the context of the new approach to community mental health services.

The President has outlined a national mental health program which would inaugurate a wholly new emphasis and approach to care for the mentally ill.

The proposed national program is centered on care and treatment of most mentally ill persons in their own home communities. Developments in mental health in the last decade have made abundantly clear that the mentally ill can more properly be treated and that many long-term custodial cases in our State mental institutions can be prevented when the care is focused within the community rather than in our existing large mental institutions.

This major shift in our approach to the prevention and treatment of mental illness requires the development throughout the country of a network of adequately staffed community facilities providing a series of preventive, diagnostic, therapeutic, and restorative services.

This is what is meant by the term "comprehensive community mental health center."

As the President stated:

> Central to a new mental health program is comprehensive community care. Merely pouring Federal funds into a continuation of the outmoded type of institutional care which now prevails would make little difference. We need a new type of health facility, one which will return mental health care to the main stream of American medicine, and at the same time upgrade mental health services.

At best, present services for the mentally ill are inadequate, haphazard, uncoordinated, and fractionated among a number of agencies and institutions. Mental health services in communities are in such short supply that almost all clinics have waiting lists making it necessary for them to delay services to applicants for periods of from 3 months to a year.

After care services are lacking, and where they exist, they often are inadequate, leading to avoidable readmission of large numbers of patients to hospitals.

As a result, patient care is fragmentary and lacking in continuity and coordination.

Recovery is hampered since these facilities do not provide a continuity in patient care—a flexible mechanism whereby a patient can transfer rapidly and smoothly from the type of service which is most

appropriate at one stage of his illness to another service as his condition warrants.

In addition, preventive services, represented by educational and consultative activities, usually are neglected.

The mentally ill person today is fortunate if he can receive those services which are designed to meet his immediate needs. The great majority of patients who are severely ill are sent to State hospitals, often to remain longer than necessary due to the lack of adequate rehabilitative or aftercare services in the community.

Some patients who are acutely ill, the fortunate ones, may go to a psychiatric unit within a general hospital, if such as facility exists in their community. A variety of outpatient mental health services exist for the moderately ill. But in all these clinics, once the patient's condition demands a different type of service than he may be receiving, he is cast into a highly disorganized situation.

As the Joint Commission on Mental Illness and Health pointed out, all too often patients are left to fend for themselves in obtaining the needed services. If such services do exist in their community, the patients face long waiting lists.

The comprehensive community mental health center is the pivot of the bold new national mental health program proposed by President Kennedy. Such centers are designed to bring order to the existing chaotic situation by providing a coordinated system of services which efficiently and effectively ministers to the mentally ill and to the entire community.

Basically, a comprehensive community mental health center is a complex of mental health services providing early diagnosis and treatment of mental illness, both on an inpatient and outpatient basis, serving as a locus for aftercare of discharged hospital patients, and providing essential preventive services to the community.

Thus, the optimal community mental health center encompasses a broad spectrum of services and programs:

A general diagnostic and evaluation service—precare.

An inpatient service.

A day and night care program.

An emergency clinic for walk-in patients operating on a 24-hour basis.

Rehabilitation facilities, including sheltered workshops or their supervision.

Consultation services to community agencies and organizations.

A public information and education service.

Supervision of foster home care facilities.

For a facility to qualify as a community mental health center, it must be comprehensive in the scope of its services and programs; it must be properly staffed; and it must be community based.

When we use the term "comprehensive" we refer to the complex of services enumerated above. This complex, when fully staffed, should serve 100,000 people. One may understand such a comprehensive community mental health center and its services by focusing on its components.

First, the center contains a hospital with 25 beds for the acutely mentally ill. Intensive treatment is provided on a 24-hour basis which requires three shifts of staff daily.

Like any other community medical facility, the center will provide round-the-clock emergency services to the community, including ambulance and home calls and services to patients.

Second, the center will also operate an outpatient department which may be called upon to provide diagnostic and treatment services to perhaps as many as 3,000 persons per year.

Third, the center provides "transitional" services, such as a day hospital and night hospital containing 50 beds. A day hospital is a service wherein patients spend the daytime hours getting treatment in the center and return to their homes and families in the evening. A night hospital is a service for those patients who are able to maintain their jobs in the community during the day, but require the sheltered environment and treatment in the evening.

Finally, a comprehensive community mental health center provides community mental health consultation services to the personnel in community agencies and organizations, such as the school system, as well as educational services to the general public.

The variety of services and programs encompassed within the comprehensive community mental health center requires the skills of many professional mental health workers.

It must be emphasized that the comprehensive community mental health center is a complex of services to people, not merely a new type of brick and mortar facility. This concept has been stated and repeatedly recommended by all of the national organizations and individuals who have made up the great groundswell of national support for this program.

Thus, proper staffing for services and programs is essential. Unless proper staffing is achieved, we run the risk of seeing these centers degenerate into miniature custodial hospitals at the community level. We cannot afford for this to happen.

The suggested staffing pattern for these centers is the present minimum professional standard which has evolved from experience within communities across the Nation.

For example, minimum standards require 1 full-time outpatient mental health team, composed of a psychiatrist, psychologist, and psychiatric social worker, for each 50,000 population.

As conceived, the proposed outpatient service of the center serving a population aggregate of 100,000 persons would demand, at minimum, 2 full-time professional mental health teams.

In addition, one must note that the existing standard is based on an 8-hour workday, whereas the center, being a community medical facility, will operate on a round-the-clock basis.

Under the proposed legislation, in order to qualify as a center to receive a grant, the applicant must provide at least for outpatient services, inpatient services, and day and night care.

Each of these services may exist at present as an independent entity in one community or another throughout the United States. Such services have their minimal staffing requirements, and combining such services in a center would not allow for any appreciable decrease in such staffing.

Beyond these minimal services required to qualify as a center, one would hope that each community would strive for the initiation of

optimal services to all people to make the mental health program truly comprehensive. The prevention of mental illness is as important as the care and treatment of the mentally ill.

What is advocated is a truly comprehensive community mental health program which will include, in addition to the basic treatment services, emergency services, rehabilitation services, and consultation and educational programs.

Therefore, the staffing pattern for a center must include the personnel needed to carry out such necessary community services.

We believe that communities must plan for the delivery of optimal services by adequate and competent staff or face the probability that these centers, once constructed, will of necessity have to limit their programs, restrict their services, and curtail their treatment and prevention programs.

The suggested staffing pattern is not meant to reflect the total number of mental health workers needed in a community.

For the community mental health center to be most effective, supporting mental health services are needed in the community; the center would be the nucleus around which all community mental health services operate.

Rehabilitative services such as sheltered workshops and halfway houses, and the services for mental patients provided in nursing homes, will require additional numbers of mental health workers.

The suggested staffing reflects no more than acceptable medical and psychiatric practice, and it is essential to carrying out a comprehensive community mental health program which will prevent severe mental illness and serve to reduce the resident population in State mental hospitals.

We believe that the staffing pattern suggested for a comprehensive community mental health center is realistic and feasible in terms of professional manpower available and being trained.

S. 1576 authorizes construction funds which would result in the construction of 294 comprehensive community mental health centers at an average construction cost of $1.3 million per unit.

Each center, if it had the full range of services, would require about 2,900 psychiatrists.

Again this need for psychiatrists, there are presently being trained about 1,000 new psychiatrists per year. Thus, over the 4-year period authorized for construction grants in S. 1576, about 4,000 new psychiatrists will be available for staffing these centers.

In addition, there were, in 1962, 14,806 psychiatrists (including residents) in the country—about 8 per 100,000 population. Some of the psychiatrists who are now working in clinics and in private practice will undoubtedly move to staff, full time and part time, the new comprehensive community mental health centers as they become the focus of care of the mentally ill in the community.

In a similar manner, some of the residents in psychiatry, of which there are approximately 3,000 at any one time, will be taking some of their training in the comprehensive community mental health centers.

Together, the three major sources of psychiatric personnel—the new psychiatrists who will be trained over the next 4 to 5 years, the practicing psychiatrists who will shift the location of their service to the new comprehensive community mental health centers, and the

residents during their 3 years of psychiatric training—constitute a manpower pool of sufficient strength to make the projections of staffing completely realistic.

The President's legislative program in the field of mental health provides for Federal grants for the initial staffing of those community mental health centers which (*a*) would be constructed with Federal grants under the provisions of the bill, and (*b*) would offer at least diagnostic services, inpatient care, outpatient care, and day care for mentally ill persons.

The Federal Government has a long history of assisting in the construction of needed facilities such as hospitals, airports, roads, and so forth.

The stimulatory philosophy underlying Federal grants for construction holds true for providing time-limited grants for the staffing costs of comprehensive community mental health centers.

There are precedents, both in and outside of the Public Health Service, wherein State and local program operations have been assisted over a limited period of time.

One of the most important of these is the mental health project grants for investigations, experiments, demonstrations, and studies with respect to the diagnosis, care, treatment, and rehabilitation of the mentally ill.

Staffing costs account for a major share of these grant funds. There are numerous illustrations in this program wherein projects supported by Federal grants have continued after the Federal grant has been terminated. Examples include a work rehabilitation program for psychotic patients in the Manhattan State Hospital in New York, an evening mental health clinic in Boston, a project involving family therapy in schizophrenia in Palo Alto, Calif., and the secondary education of adolescents in a Vermont mental hospital.

These examples illustrate the point that Federal funds have often served as "seed money" to stimulate the States and localities to continue and expand their own efforts.

Probably the best example of the "seed money" principle in the field of mental health is the Federal formula grant to States for community mental health programs. At the time this program was instituted, the States and localities were putting about $5 million into community mental health programs.

Now, with only a modest increment in the Federal grant (to $6.75 million in the current year), the States and localities are putting about $90 million into community mental health programs.

In the proposed legislation, the initial Federal staffing grants would cover a maximum of 75 percent of the staffing costs for the first 18 months of operation; 60 percent the second year; 45 percent the third year; and 30 percent the fourth year.

There would be no Federal assistance for staffing thereafter. In essence, grants for staffing provide an initial high stimulation accompanied by graduated withdrawal and termination of Federal funds.

The proposed legislation itself includes a number of provisions designed to insure that the community centers will be operated after the initial period without Federal assistance.

Section 205(a)4 of S. 1576 provides that applications by State agencies for Federal grants for the construction of community mental

health centers will set forth "reasonable assurance that adequate financial support will be available for the construction of the project and for its operation when completed."

All grants for initial staffing costs (as well as construction grants) will be based upon the State plan which outlines the necessary conditions for Federal aid in the construction of centers.

In order to receive construction support, there must be detailed for each center its source of funds not only for the non-Federal share of the construction costs, but also for financing of operations.

Federal initial staffing grants may be authorized for up to a 4½-year period on a diminishing percentage basis. However, no application for the construction of a center with Federal funds will be approved unless the center spells out its sources of operating support for its fifth year of operation, which will be its first year without Federal support.

This mechanism will guarantee that Federal support will cease after the 4½-year period and that the center will function soundly without Federal assistance.

The foregoing requirement, coupled with a provision (sec. 222(3)) that Federal initial staffing grants may be made only for those centers for which a Federal construction grant is made under title II of the bill, insures that no construction or staffing grant will be made unless there is ample evidence that the center will be adequately supported by a combination of State, local, and/or private funds.

Federal initial staffing grants would not be available for all projects constructed with Federal aid under the provisions of title II. Rather, such staffing grants would be limited to those applications which plan to provide, in the words of the bill, "at least diagnostic services, inpatient care, outpatient care, and daycare for mentally ill patients."

The Secretary of Health, Education, and Welfare, in testifying before this committee, stated that Federal initial staffing grants will be used for new or additional staff only and cannot, therefore, be used in substitution for existing sources of support.

Moreover, the bill itself limits the Federal assistance to staffing costs and not the entire operating costs of the centers.

These staffing subsidies are essentially a one-time grant—a form of support on a declining basis for the period during which centers are engaged in the costly process of recruitment and hiring of staff.

It is vital to bear in mind that the entire concept of a comprehensive community mental health center is new. Therefore, community acceptance and support is essential, and such acceptance will require for its development at least the period of time during which Federal staffing assistance will be necessary.

The basic purpose of the President's program is to redirect the locus of treatment of the mentally ill from State mental hospitals into community mental health centers.

If the objective stated in the President's message of reducing the population of State mental hospitals by 50 percent within a decade or two is achieved, the States will be able to divert into community programs a portion of the roughly $1 billion now being spent on the operation of State mental hospitals.

Moreover, the present trend toward the enactment of community mental health services laws in many States indicates the readiness of States and communities to direct funds into local programs and services.

In order to understand the underlying rationale for the proposed Federal staffing grants, there are a number of points to bear in mind concerning the operation of centers:

1. The sponsorship of centers will be a matter of local determination, so long as the sponsorship is nonprofit. In many communities, the centers will be distinctly public and in others they will be private.

2. The extent to which a center will be a single facility including the various inpatient, outpatient, and transitional facilities or a coordinated program of geographically dispersed elements will vary greatly.

Some of the major patterns which can be predicted include: A center which will be an outgrowth of the psychiatric ward of an existing general hospital; a center which will be added to the inpatient facilities of a State mental hospital; a center which will be a logical extension of an existing community mental health clinic; and a center which will be an entirely new and discrete physical entity.

The size of the various elements of a given center (such as number of inpatient beds) will obviously vary both according to the type of center, as outlined above, and the nature of the mental health problems in a particular community.

3. As in the case of the sponsorship and the physical characteristics of center, their staffing patterns will vary considerably. The staffing pattern for a community mental health center which was introduced into the record of the House hearings on H.R. 3688 (page 101) lists the minimum number of personnel needed to provide the optimal services of a fully comprehensive community mental health center.

In many sections of the Nation, other services and additional personnel will be required to meet a community's mental health needs.

It is envisioned that part-time professional workers will supplement the community mental health center's full-time staff. Private practitioners of psychiatry would be encouraged to hospitalize their patients in the center and in return to provide professional time to the center; this arrangement would somewhat complement the minimal center staff.

Private physicians, including general practitioners, psychiatrists, and other medical specialists will participate directly in the community mental health center operation, just as they participate in the operation of other community health facilities, such as general hospitals.

In the operation of a community general hospital there are salaried full-time house staff and also attending physicians. This latter group have certain privileges within the facility in return for the responsibilities to the facility which they assume.

Likewise, the staff of a community mental health center will provide now unavailable assistance and consultative services to the practicing physicians to help them in working with the emotional problems encountered in their patients.

The location of the mental health center in the community will, for the first time, provide a large proportion of private practitioners

(attending staff) with treatment privileges in a facility directly and quickly available for outpatient and inpatient care of their patients.

When the patient is in need of more extensive services than can be offered in office practice, the private practitioner may have his patient admitted to the community mental health center where he can provide continued treatment. Both the patient and physician will have available the services and facilities of the center.

For example, a private psychiatrist may continue responsibility for his patient; or a general practitioner may care for his patient with assistance from the center's psychiatrists.

In addition to these direct service activities, the center will serve as a major focus for postgraduate training in psychiatric aspects of medical practice for general practitioners and medical specialists such as pediatricians and obstetricians.

In effect the extensive involvement of the private sector in the operation and support of community mental health centers will serve to restore mental health services to their rightful place within the framework of community medical services. As the private sector becomes more involved in the operation of such centers the role of the State will diminish accordingly.

On the basis of the preceding description of the operation of community mental health centers, it is reasonable to view the Federal participation in the centers as a time-limited program.

The benefits of these community mental health programs will accrue to the Nation in terms of optimal utilization of its human resources.

Since the President's program represents a total innovation in the care, treatment, and rehabilitation of the mentally ill in community-based facilities, it is appropriate for the Federal Government to assume a portion of the costs of such service programs in view of their national implications.

The initiation of a large-scale program of this type will place a large fiscal burden on the States and localities for the immediate future.

Thus, one purpose of the Federal initial staffing grants will be to cushion the initial shock of full-scale operation.

The establishment of comprehensive community mental health centers will serve to alter the unsatisfactory status quo in the care, treatment, and rehabilitation of the mentally ill.

The development of comprehensive community mental health centers is in response to the recognized need by professional persons as well as the public that the present pattern of mental health services is totally inadequate.

Thank you, Mr. Chairman.

Mr. ROBERTS. Thank you, Mr. Jones.

Will Dr. Terry and Dr. Felix or either of them make statements?

Dr. TERRY. No; we have no prepared statement, sir.

Mr. ROBERTS. Thank you very much, Mr. Jones, for a very good statement. I take it that you envision replacement of the present State services which are in your opinion primarily custodial. I know that there is some good work going on by States and has been for some time, but your idea is that this is a new way to approach this great problem, that we will bring these services back to the grassroots, so to speak, or back to the hometown of the patient who is affected, and

that gradually large institutions that are concentrated maybe in one or two or more places in each State will be out of the picture, so to speak, as far as the overall treatment of this problem is concerned.

Mr. JONES. That is correct, Mr. Chairman. I think essentially it is putting the care of the mentally ill on the same basis in the community as is true of the physically ill.

Mr. ROBERTS. I believe in one place in your statement you stated that States were spending at the rate of about a billion dollars a year, and I believe that has been true over the past several years, has it not? The States have been spending about that sum in taking care of the mentally ill?

In the formula that we have set for the staffing in the Senate bill 1576, part B of title II, starts out with the formula of 75-percent Federal funds during the first 18 months, a maximum of 60 percent the following 12 months, a maximum of 45 percent for the next 12 months, and a maximum of 30 percent for the last 12 months, and then the pattern after 4½ years stops.

The Federal Government steps out of the picture and the States then pick up and carry on. Do you envision that the $1 billion a year, which has been documented not only in this hearing but in other hearings that we have had on these bills, will go down considerably as far as State funds are concerned?

Mr. JONES. This is hard to predict, Mr. Chairman. They won't go down in the same ratio, but it will make it possible for the funds now being spent at State mental institutions to be more effectively used in bringing better treatment to those who will necessarily remain in State mental institutions.

There will be some reduction, we would hope, as the number of patients treated in the State institutions is reduced, but what it will do, more than this, Mr. Chairman, will be to relieve the State of the obligation of taking care of many of those that are now taken care of completely at State expense.

This will be done by having available preventive services in the community and by having a community service of such a pattern that individuals, either from their own resources, or from private voluntary insurance, or third-party payments of one kind or another will receive the kind of treatment they need at the time they receive it. This will greatly reduce the expense of their mental illness.

There will be a total saving across the board.

Mr. HARRIS. If the chairman will permit——

Mr. ROBERTS. I yield.

Mr. HARRIS. Explaining it further then, you do not intend that the Federal Government assume this responsibility, but it will be absorbed by the local communities?

Mr. JONES. Quite correctly.

Mr. HARRIS. I think it is important now to get that in the record and have it clearly understood that whatever responsibility under this program is transferred from the State is not then transferred to the Federal Government, but is to be assumed and absorbed by the local communities, and that is the prime purpose of this kind of approach?

Mr. JONES. Correct.

Mr. HARRIS. I think that everyone should understand that.

Mr. ROBERTS. The majority of these patients would in most cases, would they not, be living at home while they undergo the treatment at the local level?

Mr. JONES. This will depend on the nature of their illness. The point is that they would have available in their communities whatever service that would be required in their particular condition.

Mr. ROBERTS. I mean the marginal cases.

Mr. JONES. The marginal cases could live at home, saving the expense of institutionalized care. This would be a net saving, whether it is to the individual, to the State, or to insurance companies, or others.

Mr. ROBERTS. So any way you look at it States are going to be relieved of a considerable amount of financial burden that they have been under for the last several years. Is that not correct?

Mr. JONES. That is the full and reasonable expectation demonstrated already in a few communities.

Mr. ROBERTS. Then why do we come up with a pattern of 75-percent Federal participation for the first 18 months? Why couldn't we strike a figure, say, of 50 percent? Since the States are going to be relieved of these burdens, why should we go to 75 percent?

Do you see any real reason for that?

Mr. JONES. Yes; we do, Mr. Chairman. We think it is extremely important. You will hear, I think, a little later this morning, from some of those who have direct responsibilities at the State level.

The problem is that we are proposing, as a nation, a brandnew undertaking in the care of the mentally ill, a problem which has been a long-neglected area of public concern. It will take some time for communities, for insurance programs, for the health activities in a community, to reorient toward the care of the mentally ill. This is a complete departure from responsibilities they have had before.

Mr. ROBERTS. Has the program worked any other place that you know of?

Mr. JONES. It has worked in some communities and I hope your witnesses this morning will tell you specifically as to how it has worked. In my own experience I know that in Georgia there have been programs of intensive treatment in general hospitals supported under a State plan. As I recall the figures, all but 7 percent of those who had been sent to intensive treatment centers in local communities have been able to return to their home, whereas a hundred percent of them before this program would have had to go to the large State mental institution for a long period of time.

I think the material that you have in your record of previous hearings is quite clear on this subject. Even though the cost may be high for the immediate period, the treatment is so short in relation to the average stay of about 8 years in State mental institutions, that the net saving is very great indeed, not only in terms of economic cost, but in terms of the availability of people for their normal pursuits, their normal family, home, and work responsibilities.

Mr. ROBERTS. Getting back to the initial staffing, I understand that these funds are to be used only for new or additional staffing.

Mr. JONES. These are to be used only for new or additional staffing and only in relation to facilities that are constructed under this program.

You see, Mr. Chairman, if a community undertakes to develop a facility that fits into the comprehensive community mental health center concept, it then must recruit the staff. And in this process of developing an ongoing program there is a lag in sources of income, such as fees for service that the individual pays, in meeting the expenses of operating the center. The proposed staffing grants provide a form of one-time limited support to get these new centers, never before providing such a service in the particular community, on a going basis. This will allow time for the normal community pattern of payment for health services to support the continued service in the same manner as it does in physical illness.

This is the local problem. The whole point and the only justification, but a very real one, for the Federal Government to be involved is to provide the stimulatory money. Without these funds this program will be long delayed, in our judgment, and will not be able to effectively carry this load.

Mr. ROBERTS. Don't you think if we started off with 50 percent Federal funds that that would be adequate stimulation?

Mr. JONES. This is a matter of judgment, Mr. Chairman.

In our judgment, we presented what we felt was a proper program. Your judgment will be brought into the picture by virtue of your hearings, I am sure.

Mr. ROBERTS. My feeling is that the States certainly can't abandon these people and if they can get 50 percent where they have not been getting anything from the Federal Government, it would seem to me that until we see how this works we might just provide 50 percent.

The Congress is going to be interested in this program and we will be looking at it again, providing we pass the bill and it is approved, and I just wonder whether that would be possible. That is all I have.

I am going to recognize the chairman of the full committee.

Mr. HARRIS. Mr. Chairman, at this time I want to include in the record information to supplement what Mr. Jones has given to us in his discussion of title II of the Senate bill 1576.

I would like to make it very clear that in my judgment the subcommittee has held rather extensive hearings and has a good record, which is printed and before us, on the original bills that were introduced.

I want to also say that I think the subcommittee did a very constructive job in arriving at decisions when in its consideration it considered the Senate-passed bill, which covers the same subject matter as the bills on which hearings were held, and reported its recommendations to the full committee.

I wish further to state here that one title, title III, in the Senate bill was not included in the original bills, H.R. 3688 and H.R. 3689, and others. One of the primary purposes for going back to hearings on this subject was to develop information in connection with title III.

As yet you have not mentioned title III. It is my understanding that you are going to take that up tomorrow in the hearings.

I have explained to the committee the situation with reference to title III, and the committee will give further consideration to that subject matter as we proceed, because of the jurisdictional problem.

When I sent this matter back to the subcommittee for hearings I did so because of requests that were made by various members of the committee in the executive session for the development of further information, in addition to information concerning title III.

Among the further considerations, as expressed by certain members of the committee, it was felt that the Senate-passed bill had not been given the tedious consideration that it should have been given.

However, as I have just said, the other bills related to exactly the same subject, titles I and II, and consequently an extensive record has been made. In addition, I requested the Department of Health, Education, and Welfare to prepare a section-by-section analysis of Senate bill 1576 as passed in the Senate, and since that was one of the subjects some members were interested in I am going to ask that it be included in the record at this point.

Mr. ROBERTS. Without objection, it will be included.

(The information to be furnished follows:)

SECTION-BY-SECTION ANALYSIS OF S. 1576 AS PASSED BY THE SENATE

The first section of the bill contains a short title, the "Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963." The remainder of the bill is divided into four titles:

Title I—Construction of Research Centers and Facilities for the Mentally Retarded.

Title II—Construction and Staffing of Mental Health Centers.

Title III—Training of Teachers of Mentally Retarded and Other Handicapped Children.

Title IV—General.

TITLE I—CONSTRUCTION OF RESEARCH CENTERS AND FACILITIES FOR THE MENTALLY RETARDED

Section 100. Short title

This section provides that title I of S. 1576 may be cited as the "Mental Retardation Facilities Construction Act."

PART A—GRANTS FOR CONSTRUCTION OF CENTERS FOR RESEARCH ON MENTAL RETARDATION AND RELATED ASPECTS OF HUMAN DEVELOPMENT

Section 101

This section would change the heading of title VII of the Public Health Service Act from "Health Research Facilities" to "Health Research Facilities and Mental Retardation Research Centers," would include the existing provisions in a part A ("Grants for Construction of Health Research Facilities"), and would add a part B to that title ("Centers for Research on Mental Retardation and Related Aspects of Human Development") containing the following provisions:

Section 721. Authorization of appropriations.—This section would authorize appropriations of $6 million for the fiscal year ending June 30, 1964, $8 million for fiscal 1965, $6 million each for fiscal 1966 and 1967, and $4 million for fiscal 1968, to establish a program of grants to public or other nonprofit institutions to assist in the construction of centers for research on mental retardation and related aspects of human development. Sums appropriated would remain available until expended for projects applied for before July 1, 1968, and approved before July 1, 1969.

Section 722. Applications.—This section would specify the terms under which the Surgeon General might approve an application for a grant under the part. Under subsection (a), an applicant would be required to be a public or nonprofit institution competent to engage in the research for which the facility was to be constructed, and would be required to support its application with reasonable assurances that the facility would be used for not less than 10 years for the purposes for which constructed, that sufficient funds were available for meeting the non-Federal share of its construction cost, and for meeting the costs of its operation ,and that laborers and mechanics employed in the construction of the facility would be paid not less than the prevailing wages in the locality and would

be paid overtime at rates determined in accordance with the Contract Work Hours Standards Act. Subsection (b) would require the Surgeon General, in acting on grant applications, to take into consideration the relative effectiveness of the proposed facilities in expanding national research capacity in the field of mental retardation, and such other factors as he may presecribe by regulation (after consulting the appropriate national advisory councils) to assure that the facilities constructed will best serve the purpose of advancing knowledge in the area.

Section 723. Amount of grants; payments.—This section would limit the total grants with respect to any project to 75 percent of cost. Payments of grants could be in advance or by way of reimbursement, in such installments consistent with construction progress, and on such conditions as the Surgeon General might determine.

PART B—PROJECT GRANTS FOR CONSTRUCTION OF UNIVERSITY AFFILIATED FACILITIES FOR THE MENTALLY RETARDED

Section 121. Authorization of appropriations

This section would authorize the appropriation of $5 million for the fiscal year ending June 30, 1964, $7,500,000 for the next fiscal year, and $10 million each for the following 3 fiscal years for projects grants by the Secretary of Health, Education, and Welfare for construction of public and other nonprofit facilities for the mentally retarded which are associated with a college or university. These appropriations would be for the purpose of assisting in the construction of (1) clinical facilities providing, as nearly as practicable, a full range of services, both inpatient and outpatient, for the mentally retarded; (2) facilities which will aid in demonstrating provision of specialized services for diagnosis and treatment, education, training, or care of the mentally retarded; and (3) facilities which will aid in the clinical training of physicians and other specialized personnel needed for such work or for research in connection with the mentally retarded.

Section 122. Applications

This section would specify the terms under which the Secretary of Health, Education, and Welfare might approve an application for a grant under this part. In order for an application to be approved, the facility with respect to which it is submitted would have to be associated to the extent prescribed in the Secretary's regulations, with a college or university hospital or with some other part of a college or university which the Secretary might find appropriate in the light of the purposes of this part. Hospitals affiliated with a college or university would be considered the same as a college or university hospital for this purpose. In addition, there would have to be assurances provided by the applicant that (1) the plans and specifications for the facility are in accord with the Secretary's regulations prescribed under section 133(c) of the bill; these regulations would specify general standards of construction and equipment for the facilities. Also there would have to be assurances as to the vesting of title to the site for the project, assurances that there will be adequate financial support to meet the non-Federal share of the cost of construction of the project, and for meeting the cost of its operation, and assurances that laborers and mechanics employed in the construction of the project will be paid not less than the prevailing wages in the locality and will be paid overtime at rates determined in accordance with the Contract Work Hours Standards Act.

Section 123. Amount of grants; payments

This section would limit the total grants with respect to any project to 75 percent of cost. Payments of grants could be made in advance or by way of reimbursement, in such installments consistent with construction progress, and on such conditions as the Secretary may determine.

Section 124. Recovery

This section provides for Federal recovery of a share of the current value of any facility aided under this part, which is equal to the portion of the cost of construction paid for by the Federal Government, in case the facility is, within 20 years after completion, sold or transferred to an ineligible person, agency, or organization or in case it ceases to be a public or other nonprofit facility for the mentally retarded. The Secretary could, however, for good cause, release the applicant or owner from this latter condition.

PART C—GRANTS FOR CONSTRUCTION OF FACILITIES FOR THE MENTALLY RETARDED

Section 131. Authorization of appropriations

This section would authorize the appropriation of $10 million for the fiscal year ending June 30, 1965, $12,500,000 for the first fiscal year thereafter, $15 million for the second fiscal year thereafter, and $30 million for the third fiscal year thereafter. These funds would be used for grants for construction of public and other nonprofit facilities for the mentally retarded.

Section 132. Allotments to States

Subsection (a) of this section would provide for the allotment of appropriated funds among the States on the basis of population, extent of need for the facilities, and the financial need of the States, with a minimum of $100,000 for any State (other than the Virgin Islands, American Samoa, and Guam). Allotted funds would remain available to the States for obligation in the next succeeding year.

Subsection (b) would authorize the Secretary, at the request of a State, to add a portion of the State's allotment to the allotment of another State for the purpose of meeting a portion of the Federal share (as defined in sec. 401(h)) of the cost of a project in the latter State, provided that he finds that the project would meet needs of the requesting State, and would assist in carrying out the purposes of this part.

Subsection (c) would authorize the transfer of a portion of a State's allotment under this part to its allotment under part A of title II (construction of public and other nonprofit community mental health centers), upon request of the State, provided that the State agency certifies that it has afforded a reasonable opportunity to make applications for that portion under this part, and that there have been no approvable applications for such portion, or the State makes a showing that its need for community mental health centers is substantially greater than for facilities for the mentally retarded.

Section 133. Regulations

This section would require the Secretary to prescribe, within 6 months after the enactment of this legislation and after consultation with the Federal Hospital Council, the kinds of services needed for mentally retarded residents of a State; the general manner, on the basis of relative area needs, in which the State agency shall determine the priority of projects to be approved, giving special consideration to facilities which will provide comprehensive services for a particular community or group of communities; and general standards of construction and equipment for facilities of different classes and in different types of location. The Secretary would also have to require that the State plan provide for adequate facilities to be available to all State residents, including persons unable to pay for them, and would be authorized to require that the State receive assurances that a reasonable volume of services to such indigent persons would be available before approving an application for the construction of a facility, where financially feasible.

Section 134. State plans

This section would provide for the submission to the Secretary of a State plan, after issuance of the regulations provided for in section 133. The plan would be required to (1) designate a single State agency to administer or supervise the administration of the plan; (2) contain satisfactory evidence of the agency's authority to carry out the plan in conformity with this part; (3) provide for the designation of a State advisory council which would include, among others, representatives of consumers of the services provided by the facilities; (4) set forth a construction program, conforming with the requirements of this part, which would be based on a statewide inventory of existing facilities and survey of need; (5) set forth the relative need for the projects included in the program, and provide for their construction, insofar as possible, in the order of such relative need; (6) provide for methods of administration, including personnel standards on a merit basis, that are found by the Secretary to be necessary for the proper and efficient operation of the plan; (7) provide minimum standards (to be fixed in the discretion of the State) for the maintenance and operation of facilities aided under this part; (8) provide for affording every applicant an opportunity for hearing before the State agency; (9) provide for the making of reports and the maintenance and availability of necessary records; and (10) provide for State review of its State plan no less

often than annually. The Secretary would have to approve any plan meeting these requirements and could not finally disapprove of a plan without affording reasonable notice and opportunity for hearing to the State.

Section 135. Approval of projects

This section provides that for each State-approved project there shall be submitted to the Secretary, through the State agency, an application setting forth a description of the site; plans for the project; reasonable assurances that title will vest in the applicant or the agency which is to operate the facility, that adequate financial support will be available for the construction, maintenance, and operation of the project, that laborers and mechanics employed in the construction of the facility will be paid not less than prevailing wages in the locality and overtime pay at rates determined in accordance with the Contract Work Hours Standards Act; and certification by the State agency of the Federal share (as defined by section 401(h) for the project).

Subject to the availability of funds, the Secretary would be required to approve the project application if the application conforms to these requirements, and to those of the State plan (and applicable regulations); contain an assurance that the facility will be operated in conformity with that plan, and with State standards for its operation and maintenance; and is entitled to priority over other projects within the State as determined under the State priority system established pursuant to the State plan. No application would be disapproved by the Secretary until he has afforded the State agency an opportunity for a hearing. Amendment of an approved application would be subject to approval in the same manner as an original application.

Section 136. Withholding of payments

This section would authorize the Secretary to withhold payments to a State completely, or with respect to the specific projects affected, upon his finding, after reasonable notice and opportunity for hearing to the State agency, that the State agency is not complying substantially with the State plan or with regulations, that the assurances required of applicants are or cannot be carried out, that there is a substantial failure to carry out the plans and specifications approved by the Secretary, or that adequate State funds are not being provided for the direct administration of the State plan. Payments may be withheld until the grounds for the Secretary's action have been removed or, if this is impossible, until repayment of Federal moneys to which the recipient was not entitled.

TITLE II—CONSTRUCTION AND STAFFING OF MENTAL HEALTH CENTERS

Section 200. Short title

This section provides that title II of S. 1576 may be cited as the Community Mental Health Centers Act.

PART A—GRANTS FOR CONSTRUCTION OF COMMUNITY HEALTH CENTERS

Section 201. Authorization of appropriations

This section would authorize appropriations of $35, $50, $65, and $80 million, respectively, for the fiscal year ending June 30, 1965, and each of the next 3 fiscal years, for grants for construction of public and other nonprofit community mental health centers.

Section 202. Allotments to States

Subsection (a) of this section would provide for the allotment of appropriated funds among the States, on the basis of population, extent of need for the facilities, and the financial need of the States, with a minimum of $100,000 for any State (other than the Virgin Islands, American Samoa, and Guam). Allotted funds would remain available to the States for obligation in the next succeeding year.

Subsection (b) would authorize the Secretary, at the request of a State, to add a portion of the State's allotment to the allotment of another State for the purpose of meeting a portion of the Federal share of the cost of a project in the latter State, provided that he finds that the project would meet needs of the requesting State, and would assist in carrying out the purposes of this part.

Subsection (c) would authorize the transfer of a portion of a State's allotment under this part to its allotment under part C of title I (construction of

public and other nonprofit facilities for the mentally retarded), upon request of the State, provided that the State agency certifies that it has afforded a reasonable opportunity to make applications for that portion under this part, and that there have been no approvable applications for such portion, or the State makes a showing that its need for facilities for the mentally retarded is substantially greater than for community mental health centers.

Section 203. Regulations

This section would require the Secretary to prescribe, within 6 months after the enactment of S. 1576, and after consultation with the Federal Hospital Council, the kinds of services needed to provide adequate mental health services for residents of a State; the general manner, on the basis of relative area needs, in which the State agency shall determine the priority of projects to be approved, giving special consideration to community mental health centers which (alone or in conjunction with affiliated facilities) will provide comprehensive services for a particular community or group of communities, or which will be part of or closely associated with a general hospital; and general standards of construction and equipment for centers of different classes and in different types of location. The Secretary would also have to require that the State plan provide for adequate community mental health centers to be available to all State residents, including persons unable to pay for them, and would be authorized to require that the State receive assurances that a reasonable volume of services to such indigent persons would be available before approving an application for the construction of a facility, where financially feasible.

Sections 204, 205, and 206. State plans; approval of projects; withholding of payments

These sections are substantially identical with the corresponding sections—134, 135, 136—of title I, part C. It should be noted, however, that approval of applications for projects would be limited to those for construction of community mental health centers which (alone or together with affiliated facilities) would provide services as part of programs providing, principally, for persons in the community or nearby, at least those essential elements of comprehensive mental health services which are prescribed by the Secretary of Health, Education, and Welfare in accordance with regulations.

PART B—INITIAL STAFFING OF COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTERS

Section 221. Authorization of appropriations

This section would authorize the appropriations, for the fiscal year ending June 30, 1966, and the next 7 fiscal years, for grants by the Secretary of Health, Education, and Welfare to assist in meeting the cost of initial staffing of community mental health centers, of the following amounts:

Fiscal year:	*Amount in millions*	Fiscal year—Continued	*Amount in millions*
1966	$10	1970	$99
1967	34	1971	69
1968	62	1972	42
1969	93	1973	18

Section 222. Applications and grants

This section would authorize grants upon the application of a public or nonprofit private agency which owns or operates a community mental health center whose construction was aided by a grant under part A of this title. The center, however, would be required to provide, alone or in conjunction with other facilitites associated with the applicant, at least diagnostic services, inpatient care, outpatient care, and day care for mentally ill persons, as part of a program of community services.

Section 223. Duration and amount of grants

This section would limit grants for the staffing of any center to 75 percent of the cost during the first 18 months of operation. In the first year following the initial 18-month period, grants would be limited to 60 percent of the cost; in the second year after such period, 45 percent; and in the third year after such period, 30 percent.

Section 224. Payments

This section would permit grants to be paid in advance or by way of reimbursement, on such terms and conditions and in such installments, as the Secretary might determine.

Section 225. Regulations

This section would direct the Secretary to prescribe general regulations concerning the eligibility of centers and the terms and conditions for approving their applications, after consultation with the National Advisory Mental Health Council.

TITLE III—TRAINING OF TEACHERS OF MENTALLY RETARDED AND OTHER HANDICAPPED CHILDREN

Title III of the bill would amend the act of September 6, 1958 (Public Law 85–926), which authorizes grants by the Commissioner of Education to institutions of higher learning for training personnel who can, in turn, train teachers of mentally retarded children, as well as grants to State educational agencies to assist them in providing training of teachers of mentally retarded children and supervisors of such teachers. This title would also authorize grants for research and demonstration projects in education of handicapped children.

Section 301. Training of teachers of handicapped children

This section would amend the act of September 6, 1958, to extend it to all handicapped children, and to extend the grants to the institutions to include grants for training teachers (and supervisors of teachers) of all handicapped children along with other specialized and research personnel for work in this area. For the fiscal year ending June 30, 1964, however, the act of September 6, 1958, would not include any grants with respect to teachers of deaf children. Instead, the act of September 22, 1961 (Public Law 87–276), would be extended from its present expiration date of June 30, 1963, to June 30, 1964. Effective July 1, 1964, the act of September 6, 1958, would apply in the case of deaf children as well as other handicapped children and would further be amended to authorize grants to institutions of higher learning for scholarships for training teachers of the deaf.

The $1 million per year authorization of appropriations for carrying out the act of September 6, 1958, would be replaced by an authorization for $11,500,000 for the fiscal year ending June 30, 1964, $14,500,000 for the fiscal year ending June 30, 1965, and $19,500,000 for the fiscal year ending June 30, 1966.

Section 302. Research and demonstration projects in education of handicapped children

This section of the bill would authorize appropriations for the fiscal year ending June 30, 1964, and each of the next 2 fiscal years, of $2 million for grants by the Commissioner of Education to States and public and nonprofit private educational or research agencies and organizations for research or demonstration projects relating to education of handicapped children. It would also authorize the Commissioner of Education to appoint special or technical advisory committees to advise him on matters of general policy in particular fields of education of handicapped children. It would also direct the Commissioner to appoint panels of experts to evaluate the various types of research or demonstration projects aided under this section. The advice and recommendations of such a panel would have to be secured before making a grant in the particular field in which the experts were competent. Members of any advisory committee or panel could be paid up to $75 per day plus allowances for travel expenses, including per diem in lieu of subsistence.

The Commissioner of Education would also be authorized to delegate any of his functions under this section to any officer or employee of the Office of Education. This authority would not, however, extend to promulgation of regulations.

TITLE IV—GENERAL

Section 401. Definitions

This section would define the terms "State," "facility for the mentally retarded," "community mental health center," "nonprofit facility for the mentally retarded," "nonprofit community mental health center," "nonprofit private institution of higher learning," "construction," "cost of construction," "title," "Federal share," and "Secretary."

The term "State" would be defined so as to permit the participation of Puerto Rico, Guam, American Samoa, the Virgin Islands, and the District of Columbia in the benefits of the programs established by the bill.

The term "facility for the mentally retarded" would be defined as a facility designed for diagnosis, treatment, education, training, or custodial care of the mentally retarded and would include facilities for training specialists. It would also include sheltered workshops for the mentally retarded when they are part of comprehensive service facilities for the mentally retarded.

The term "community mental health center" would be defined as a facility providing services for the prevention or diagnosis of all types of mental disorders (including drug addiction), or care and treatment or rehabilitation of such mentally ill patients, but only if the services are principally for persons residing in a particular community or communities in or near which the facility is situated. A community mental health center could not be constructed solely for the care and treatment of narcotic addicts under the provisions of this legislation, but such a center could provide for the specialized care of patients addicted to narcotic drugs.

The term "construction" would include alteration of existing buildings, and initial equipment of buildings, but would not include acquisition of land.

Sections 401(h) and 402. "Federal share"; State standards for variable Federal share

Section 402 would authorize the inclusion, in a State plan approved under part C of title I or part A of title II, of standards for determining the Federal share of the cost of projects approved in the State under such part. Under such standards, which would base variations on economic status of areas and other relevant factors, the Federal share could vary between 45 and 75 percent of the cost of the construction of a project. If a State plan contains such standards at the time that a project application is approved, section 401(h) would provide that the Federal share of the project would be the amount determined under them.

If a State plan did not contain such standards, the Federal share would be the proportion of project cost established by the State agency for all projects in the State. This cost could not be less than 45 percent; nor more than the lower of 75 percent or the "Federal percentage." The Federal percentage for a State, determined by the Secretary between July 1 and August 31 of each even-numbered year on the basis of data for the three most recent consecutive years for which such data are available from the Department of Commerce, would be determined as follows: The ratio of the per capita income of the State (as numerator) to the per capita income of the 50 States and the District of Columbia (as denominator) would be multiplied by 40 percent. The resulting percentage would then be subtracted from 100 percent to arrive at the Federal percentage. The Federal percentage for Puerto Rico, Guam, American Samoa, and the Virgin Islands would be fixed at 75 percent.

Section 403. Payments for construction

This section would direct the Secretary to make payments from a State allotment, under part C of title I or part A of title II of the bill, upon appropriate certification by the State agency that a payment is due by reason of work performed or purchases made. Payments would be made to the State, or would be made directly to the applicant if the State were not authorized by law to make such payments. Payment could be withheld, upon notice of opportunity for hearing, if the Secretary had reason to believe that action under section 136 or 206 (withholding of payments) were required. In cases in which an amendment to an approved application is approved, or the estimated project cost is revised, additional payments may be made from the applicable State allotment for the fiscal year in which such amendment or revision is approved.

Section 404. Judicial review

This section would provide for judicial review of the Secretary's refusal to approve any project application under section 135 or 205, or to approve a State plan (sec. 134(b) or 204(b)), or of his action withholding payments (sec. 136 or 206), by filing a petition with the U.S. court of appeals for the circuit in which the State is located within 60 days after the action. The court would have jurisdiction to affirm the Secretary's action or to set it aside, in whole or in part. The findings of the Secretary as to the facts, if supported by substantial evidence, would be conclusive, although the court could remand the case to the

Secretary for the taking of further evidence. The judgment of the court would be subject to final review by the Supreme Court on certiorari or certification. Commencement of judicial proceedings, however, would not operate as a stay of the Secretary's action in the absence of a court order to that effect.

Section 405. Recovery

Under this section, the United States would be entitled to recover the value of its interest in a facility for the mentally retarded or a community mental health center if, within 20 years after the completion of construction, the facility or center were transferred to an agency not qualified to file a project application under section 135 or 205 (i.e., other than the State or a political subdivision, or a public or other nonprofit agency), or an agency not approved as a transferee by the applicable State agency or the facility ceased to be a public or nonprofit facility for the mentally retarded or community mental health center, subject to such exceptions, in the case of the latter contingency, as might be made by the Secretary, in accordance with regulations, for good cause. The amount recoverable would be a proportion of the then value of so much of the facility or center as had constituted an approved project. This proportion would be equal to the ratio that the amount of the Federal participation in the project bore to the cost of the project.

Section 406. State control of operations

This section would bar Federal officials from exercising any supervision or control over the operation of any facility for the mentally retarded or community mental health center aided under the bill, except as otherwise specifically provided.

Section 407. Conforming amendment

This section would enlarge the Federal Hospital Council, established by section 633(b) of the Public Health Service Act, from 8 to 12 members. The additional four members would be equally divided between professional or expert personnel and representatives of consumers. One of the six professional persons would be required to be an authority in matters relating to the mentally retarded, and one an authority in matters relating to mental health, and, as at present, three would be required to be authorities on the operation of medical facilities. Terms of the four additional members who first take office under the bill would be staggered between 1 and 4 years.

Mr. HARRIS. I want copies, Mr. Clerk, of that analysis made available to every member of this committee today, not just the subcommittee. I want a copy delivered to the offices of the members who are not in attendance today for their information.

In addition to that, it was indicated at the meeting that certain other information was desired for the benefit of the members, including a statement as to the relationship of S. 1576 to other elements of the administration's mental retardation program.

That has to do with other proposals which have been introduced on this program and referred to other committees.

At my request, Mr. Jones, your agency has a prepared a brief statement on this relationship having to do with the part of the program that went to other committees, and particularly the program that went to the Ways and Means Committee. For the record that relationship will be established, and I ask that it be included in the record at this point.

Mr. ROBERTS. Without objection.

(The document referred to follows:)

STATEMENT OF THE RELATIONSHIP OF S. 1576 TO OTHER ELEMENTS OF THE ADMINISTRATION'S MENTAL RETARDATION PROGRAM

The legislative proposals in the administration's mental retardation program are contained in four bills now pending in Congress, as follows:

S. 1576, "Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963."

H.R. 3386 and S. 1072, "Maternal and Child Health and Mental Retardation Planning Amendments of 1963."
H.R. 5194 and S. 968, "Vocational Rehabilitation Act Amendments of 1963."
H.R. 3000 and S. 580, "National Education Improvement Act of 1963."

S. 1576

S. 1576 contains those aspects of the administration's program to combat mental retardation that relate to (1) the construction of research centers, university-affiliated clinical facilities, and facilities for the mentally retarded; and (2) the training of teachers of mentally retarded and other handicapped children. (A section-by-section analysis of S. 1576 is contained in a separate statement.)

H.R. 3386

The provisions of H.R. 3386 are directed to preventing mental retardation by extending maternity and infant care and by increasing and improving maternal and child health services. The bill also would authorize grants to assist the States in planning comprehensive action to combat mental retardation.

More specifically, the bill would amend the Social Security Act by (1) raising, over a period of years, the present appropriation ceilings on the maternal and child health and crippled children's programs from $25 to $50 million on each program; (2) authorize project grants for research needed to improve maternal and child health and child health services; and (3) authorize project grants to provide care to prospective mothers and their babies in high risk, low income categories who are unlikely to receive necessary health care.

The planning funds would help the States take necessary steps leading to State and community action, including measures to insure coordinatin of services, such as those related to education, employment, rehabilitation, welfare, health, and residential institutions.

H.R. 5194

This bill would amend the Vocational Rehabilitation Act to assist in providing more flexibility in the financing and administration of State rehabilitation programs and to assist in expansion of services and facilities provided under such programs, particularly for groups presenting special vocational rehabilitation problems.

Especially pertinent to the rehabilitation of mentally retarded persons are the provisions of the bill that would (1) authorize Federal assistance to plan, build, equip, and initially staff rehabilitation facilities and workshops; and (2) extend the period of time to 18 months that a vocational rehabilitation agency might be allowed to establish the vocational rehabilitation potential of persons with certain designated disabilities.

H.R. 3000

The provisions of H.R. 3000 (title V) on the training of teachers of handicapped children and on research and demonstration projects in the education of handicapped children, have been incorporated in S. 1576.

H.R. 3000 (title IV) also provides funds for projects designed (1) to improve educational quality or opportunity in public elementary and secondary education through meeting more effectively the special education needs of educationally deprived children in slums or similarly depressed urban or rural areas; and (2) to impove or develop progams designed to meet the special education needs of mentally retarded and other handicapped children.

Other

In addition to the measures summarized above, the mental retardation program includes a number of proposals to strengthen and extend research, training, and other activities authorized under existing legislation. These additions were provided for in the President's budget for fiscal year 1964 and are now under consideration before the Appropriations Committees.

Mr. HARRIS. In addition thereto, Mr. Chairman, the question was raised by certain members of the committee, on which they desired more information, as to how much NIH is now doing in the field of mental health and retardation under existing authority and also what can be done in Senate bill 1576 that cannot be done under the present law.

That included staffing needs and whether or not there were precedents. You have discussed that very thoroughly this morning. It was asked that the existing authority on all these programs be gone into and made available for the record.

In view of these inquiries I have asked the Department to prepare information, in order that we may have it for the record, on these subjects. Pursuant to that request I have, Mr. Chairman, a rather detailed statement on the current mental health programs of the Department of Health, Education, and Welfare as of July 1963 which includes a table of contents and a discussion of these various programs, an explanation of the authorization for the programs, the budget of the programs for fiscal 1963 and fiscal 1964, and the relationship of each one of these programs to S. 1576.

This statement contains a rather detailed discussion and information as to what the present situation is and its relationship to this program, and I ask that this be included in the record for the benefit of the committee and the House.

Mr. ROBERTS. Without objection, it will be included.

(The document referred to follows:)

CURRENT MENTAL HEALTH PROBLEMS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, JULY 1963

I. MENTAL HEALTH RESEARCH

A. INTRAMURAL RESEARCH

1. Description of program

The intramural research program is conducted by staff of the National Institute of Mental Health primarily in Bethesda, Md., but also at the Clinical Neuropharmacology Research Center at St. Elizabeths Hospital in Washington, D.C., and at the Addiction Research Center in the PHS Hospital in Lexington, Ky.

The primary areas of investigation in basic research include studies of the structure, function, and metabolism of the central nervous system. The Addiction Research Center is particularly concerned with basic studies in the pharmacological aspects of drug addiction.

Clinical studies include the behavioral capacities of the aging, fundamental characteristics of perception and learning, the various aspects of schizophrenia, the influence of family interaction on the individual family members, and the relationship of parent behavior to child behavior.

2. Statutory authority

Section 301 of the Public Health Service Act directs the Surgeon General to "conduct in the Service * * * research, investigations, experiments, demonstrations, and studies relating to the causes, diagnosis, treatment, control, and prevention of physical and mental diseases and impairments of man, * * *"

3. Funds

Estimated obligations for 1963, $10,222,000.
President's budget for 1964, $10,608,000.

4. Relationship to provisions of S. 1576

There is no direct relationship.

B. RESEARCH GRANTS

1. Description of program

Grants are made to universities, hospitals, laboratories, and other public or private nonprofit organizations and are usually made in the name of a principal investigator. Grants are approved only after review of a research proposal by a study section comprised of scientists who are experts in the particular field of inquiry and upon recommendation of the National Advisory Mental Health Council.

In addition, a proportion of the research grant funds available to the NIMH is transferred, along with funds appropriated to other institutes of the NIH, to a fund from which grants are made to universities and other research institutions for the general support of their research and research training programs. Such grants differ from project grants in that the institution makes the judgment on the particular research and research training activities to be supported with a general research support grant.

2. Statutory authority

Section 301(d), Public Health Service Act, authorizes the Surgeon General, on recommendation of the appropriate advisory council, to "make grants-in-aid to * * * public or private institutions, and to individuals for * * * research projects" relating to "the causes, diagnosis, treatment, control and prevention of physical and mental diseases and impairments of man * * *."

3. Funds

Estimated obligations for 1963, $41,714,000.
President's budget for 1964, $53,565,000.

4. Relationship to provisions of S. 1576

There is no direct relationship, except that section 302(a) of the bill authorizes research project grants relating to the education of emotionally disturbed children.

C. COLLABORATIVE STUDIES

1. Description of program

The term "collaborative studies" refers to research and related activities which are initiated by the National Institute of Mental Health, but which may be carried out either by staff of the Institute or by outside scientists through grants or contracts or by a combination of these mechanisms. The specific program areas follow:

(*a*) Biometrics research: This includes: (1) the collecting, processing, and analyzing of data on the extent of the problem of mental disorders as reflected by statistical data on patients under treatment in mental hospitals, general hospitals with psychiatric facilities, outpatient psychiatric facilities and other community mental health programs; (2) consultative statistical services to State mental health and hospital authorities; and (3) mathematical and statistical guidance to research investigators.

(*b*) Mental Health Study Center: Located at Adelphi in Prince Georges County, Md., the Study Center provides a setting for NIMH staff to cooperate with various agencies and groups in the county concerned with mental health. The Center is concerned with research on various community mental health services and problems. The Center also functions as a pilot mental health unit concerned with the demonstration and evaluation of various mental health programs.

(*c*) Psychopharmacology Service Center: The Center helps to stimulate research concerning the psychoactive drugs, including tranquilizers and energizers. It also issues technical information and provides consultative services to investigators in this field.

2. Statutory authority

Section 301, Public Health Service Act, directs the Surgeon General to conduct in the Service, and "encourage, cooperate with, and render assistance to other appropriate public authorities, scientific institutions, and scientists in the conduct of, * * * research, investigations, * * * and studies relating to the causes, diagnosis, treatment, control, and prevention of physical and mental diseases and impairments of man * * *."

3. Funds

Estimated obligations for 1963, $3,842,000.
President's budget for 1964, $4,363,000.

4. Relationship to provisions of S. 1576

While there is no direct relationship, the data provided through the biometrics program will be of considerable importance in terms of the incidence and prevalence of mental illness. The experience of the Study Center will be of considerable value in the development of community mental health programs.

II. Training of Mental Health Personnel

A. INTRAMURAL TRAINING

1. Description of program

In the field of mental health the principal emphasis of the PHS intramural training activities is centered in the PHS career development program for psychiatrists. This program, comprising residency training, clinical or research training and experience, limited staff assignment, and postgraduate subspecialty training, is designed to provide the PHS with an adequately trained pool of career medical officers in psychiatry. There is great need for such well-trained psychiatrists throughout the PHS—from the Divisions of Foreign Quarantine, Indian Health, Hospital, Accident Prevention, and International Health to the Coast Guard, the Bureau of Prisons, and the basic research programs in the NIMH.

2. Statutory authority

The Public Health Service Act authorizes the Surgeon General to provide training and instruction in the diseases relating to mental health (sec. 303(a)(1)), and neurological disorders (sec. 433(a)), and with respect to diseases relating to child health and human development (sec. 444). In addition, section 218 of the act authorizes use of appropriated funds for tuition, fees, pay, and allowances of commissioned officers receiving training at any Federal or non-Federal eductional institution. Noncommissioned personnel may also be trained under the authority of the Government Employees Training Act, Public Law 85-507 (5 U.S.C. 2301 et seq.).

3. Funds

Estimated obligations for 1963, $596,000.
President's budget for 1964, $1,001,000.

4. Relationship to provisions of S. 1576

There is no direct relationship.

B. GRANTS TO TRAINING INSTITUTIONS

1. Description of program

The NIMH supports mental health training in two ways: first, by making grants to training institutions (which in turn support both teaching and student costs); and second, by making direct grants awards to promising students. The latter, entitled "Research Fellowships," will be discussed under section C.

The major portion of the mental health training program falls within the category of regular graduate training. This includes graduate training in psychiatry, psychology, social work, and psychiatric nursing, as well as pilot projects and training in public health as related to mental health. It also includes research training—as distinguished from the above-mentioned programs in which there is such an integral relationship between service and research training that it is not possible to separate out the research component. Another segment of this program is the training of general practitioners in psychiatry. This latter program was initiated in 1959 to fill a critical need for additional psychiatrists and to provide a mechanism for increasing the psychiatric skills of general practitioners and other nonpsychiatric physicians.

The undergraduate program has consisted primarily of providing funds for teaching support to departments of psychiatry in schools of medicine and support for undergraduate psychiatric nursing teaching in collegiate schools of nursing. In addition, funds have been available for part-time student stipends for medical students to pursue extracurricular activities in psychiatry, and for teaching programs in human behavior in medical schools.

2. Statutory authority

Section 433(a) of the Public Health Service Act, which pertains to the functions of the several institutes established under part IV of the act, authorizes grants to public or other nonprofit institutions to provide training in matters relating to the diagnosis, prevention and treatment of diseases to which the activities of the institute are directed.

3. Funds

1963 estimated obligations, $49,373,000.
1964 President's budget, $62,744,000.

4. Relationship to provisions of S. 1576

While there is no direct relationship, the additional demands for professional manpower that will result from expanded community mental health programs will give new emphasis and significance to the training programs supported through the NIMH.

C. RESEARCH FELLOWSHIPS

1. Description of program

The overall program is designed to support the training of an increasing number of scientists for research on the problems of mental illness, and can be divided into four major areas:

(*a*) The biological bases of mental illness.
(*b*) The psychiatric and psychological study of mental illness.
(*c*) The social and community aspects of mental illness.
(*d*) The basic psychological processes.

2. Statutory authority

Section 301(c), Public Health Service Act, authorizes the Surgeon General to establish research fellowships with respect to any of the physical or mental diseases or impairments of man. In addition, under section 301(d) of the act, the Surgeon General may make grants for research training projects as to any such disease or impairment, and may, under section 433(a) provide for research fellowships by making grants to public or other private nonprofit institutions.

3. Funds

1963 estimated obligations, $5,940,000.
1964 President's budget, $8,534,000.

4. Relationship to provisions of S. 1576

There is no direct relationship.

III. Stimulation or Support of State and Community Mental Health Programs

A. FORMULA GRANTS TO STATES

1. Description of program

One of the categorical formula grants to the States made under the general authority and limitations of section 314(c) of the Public Health Service Act is a grant for State and community mental health activities. While there is considerable variation among the States in the purposes for which such grant funds have been used, they include three principal categories. The first is partial support for the staffing and program of the State mental health agency—including advice and assistance to local agencies and mental health education and consultation with other agencies concerned with mental health problems. The second is the stimulation and partial support of community mental health programs within the State, including demonstrations or pilot programs to develop new or improved methods of preventing or treating mental illness. These grant funds are not available, however, for inpatient care and treatment of the mentally ill in mental health institutions.

The third major use of these grant funds is for a special program initiated in fiscal year 1963, when $4.2 million of the funds appropriated for the formula grants were made available to the States for the planning of comprehensive mental health programs. These funds are being used primarily for the expenses of planning staffs and advisory groups and for various contracts connected with the planning process.

2. Statutory authority

Ending with the fiscal year 1966, section 314(c), Public Health Service Act, authorizes an annual appropriation of a maximum of $50 million to be used in part by the Surgeon General for allotment by formula among the States for establishing and maintaining adequate public health services. These include services in the field of mental health to the extent provided in State plans submitted pursuant to section 314(g) by the mental health authority of the

State and approved by the Surgeon General. Section 314(c) also provides for earmarking by appropriation act a portion of the total authorized for a particular purpose. (For fiscal year 1963 Congress, in appropriating for mental health activities under section 314(c), included a sum of $4,200,000 for allotment to the States for developing comprehensive mental health plans.)

3. Funds

	1963 estimated obligations	1964 President's budget
State and community mental health programs	$6,750,000	$6,750,000
Preparation of State plans for community mental health services	4,200,000	4,200,000
Total	10,950,000	10,950,000

4. Relationship to provision of S. 1576

This grant program has a threefold relationship to the mental health provisions (title II) of S. 1576:

(a) The grant funds specifically allotted to the States for the preparation of comprehensive mental health plans will have a direct and supportive relationship to the grants for community mental health centers authorized by title II. Among the principal objectives of the planning grants will be the development of fundamental data needed for statewide plans relating to community mental health facilities required by title II, part A, of S. 1576.

(b) The development of the community based mental health programs pursuant to title II will give new emphasis to the consultative and advisory services of State mental health agencies. No grant funds for this purpose are authorized by S 1576, but the existing formula grants to the States will help to insure that adequate supportive and advisory services will be available through the State mental health agencies.

(c) In awarding and determining the amount of an initial staffing grant under S. 1576, account will be taken of all other sources of revenue available for the same purpose, including any funds derived from formula grants under section 314(c) of the Public Health Service Act.

B. PROJECTS GRANTS FOR EXPERIMENTS AND DEMONSTRATIONS RELATING TO IMPROVED MENTAL HEALTH METHODS

1. Description of program

In addition to the mental health formula grants, there is a program of direct Federal project grants to State or local agencies, laboratories and other institutions or individuals for investigations, demonstrations, and studies leading to the development and establishment of improved methods for the diagnosis, care, treatment, and rehabilitation of the mentally ill. About 350 such projects are currently being supported, including a number of projects in such specialized fields as delinquency, alcoholism, narcotic addiction, suicide, and industrial mental health. The majority of these project grants have been awarded to hospitals, colleges and universities, and private nonprofit agencies, rather than to State and local mental health agencies.

2. Statutory authority

Section 303(a)(2), Public Health Service Act, authorizes the Surgeon General upon recommendation of the National Advisory Mental Health Council, to make project grants to State and local agencies and other nonprofit institutions for demonstrations with respect to improved methods for diagnosing mental illness and for the care, treatment and rehabilitation of the mentally ill.

3. Funds

1963 estimated obligations, $14,700,000.
1964 President's budget, $15,000,000.

4. Relationship to provisions of S. 1576

While there is some overlapping in the activities aided by these project grants and those of the initial staffing grants authorized under part B, title II, of S. 1576, the emphasis of the two grant programs will be quite different.

Project grants under section 303 of the Public Health Service Act will be used to develop and test new program methods, while initial staffing grants under S. 1576 will help communities to establish these tested methods in comprehensive community-based programs.

C. PROJECT GRANTS FOR DEMONSTRATION AND ESTABLISHMENT OF IMPROVED METHODS IN STATE MENTAL INSTITUTIONS

1. Description of program

Under the general authority for the program of mental health project grants authorized by section 303 of the Public Health Service Act, the President's budget for fiscal 1964 includes funds to inaugurate a special program of project grants for the purpose of developing, demonstrating, and establishing improved methods of care and treatment in State mental institutions.

Grants would be awarded for projects for improving the quality of patient care, strengthening therapeutic services, encouraging the transition to open institutions, and developing relationships with community mental health programs. Project grants would also be awarded for related inservice training of State mental hospital authority and would be competitive with other applications, except that it is anticipated that a least one project will be supported in each State in 1964.

2. Statutory authority

Section 303(a)(2), Public Health Service Act, specifically authorizes "grants to State agencies responsible for the 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 such institutions."

3. Funds

1963 estimated obligations, none.
1964 President's budget, $15,400,000.

4. Relationship to provisions of S. 1576

Grants under this program would be made only to State mental institutions, while initial staffing grants under S. 1576 would be made only to community mental health centers. In the exceptional case where a portion of a State mental hospital constitutes an element or community mental health center, the initial staffing grant under S. 1576 would be limited to that portion.

D. PROFESSIONAL AND TECHNICAL ASSISTANCE

1. Description of program

This activity can be divided into three major areas:

(*a*) Research utilization activities: A special staff in the central office of the NIMH is responsible in broad terms for assuring that research findings and new techniques in mental health are translated into State and community programs. They provide consultative services to States, stimulate and review applications for mental health project grants (discussed under III B), sponsor technical assistance projects, and survey State programs.

(*b*) Regional office staffs: These staffs are located in the DHEW regional offices throughout the Nation. They are administratively responsible to the regional health director and receive professional and technical guidance from the National Institute of Mental Health. They provide a wide range of consultative services to the States and are the primary point of contact with State programs.

(*c*) National Clearinghouse for Mental Health Information: This newly established organization (October 1962) is responsible for the collection, storage, abstracting, indexing, retrieving, and disseminating of all information relevant to mental health. Thus, it will provide a major resource to the States, localities, the Federal agencies, private agencies, and the scientific community concerning the latest developments in the field of mental health.

2. Statutory authority

Section 311, Public Health Service Act, authorizes the Surgeon General to assist States and localities in establishing and maintaining public health services, including mental health services, as provided in section 314(c), and to advise States and localities on any matters relating to the preservation and improvement of the public health. Section 214(b), Public Health Service Act, authorizes the

detail of PHS personnel to States on the request of the State mental health authority, and section 301 of the act directs the Surgeon General to assist any public authority in the conduct of research or demonstrations relating to the cause, treatment, control, or prevention of any disease or impairment of man.

3. Funds

1963 estimated obligations, $2,926,000.
1964 President's budget, $3,998,000.

4. Relationship to provisions of S. 1576

While there is no direct relationship, the professional and technical assistance staffs would be significantly involved in the administration of the programs proposed in the bill.

IV. Financial Aid for the Construction of Mental Health Facilities

A. Mental health research facilities

1. Description of the program

While there is no Federal grant program directed specifically toward the construction of mental health research facilities, such facilities are eligible for grants under the broader health research facilities construction grant program administered by the Public Health Service since 1956.

Of the $230 million appropriated for this program through 1963, approximately $12.6 million has been expended or obligated for facilities devoted exclusively to mental health. In addition, research relevant to mental health is conducted in many of the multipurpose research facilities constructed under this program.

2. Statutory authority

Within the limit of a $50 million annual appropriation authorization ending with fiscal year 1966, title VII of the Public Health Service Act authorizes grants to meet up to 50 percent of the cost of construction of facilities operated by qualified public or other nonprofit private institutions for research in "the sciences related to health." Grants are awarded by the Surgeon General upon recommendation of the National Advisory Council on Health Research Facilities.

3. Funds

It is not possible to identify or estimate in advance the proportion of the total grant funds available which will be awarded for mental health research facilities.

4. Relationship to provisions of S. 1576

There is no direct relationship, since S. 1576 does not include any new authority for the construction or staffing of mental health research facilities.

B. State and community hospitals and related medical care facilities

1. Description of program

Construction grants for certain kinds of State and local mental health facilities can and have been made under the hospital and medical facilities construction grant program (the "Hill-Burton" program) administered by the Public Health Service. From the beginning of the program (1947) through fiscal 1962, Federal grants have helped to build about 17,500 beds in mental hospitals and have added nearly 7,000 psychiatric beds in general community hospitals. In addition, some grant awards have been made from categorical grant funds (chronic disease hospitals, diagnostic or treatment centers, nursing homes, and rehabilitation centers) for facilities designed in whole or in part for mental patients.

No grant funds under this program are specifically earmarked for mental health facilities, and over the life of the program only about 3 percent of the grant funds appropriated have been awarded for such facilities.

2. Statutory authority

Title VI of the PHS Act authorizes for each fiscal year ending with fiscal year 1964 appropriations in several categories for allotment by formula among the States to be used to meet from one-third to two-thirds the cost of construction of public or private, nonprofit, State or community medical facilities. The categories include $150 million for hospitals, public health centers and related facilities; $20 million for diagnostic and treatment centers; $20 million for hospitals

for the chronically ill and impaired; $10 million for rehabilitation facilities; and $20 million for nursing homes providing skilled nursing care and related medical services. While there is no categorical authorization for mental health facilities, facilities related to the care of the mentally ill would be eligible under each of these categories if found by the State to have priority over other eligible applicants within the State. Title VI also authorizes (sec. 636) project grants for the construction of experimental hospital and related facilities, but to date no such grants have been made for mental health facilities.

3. Funds

It is not possible to project the portion of the funds which will be used for mental health facilities. The only basis for any such projection is the inference, roughly 3 percent of the total funds available in this program have been used for this purpose.

4. Relationship to provisions of S. 1576

There is some overlapping in the eligibility provisions for construction grants under the Hill-Burton program and for grants under title II, part A of S. 1576. This overlapping is more apparent than real, however. Even in the absence of construction grant aid from any other source, only about 3 percent of the Hill-Burton grant funds have gone to build mental health facilities. With a grant program specifically designed for this purpose, few if any Hill-Burton grants for community mental health facilities are anticipated in future years. Assuming some extension of the Hill-Burton grant authorizations beyond their present expiration date of June 30, 1964, it is anticipated that mental health facility grants under this program would be limited to: (*a*) grants for the expansion or improvement of State mental hospitals (which would not be eligible for grants under S. 1576) and (*b*) grants for a general community medical care facility (hospital, diagnostic center, etc.) which may provide some services for mentally ill persons but is not planned especially or exclusively for such services.

Since the Hill-Burton program is limited to construction grants, there is no overlapping whatsoever with the initial staffing grant provisions in title II. part B, of S. 1576.

V. Direct Operation of Care and Treatment Program for the Mentally Ill

A. PHS HOSPITALS

1. Description of program

Seven of the fifteen PHS hospitals provide some psychiatric services. Two of the seven, one at Lexington, Ky., and the other at Fort Worth, Tex., are exclusively devoted to the treatment of drug addiction and neuropsychiatric disorders. The other five are general hospitals which have psychiatric services—in Baltimore, New Orleans, San Francisco, Seattle, and New York City (Staten Island).

The two neuropsychiatric hospitals are devoted almost exclusively to the treatment of drug addicts. Both provide valuable training opportunities for PHS physicians.

Also located at the Lexington hospital is the Addiction Research Center of the NIMH in which scientists investigate the addiction properties of new pain-relieving drugs and the psychological causes and effects of drug addiction.

2. Statutory authority

Under sections 321 and 322, PHS Act, the Surgeon General is directed to provide medical treatment and hospitalization to certain classes of beneficiaries (such as seamen on American vessels). This includes hospitalization for mental illness (sec. 504, PHS Act). In addition, the Surgeon General provides care for mentally ill Indians in Service facilities and elsewhere, a responsibility transferred from the Department of the Interior by PL 568, 83d Congress. The Service maintains two special hospitals, one at Lexington, Ky., and one at Fort Worth, Tex., for the care of the mentally ill and also for narcotic addicts pursuant to the provisions of sections 341 to 344 of the PHS Act.

3. Funds

PHS neuropsychiatric hospitals:

1963 estimated obligations, $7,512,000.
1964 President's budget, $7,600,000.

4. Relationship to provisions of S. 1576

None.

B. ST. ELIZABETHS HOSPITAL

1. Description of program

St. Elizabeths Hospital provides care and treatment for the mentally ill, trains personnel in the medical, nursing, and associated disciplines concerned with the treatment of psychiatric patients, and conducts or cooperates with others in scientific research activities dealing with mental illness. The patient load consists of residents of the District of Columbia and beneficiaries of the Federal Government, both direct and reimbursable.

2. Statutory authority

St. Elizabeths Hospital in the District of Columbia was established for the most humane care and enlightened curative treatment of the insane by the act of March 3, 1855, Revised Statutes 4838 (10 Stat. 602). It was transferred from the Department of the Interior to the Federal Security Administrator by Reorganization Plan IV, April 1940, and to the Department of Health, Education, and Welfare by 1953 Reorganization Plan I.

3. Funds

1963 estimated appropriations, $6,332,000.
1964 President's budget, $9,716,000.

4. Relationship to provisions of S. 1576

There is no relationship, except insofar as St. Elizabeths might serve as a model for one type of comprehensive community mental health center, i.e., one affiliated with an established mental hospital.

VI. MENTAL HEALTH RELATED ACTIVITIES IN THE VOCATIONAL REHABILITATION ADMINISTRATION

1. Description of program

Services to disabled individuals in the nationwide program are provided by State vocational rehabilitation agencies, with financial and technical aid from the Federal Government. Such services, including those for psychiatrically disabled, are furnished by all States and territories of the United States.

(*a*) Special services: Rehabilitation services for the mentally ill patient, which often begin in the mental hospital, includes psychiatric diagnosis and treatment, training when indicated, placement in a job in keeping with his mental capacity, and followup to make sure that both the patient and his employer are satisfied. A majority of State agencies employ consulting psychiatrists on a part-time basis to assist in planning for and working with mentally ill persons.

(*b*) Research into mental and personality disorders: Fifty-nine research and demonstration projects have been approved by Vocational Rehabilitation Administration, to explore new methods or patterns of services which will assist in the vocational rehabilitation of persons handicapped by mental or emotional disorders (as distinct from problems of retardation).

(*c*) Training of personnel: Vocational Rehabilitation Administration has been appropriated funds authorized for the training of professional personnel, in which there is a shortage in the expanding rehabilitation program. The use of these funds is effecting increases in the number of specially trained counselors, and making training possible in those aspects to medicine, nursing, occupational and physical therapy, social work, and related fields all of which have a bearing on vocational rehabilitation of handicapped persons, including the mentally disabled. In addition, short-term training courses are held for vocational rehabilitation counselors as well as for personnel from other agencies and institutions working with the mentally ill and retarded.

2. Statutory authority

The authority for these programs and activities is found in the Vocational Rehabilitation Act, as amended, sections 2, 3, 4, and 7; 29 U.S.C. 32, 33, 34, and 37.

3. Funds

Information presently available does not permit separate identification of funds for mentally handicapped persons.

4. Relationship to the provisions of S. 1576

There is no direct relationship.

Mr. HARRIS. Furthermore, I requested the same information with reference to the current mental retardation programs of the Department of Health, Education, and Welfare. This statement, which has a July 1963 date, is a rather elaborate, detailed analysis of what the present programs are.

The table of contents makes it very easy for members of the committee to find a particular program in which they might be interested, a brief explanation of it, together with the relationship to the provisions of S. 1576.

This is detailed information which I think has been very elaborately prepared for us in order to meet the request of the members of the committee for full and complete, detailed information as to what is the existing situation and its relationship to the proposal here, and I ask that this be included in the record.

Mr. ROBERTS. Without objection, it will be included.

(The document referred to follows:)

CURRENT MENTAL RETARDATION PROGRAMS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

I. RESEARCH

A. INTRAMURAL RESEARCH

1. *Program description.*—Intramural research activities form an integral part of the total mental retardation programs of the PHS, VRA, and OOE. In each instance the nature of the research is in keeping with the program responsibilities of each agency.

Statutory authority:

PHS: Section 301 of the PHS Act directs the Surgeon General to "conduct in the Service, * * * research, investigations, experiments, demonstrations, and studies relating to the causes, diagnosis, treatment, control, and prevention of physical and mental diseases and impairments of man. * * *."

VRA: Section 7(a) of the Vocational Rehabilitation Act provides that, in carrying out his duties under the act, the Secretary shall "make studies, investigations, demonstrations, and reports with respect to abilities, aptitudes, and capacities of * * * handicapped individuals, development of their potentials, and their utilization in gainful and suitable employment."

OOE: The law establishing the Office of Education (39th Cong., 14 Stat. 434, 20 U.S.C. 1) provides that the purpose and duties of the Office "shall be to collect statistics and facts showing the condition and progress of education in the several States and territories, and to diffuse such information respecting the organization and management of schools and school systems, and methods of teaching, as shall aid the people of the United States in the establishment and maintenance of efficient school systems, and otherwise maintenance of efficient school systems, and otherwise promote the cause of education throughout the country."

Data are not readily available on the funds for intramural mental retardation research.

Relationship to provisions of S. 1576: This activity is a part of the Department's total mental retardation program, but does not relate specifically to the provisions of S. 1576.

B. RESEARCH GRANTS

1. *Program description.*—Research grants program of the National Institute of Neurological Diseases and Blindness.

This program is designed to stimulate and support scientific investigations in the neurological, sensory, communicative, and related fields.

Awards for research are made by the National Institute of Neurological Diseases and Blindness to an institution on behalf of an individual. Awards are made following review and recommendation of approval of an application by the Advisory Council of the National Institute of Neurological Diseases and Blindness.

The program supports research concerned with the cause, development, diagnosis, therapy, and prevention of such disorders as: multiple sclerosis, cerebrovascular diseases, epilepsy, muscular dystrophy, cerebral palsy, mental retardation, encephalitis, glaucoma, cataract, diabetic rectinopathy, Meniere's syndrome, aphasia, otosclerosis, and other disorders of the nervous system, vision, hearing, equilibrium, and speech.

Support is given for basic research as well as clinical studies. Areas of basic science support include neuronatomy, neurochemistry, neuropathology, epidemiology, neuropharmocology, neurophysiology, neuroradiology, sensory physiology, psychology, physics, and related disciplines.

Statutory authority: Section 301(d), PHS, authorizes the Surgeon General, on recommendation of the appropriate advisory council, to "make grants-in-aid to * * * public or private institutions, and to individuals for * * * research projects" relating to the causes, diagnosis, treatment, control, and prevention of physical and mental diseases and impairment of man."

Funds: 1963 appropriation, $49,754,000; 1964 budget, $58,537,000.

Relationship to provisions of S. 1576: This activity is a part of the Department's total mental retardation program, but does not relate specifically to the provisions of S. 1576.

2. *Program description.*—Research grants program of the National Institute of Child Health and Human Development.

To stimulate and support scientific investigations in child health and human development, including special health problems and requirements and in the basic sciences relating to processes of human growth and development.

Statutory authority: Section 301(d), Public Health Service Act, authorizes the Surgeon General, on recommendation of the appropriate advisory council to "make grants-in-aid to * * * public or private institutions, and to individuals for * * * research projects" relating to the causes, diagnosis, treatment, control and prevention of physical and mental diseases and impairments of man."

Funds, 1964 budget: $23,200,000. (Of this amount, it is estimated that $2,200,000 will be used to support research in the area of mental retardation.)

Relationship to provisions of S. 1576: This activity is a part of the Department's total mental retardation program, but does not relate specifically to the provisions of S. 1576.

3. *Program description.*—Research and experimentation in more effective utilization of television, radio, motion pictures, and related media for educational purposes (administering agency, Office of Education).

Under this program the Commissioner of Education is authorized (1) through grants-in-aid or contracts to conduct, assist, and foster research and experimentation in the educational uses of new communications media, such as motion pictures, video tapes, filmstrips, slides, recordings, radio or television program scripts; and (2) either directly, using Office of Education personnel, or by contracts to disseminate information concerning these new media to State and local public school systems and to colleges and universities.

Grants-in-aid are used to support proposals initiated, developed, and submitted by "public or nonprofit private agencies, organizations, and individuals." Contracts are used for the conduct of research and experimentation originated by the Office of Education, such contracts being awarded to "public or private agencies, organizations, groups, and individuals." All requests for grants-in-aid and proposals for contracts for projects of research and experimentation must be approved by the Advisory Committee on New Educational Media, established by law, before awards are made by the Commissioner of Education.

Statutory authority: National Defense Education Act of 1958, as amended, Public Law 85-864, title VII, 72 Stat. 1595, 20 U.S.C. 541 et seq., Public Law 87-344, sec. 206.

Funds: 1963 appropriation, $5 million (present ceiling); 1964 budget, $5 million (present ceiling).

Relationship to provisions of S. 1576: There is some overlapping between this program and section 302 of S. 1576. The purpose of section 302 is to assure that amounts appropriated thereunder for research and demonstration projects be devoted exclusively to education of handicapped children—a purpose which cannot be achieved under the instant program where application of projects for educational media useful for these children must compete with applications covering the entire range of educational media.

4. *Program description.*—Grants for research and demonstration in vocational rehabilitation (Administering agency: Vocational Rehabilitation Agency).

This is a program of grants to States and to public and private nonprofit agencies to pay part of the cost of research, demonstrations, and the establishment of special facilities and services which hold promise of making a contribution to the solution of vocational rehabilitation problems common to all or several States. It is the purpose of this grant program to thereby improve and expand the Nation's public and private programs for the vocational rehabilitation of the disabled, including the mentally retarded.

Projects sponsored under this program include: research; special (regional) facilities and services; and demonstrations of new methods and those designed to provide for prompt and widespread application of knowledge and experience already acquired in the research and demonstration program.

The major objectives of these several types of grants are: (1) the development of new professional information, methods, and devices for more effectively reducing physical, psychological, and social components of disability and for evaluating, training, and placing into employment disabled persons including the extension of vocational rehabilitation services to those disabled persons with more severe disabilities for whom little could be done previously; (2) the creation of new job opportunities by demonstrating, through the use of new knowledge and methods, the capacity of disabled persons to produce under competitive conditions in jobs previously closed to them; (3) increasing the effectiveness of existing public and private programs by developing greater public understanding and increased community cooperation and financial support, through the demonstration of what can be accomplished with new methods and knowledge; (4) providing new professional information and ideas to administrators and policymakers in State agencies, thereby enabling them to acquire and apply broader perspectives and more systematic approaches to the development of State rehabilitation programs.

Statutory authority: The Vocational Rehabilitation Act, as amended, section 4 (Public Law 565, 83d Cong., 68 Stat. 655, as amended by Public Law 85–198, 71 Stat. 473–4, 29 U.S.C. 34) authorizes "grants to States and public and other nonprofit organizations and agencies * * * for paying part of the cost of projects for research, demonstrations * * * and projects for the establishment of special facilities and services, which * * * hold promise of making a substantial contribution to the solution of vocational rehabilitation problems common to all or several States."

Funds: 1963 appropriation, $25,500,000[1]; 1964 budget, $36,830,000.[1]

Relationship to provisions of S. 1576: This activity is a part of the Department's total mental retardation program but does not relate specifically to the provisions of S. 1576. While this activity may include construction of experimental or demonstration sheltered workships or rehabilitation facilities for the mentally retarded, and while such facilities may be included in the definition of "facility for the mentally retarded" at section 401(b) of S. 1576, it is unlikely that any significant portion of the appropriations available for this activity would be so used since these funds are available to promote the vocational rehabilitation of all handicapped persons. Also, S. 1576 permits use of construction funds for a workshop for the mentally retarded only if such workshop is part of a facility providing comprehensive services for the mentally retarded.

C. COLLABORATIVE RESEARCH

1. *Program description.*—Collaborative perinatal research project (Administering agency: Public Health Service, National Institute of Neurological Diseases and Blindness).

The collaborative perinatal research project has as its primary goal the discovery of clues to the causes of mental retardation, cerebral palsy, and kindred disorders of infancy and childhood. Teams of medical and allied scientists at 15 medical centers throughout the country are studying expectant mothers from early pregnancy through labor and delivery, and are examining their babies periodically from birth through school age. As analysis of the information collected reveals suspicious factors, they will be tested and their role evaluated.

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[1] These amounts include funds for both the research and demonstration and the training program in vocational rehabilitation. An estimated $1,225,000 in fiscal year 1963 was used for vocational rehabilitation research and training programs for the mentally retarded. It is estimated that $3,235,000 will be used for these purposes in fiscal year 1964.

As of October 31, 1962, some 30,500 pregnant women were enrolled in this project. Based on the present enrollment rate, the goal of 50,000 study mothers will be reached early in 1965.

Statutory authority: Section 301, Public Health Service Act, directs the Surgeon General to "encourage, cooperate with, and render assistance to other appropriate public authorities, scientific institutions, and scientists in the conduct of * * * research, investigations * * * and studies relating to the causes, diagnosis, treatment, control, and prevention of physical and mental diseases and impairments of man * * *."

Funds: 1963 appropriation, $1,986,000; 1964 budget, $2,228,000.

Relationship to provisions of S. 1576: This activity is a part of the Department's total mental retardation program but does not relate specifically to the provisions of S. 1576.

2. *Program description.*—Cooperative research program (Office of Education).

The cooperative research program is operated under the terms of Public Law 531, 83d Congress, which authorizes the Commissioner of Education to "enter into contracts or jointly financed cooperative arrangements with universities and colleges and State educational agencies for the conduct of research, surveys, and demonstrations in the field of education." The purpose of this program is to develop new knowledge about major problems in education or to devise new applications of existing knowledge in solving such problems.

Statutory authority: An act to authorize cooperative research in education, Public Law 531, 83d Congress, 68 Stat. 535, 20 U.S.C. 351–2.

Funds: 1963 appropriation, $6,985,000; 1964 budget, $17,000,000.

The initial appropriation of $1 million to the cooperative research program, authorized under Public Law 83–531 in 1957, was made available with the request that approximately two-thirds be used to support research pertaining to problems in the education of the mentally retarded. Total Federal support through fiscal year 1962 for all projects under the program has been approximately $24.5 million. About 11.4 percent, or over $4.8 million has been given for research on problems in the field of mental retardation.

Relationship to provisions of S. 1576: There is overlapping between this program and section 302 of S. 1576. The purpose of section 302 is to assure that amounts appropriated thereunder for research and demonstration projects be devoted exclusively to education of handicapped children, a purpose which cannot be achieved under the present cooperative research program where application of projects for these children must compete with applications covering the entire range of education.

II. Training of Personnel

A. Intramural training

1. *Program description.*—Intramural training activities form an integral part of the total mental retardation programs of the PHS and VRA. In each instance the nature of the training is in keeping with the program interests of each agency.

Statutory authority:

PHS: The Public Health Service Act authorizes the Surgeon General to provide training and instruction in the diseases relating to mental health (sec. 303(a)(1)), and neurological disorders (sec. 433(a)), and with respect to diseases relating to child health and human development (sec. 444). In addition, section 218 of the act authorizes use of appropriated funds for tuition, fees, pay, and allowances of commissioned officers receiving training at any Federal or non-Federal educational institution. Noncommissioned personnel may also be trained under the authority of the Government Employees' Training Act, Public Law 85–507 (5 U.S.C. 2301 et seq.).

VRA: Pursuant to section 7(a)(3) of the Vocational Rehabilitation Act, the Secretary shall, in carrying out his duties under the act, "provide short-term training and instruction in technical matters relating to vocational rehabilitation services."

Data are not readily available on funds for intramural training of personnel in fields related to mental retardation.

Relationship to provisions of S. 1576: This activity is a part of the Department's total mental retardation program, but does not relate specifically to the provisions of S. 1576.

B. GRANTS TO TRAINING INSTITUTIONS

1. *Program description.*—The graduate fellowship program in the education of mentally retarded children (administering agency, Office of Education).

The purpose of this program is to prepare promising persons for positions as (1) instructors and directors of college or university programs for the training of teachers of the mentally retarded or (2) supervisors and directors of educational programs for mentally retarded children in State and local school systems.

Statutory authority: Under Public Law 85-926 (72 Stat. 1777, as amended by Public Law 86-158, 73 Stat. 346, 20 U.S.C. 611-7) the Commissioner of Education is authorized to make grants (1) to public or other nonprofit institutions of higher learning (*a*) to assist them in providing training of professional personnel to conduct training of teachers in fields related to education of mentally retarded children and (*b*) to assist in covering the cost of courses of training or study for such personnel and for establishing and maintaining fellowships, with such stipends as may be determined by the Commissioner of Education and (2) to State educational agencies (*a*) to assist them in establishing and maintaining, directly or through grants to public or other nonprofit institutions of higher learning, fellowships or traineeships for training personnel engaged or preparing to engage in employment as teachers of mentally retarded children or as supervisors of such teachers and (*b*) to assist such institutions in meeting the costs of training such personnel.

Funds: 1963 appropriation, $1 million (present ceiling); 1964 budget, $1 million.

Relationship to provisions of S. 1576: S. 1576 would (*a*) extend authority for training to include the training of personnel to teach children with other handicapping conditions, (*b*) authorize grants for the training of teachers, supervisors, or specialists in the education of such children, and (*c*) raise the authorization ceiling to $11.5 million in fiscal year 1964; $14.5 million in fiscal year 1965 and $19.5 million in fiscal year 1966. Present authority is insufficient to permit the training of enough persons needed to teach children with handicapping conditions.

While the other training grant and research fellowship programs described in succeeding portions of this analysis would augment the number of specialists and researchers available for work in the prevention, diagnosis, treatment, rehabilitation, and care of mentally retarded and the handicapped, training grants under the instant program, as extended by title III of S. 1576, would focus on the training of teachers, supervisors, and auxiliary personnel engaged in the education of mentally retarded and other handicapped children, or in research in such education.

2. *Program description.*—National Institute of Neurological Diseases and Blindness training grants program.

Training for careers in research and training, and for careers in organized community health service and in public health is supported by the National Institute of Neurological Diseases and Blindness (NINDB) to develop teacher-investigators, scientist-physicians, and community health personnel in the neurological, sensory, communicative, and related fields.

The following types of training grants are made to institutions:

Development training grants: These grants are awarded on a competitive basis to those schools of medicine and schools of osteopathy within which there is a recognized need for the development or improvement of training programs in the broad clinical areas of neurology (medical neurology and neurological surgery), ophthalmology, and otolaryngology.

Graduate training grants: These grants are awarded on a competitive basis to institutions and organizations providing training in the disciplinary areas related to neurological, sensory, or communicative disorders. The primary objective of the NINDB graduate training grant program is the training of teacher-investigators, scientist-physicians, and community health and public health personnel in the specialty, discipline, or field for which the grant is made.

Statutory authority: Section 433(*a*), Public Health Service Act, authorizes grants to public or other nonprofit institutions to provide training in matters relating to the diagnosis, prevention, and treatment of diseases relating to mental health and of neurological disorders. Section 444 of the act provides the same grant authority with respect to child health and human development.

Funds: 1963 appropriation, $13,267,000; 1964 budget, $14,382,000. (The portions of the above amounts that are allocable to training in the area of mental retardation cannot be identified.)

Relationship to provisions of S. 1576: For relation to title III of S. 1576, see discussion under "Graduate Fellowship Program in the Education of Mentally Retarded Children," above.

3. *Program description.*—National Institute of Child Health and human development graduate training grants program.

These grants are to be awarded to institutions to assist in establishing new training programs in areas where there is a critical shortage in the supply of full trained personnel who work in the basic and clinical sciences related to child health and human development.

Statutory authority: Section 433(a), Public Health Service Act, authorizes grants to public or other nonprofit institutions to provide training in matters relating to the diagnosis, prevention, and treatment of diseases relating to mental health and of neurological disorders. Section 444 of the act provides the same grant authority with respect to child health and human development.

Funds: 1964 budget, $6,800,000. (The portion of the above amount that is allocable to training in the area of mental retardation cannot be identified.)

Relationship to provisions of S. 1576: For relation to title III of S. 1576, see discussion under "Graduate Fellowship Program in the Education of Mentally Retarded Children," above.

4. *Program description.*—Neurological and sensory disease service project grants, training projects (administering agency: Public Health Service, Bureau of State Services, neurological and sensory disease service program).

Grants are available for the training of health personnel to provide services in the neurological and sensory disease area, including undergraduate, graduate, and postgraduate training in regular academic programs and short courses, seminars, institutes (i.e., of a duration less than a regular academic session), etc., at all levels directed to the improvement of knowledge in the epidemiologic, diagnostic, therapeutic, and community service aspects of neurological and sensory disorders. This includes training of physicians and other health personnel working in programs under medical direction, such as nurses, therapists, etc.

Statutory authority: Chronic disease and health of the aged appropriation, DHEW Appropriation Act, 1963.

Funds: 1963 appropriation, $1,600,000. (An estimated $70,000 of the total appropriation was used for mental retardation training programs.)

The 1964 budget, $1,800,000. (This amount includes both community service projects and training projects within the neurological and sensory disease service project grant program. An estimated $1 million of this amount will be used for mental retardation community service and training programs.)

Relationship to provisions of S. 1576: For relation to title III of S. 1576, see discussion under "Graduate Fellowship Program in the Education of Mentally Retarded Children," above.

5. *Program description.*—Grants for training and traineeships in vocational rehabilitation (administering agency: Vocational Rehabilitation Agency).

This is a program of training grants to assist cooperating institutions to expand their resources for training personnel in all fields contributing to the rehabilitation of physically or mentally handicapped individuals. Grants are made to States, public and other nonprofit organizations, including educational institutions, to pay part of the cost of instruction (teaching grants) and traineeships (stipends to individuals). Support is also given for short-term training in technical matters relating to vocational rehabilitation services, traineeships and research fellowships.

The goals of the training program are (1) to increase the number of qualified workers now in short supply in the fields which serve disabled persons; (2) to raise the level of competence of personnel already working in rehabilitation programs; and (3) to improve the quality of both basic and advanced professional training through increased emphasis on interdisciplinary training and coordination of training resources on both community and regional levels.

Grants are now being made in the fields of rehabilitation counseling, medicine, nursing, occupational therapy, physical therapy, prosthetics and orthotics, and in other specialized areas of services.

Rehabilitation research fellowships are also awarded in order to expand and strengthen research resources through increasing the competence of research workers in the professional fields which contribute to the vocational rehabilitation of disabled individuals, including the mentally retarded.

Statutory authority: The Vocational Rehabilitation Act, as amended, authorizes, (1) under section 4 (Public Law 565, 83d Cong., 68 Stat. 655, as amended by Public Law 85-198, 71 Stat. 473-4, 29 U.S.C. 34), "grants to States and public and other nonprofit organizations and agencies * * * for paying part of the cost of projects for * * * training, and traineeships, * * * which * * * hold promise of making a substantial contribution to the solution of vocational rehabilitation problems common to all or several States" and (2) under section 7(a)(3) (Public Law 565, 83d Cong., 68 Stat. 658, as amended by Public Law 85-198, 71 Stat. 474, 29 U.S.C. 37(a)(3)), "short-term training and instruction in technical matters relating to vocational rehabilitation services, including the establishment and maintenance of * * * research fellowships and traineeships * * *".

Funds: 1963 appropriation, $25,500,000[1]; 1964 budget, $36,830,000.[1]

An estimated $1,225,000 in fiscal year 1963 was used for vocational rehabilitation research and training programs for the mentally retarded. It is estimated that $2,235,000 will be used for these purposes in fiscal year 1964.

Relationship to provisions of S. 1576: For relation to title III of S. 1576, see discussion under "Graduate Fellowship Program in the Education of Mentally Retarded Children," above.

C. RESEARCH FELLOWSHIPS

1. *Program description.*—National Institute of Neurological Diseases and blindness training grants program.

Training for careers in research and teaching, and for careers in organized community health service and in public health is supported by the National Institute of Neurological Diseases and Blindness (NINDB) to develop teacher-investigators, scientist-physicians, and community health personnel in the neurological, sensory, communicative, and related fields.

The following types of grants are made to individual scientists:

Postdoctoral fellowships: Postdoctoral fellowships provide stipend support to scientists with fewer than 3 years of postdoctoral experience who require additional research training in the disciplines related to the neurological, sensory, or communicative fields. These awards support individuals with M.D., Ph. D., or equivalent degrees who are taking training in this country or abroad.

Special fellowships: Special fellowships provide stipend support to basic or clinical scientists who desire highly specialized training in disciplines related to neurological, sensory, or communicative areas. These awards are made for research training at any institution in the United States or abroad qualified to provide the necessary facilities and guidance for the applicant. A candidate must have had at least 3 years of pertinent postdoctoral training or research experience or have completed the training requirements for a clinical specialty.

Career awards: Awards in this group are intended to provide additional stable positions for experienced investigators who are pursuing productive careers of independent research and teaching. A limited number of these awards are made on the basis of nationwide competition.

Statutory authority: Section 301(c), PHS Act, authorizes the Surgeon General to establish research fellowships with respect to any of the physical or mental diseases or impairments of man. In addition, under section 301(d) of the act, the Surgeon General may make grants for research training projects as to any such disease or impairment, and may, under sections 433(a) and 444, provide for research fellowships by making grants to public or other private nonprofit institutions with respect to mental illness, neurological disorders, and child health and human development.

Funds: 1963 appropriation, $1,986,000; 1964 budget, $2,228,000.

Relationship to provisions of S. 1576: For relation to title III of S. 1576, see discussion under "Graduate fellowship program in the education of mentally retarded children," above.

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[1] These amounts include funds for both the research and demonstration and the training program in vocational rehabilitation.

2. *Program description.*—National Institute of Child Health and Human Development fellowships and awards program.

The fellowships and awards program of the National Institute of Child Health and Human Development consists of the following areas:

Postdoctoral fellowships: To support research training of qualified scholars for research and academic careers in the basic and clinical sciences related to child health and human development and thereby increase number of trained research investigators and teachers in the field.

Special fellowships: To support advanced training of persons whose qualifications and needs make other types of fellowship support inapplicable.

Career and development awards: To increase number of stable full-time career opportunities for scientists of superior potential and capability in sciences related to child health and human development.

Statutory authority: Section 301(c), Public Health Service Act, authorizes the Surgeon General to establish research fellowships with respect to any of the physical or mental diseases or impairments of man. In addition, under section 301(d) of the act, the Surgeon General may make grants for research training projects as to any such disease or impairment, and may, under sections 433(a) and 444, provide for research fellowships by making grants to public or other private nonprofit institutions with respect to mental illness, neurological disorders, and child health and human development.

Funds: 1964 budget, $2,800,000.

Relationship to provisions of S. 1576: For relation to title III of S. 1576, see discussion under "graduate fellowship program in the education of mentally retarded children," above.

III. Stimulation or Support of State and Community Programs

A. Formula grants to states for state and community programs

1. *Program description.*—Maternal and child health services (administering agency: Welfare Administration, Children's Bureau).

The State health departments have been making use of some of the funds allotted them under this program to establish demonstration programs centering about child health supervision and the problems in growth and development of children who are retarded or suspected of being retarded. By the end of fiscal 1960, special project demonstrations of services for mentally retarded children were in operation in 52 States and territories (31 States utilizing earmarked and reserve B funds plus 21 States utilizing regularly allotted maternal and child health funds).

Statutory authority: Social Security Act, as amended, title V, part 1, 42 U.S.C. 701–5. DHEW Appropriation Act, 1963.

Funds: 1963 appropriation, $25 million. (This appropriation is at the present ceiling. Of this amount, it is estimated that $1,665,000 was used for mental retardation programs.)

The 1964 budget, $25 million. (It is estimated that $2,665,000 will be used for mental retardation programs.)

Relationship to provisions of S. 1576: This program is a part of the administration's total mental retardation program, but does not relate specifically to any of the provisions of S. 1576.

2. *Program description.*—Crippled children's service grant (administering agency: Welfare Administration, Children's Bureau).

The purpose of this grant is to enable each State to extend and improve (especially in rural areas and in areas suffering from severe economic distress), as far as practicable under the conditions in such State, services for locating crippled children and for providing medical, surgical, corrective, and other services and care, and facilities for diagnosis, hospitalization, and aftercare, for children who are crippled or who are suffering from conditions which lead to crippling.

Initially the crippling conditions for which children received care under this program were mostly orthopedic. Since 1939, however, there has been a steady increase in the number of children with other handicaps included in the State crippled children's programs.

The 1960 Amendments to the Social Security Act provide that special project grants may be made to State agencies (as was previously done), and also directly to public or other nonprofit institutions of higher learning for special projects

of regional or national significance which may contribute to the advancement of services for crippled children.

Statutory authority: Social Security Act, as amended, title V, part 2, 42 U.S.C. 711–5.

Funds: 1963 appropriation, $25 million (present ceiling); 1964 budget, $25 million (present ceiling).

Relationship to provisions of S. 1576: This activity is a part of the Department's total mental retardation program, but does not relate specifically to the provisions of S. 1576.

3. *Program description.*—Grants to States for support of vocational rehabilitation services (administering agency: Vocational Rehabilitation Agency).

This program provides funds to the States for basic support of vocational rehabilitation services. Each State is entitled to an allotment, the amount of which is determined by (1) the need, as measured by the State's population, and (2) the fiscal capacity, as measured by its per capita income.

Mentally retarded individuals are among the disabled persons who benefit from this vocational rehabilitation program. Vocational rehabilitation services include diagnostic services incidental to the determination of eligibility and the nature and scope of services to be provided; training, guidance, and placement services; and, in the case of an individual in financial need, any other goods and services necessary to render such individual fit to engage in a remunerative occupation, including physical restoration. Vocational rehabilitation services also include the acquisition of vending stands or other equipment and initial stocks and supplies for use by severely handicapped individuals in small businesses managed and supervised by the State agency, and the establishment of public and private nonprofit rehabilitation facilities and workshops.

Statutory authority: The Vocational Rehabilitation Act, as amended (29 U.S.C. 31–42), provides for grants to the States for vocational rehabilitation services. Each State receives an amount equal to the Federal share (50 to 70 percent, depending on relative per capita income) of the expenditures under its State plan, up to the amount of its allotment. Vocational rehabilitation services may be furnished to "any individual who is under a physical or mental disability which constitutes a substantial handicap to employment, but which is of such a nature that vocational rehabilitation services may reasonably be expected to render him fit to engage in a remunerative occupation."

Funds: 1963 appropriations, $71,240,000; 1964 budget, $85,700,000.

Relationship to provisions of S. 1576: This activity is a part of the Department's total mental retardation program but does not relate specifically to the provisions of S. 1576. States may use their allotments under this program for the expansion, remodeling, or alteration of existing buildings to adapt them for use as sheltered workshops or rehabilitation facilities for handicapped persons, including the mentally retarded. While such facilities (if limited to the mentally retarded) would be included in the definition of "facility for the mentally retarded" at section 401(b) of S. 1576, it is unlikely that any State could use any significant portion of its allotment under the instant program for workshops or rehabilitation facilities limited to the mentally retarded since these allotments must run the full range of vocational rehabilitation needs in services and facilities for all handicapped persons.

4. *Program description.*—Grants to States for initiating projects for the Extension and Improvement of Vocational Rehabilitation Services (administering agency: Vocational Rehabilitation Administration).

In addition to the grants to States for Support of Vocational Rehabilitation Services the Vocational Rehabilitation Act provides that States may receive grants to assist them in initiating projects for the extension and improvement of vocational rehabilitation services under the approved State plan. In order to receive approval, each such project undertaken by a State agency must be an organized plan of identifiable activities to extend or improve the provision of vocational rehabilitation services, over and above those services currently being provided.

Mentally retarded individuals are among the disabled persons who benefit from this vocational rehabilitation program.

Statutory authority: Vocational Rehabilitation Act, as amended, section 3, 29 U.S.C. 33.

Funds: 1963 appropriation, $1,700,000; 1964 budget, $3 million.

Relationship to provisions of S. 1576: This activity is a part of the Department's total mental retardation program, but does not relates specifically to the provisions of S. 1576. States may use their allotments under this program for

the expansion, remodeling, or alteration of existing buildings to adapt them for use as sheltered workshops or rehabilitation facilities for handicapped persons, including the mentally retraded. While such facilities (if limited to the mentally retarded) would be included in the definition of "facility for the mentally retarded" at section 401(b) of S. 1576, it is unlikely that any State could use any significant portion of its allotment under the instant program for workshops or rehabilitation facilities limited to the mentally retarded since these allotments must run the full range of vocational rehabilitation needs in services and facilities for all handicapped persons.

B. PROJECT GRANTS FOR IMPROVING STATE AND LOCAL PROGRAMS

1. *Program description.*—Neurological and Sensory Disease Service project grants, community service projects (Public Health Service, Bureau of State Services, neurological and sensory disease service program).

Grants are available to stimulate the development, expansion of improvement of community activities to identify and deal wtih problems of neurological, visual, and communicative disorders such as mental retardation, epilepsy, glaucoma, hearing disability, etc. These activities may involve the preventive, diagnostic, treatment, and rehabilitative aspects of these disorders, and may include services to patients, population screening programs, demonstration of techniques to health personnel, the establishment of referral procedures, etc.

Statutory authority: Under section 301, Public Health Service Act, the Surgeon General is directed to assist public authorities and scientists in the conduct of demonstrations relating to the cause, diagnosis, treatment, control, and prevention of any physical disease and impairment of man. Under the appropriation act for fiscal 1963, Congress authorized the use of the funds appropriated for grants to States and other public institutions for demonstration and control activities relating to neurological disorders (Public Law 87-582).

Funds: 1963 appropriation, $1 million. (an estimated $220,000 of the total appropriation was used for mental retardation programs.)

The 1964 budget, $1,830,000. (This amount includes both community service projects and training projects within the Neurological and Sensory Disease Service project grants program. An estimated $1 million of this amount will be used for mental retardation community services and training programs.)

Relationship to provisions of S. 1576. This activity is a part of the Department's total mental retardation program, and is not specifically related to the provisions of S. 1576.

C. PROFESSIONAL AND TECHNICAL ASSISTANCE

A part of the total mental retardation program of all of the agencies included in this report consists of professional and technical assistance. These activities form an integral part of the mental retardation programs in the areas of research, training, stimulation, support and construction, and are carried on under the same statutory authority.

In administering the programs discussed herein, the Federal agency staff furnish consultation and technical advice to public and private entities, and on occasion conduct studies, as may be pertinent to the program interest. Because the amounts spent for these activities are relatively small, and difficult to ascertain we have not identified these activities separately or attempted to give a specific expenditure figure.

IV. Financial Aid for the Construction of Facilities

A. RESEARCH FACILITIES

1. *Program description.*—Health Research Facilities Construction (Administering agency: Public Health Service, National Institutes of Health, Division of Research Grants).

To promote health research through construction of research facilities, including laboratory and accessory space and through provision of scientific and related equipment.

Statutory authority: Within the limit of a $50 million annual appropriation authorization ending with fiscal year 1966, title VII of the PHS Act authorizes grants to meet up to 50 percent of the cost of construction of facilities operated by qualified public or other nonprofit private institutions for research in the

sciences related to health. Facilities for research in mental retardation are eligible.

Funds: 1963 appropriation, $30 million (present ceiling); 1964 budget, $30 million.

Relationship to provisions of S. 1576: S. 1576 would (*a*) add a new part B to title VII authorizing $30 million over a 5-year period for the construction of centers for research on mental retardation and related aspects of human development; and (*b*) provide for Federal matching up to 75 percent.

There is overlapping between the existing health research facilities program and section 101 of S. 1576. The purpose of section 101 is to assure that the appropriations authorized under the new part B of title VII be devoted exclusively to construction of centers for research on mental retardation and related aspects of human development—a purpose which cannot be achieved under the present research facilities construction program where applications for such centers must compete with applications for all types of health research facilities within the $50 million authorization for that program.

B. STATE AND COMMUNITY HOSPITALS AND RELATED MEDICAL CARE FACILITIES

1. *Program description.*—Hospital and medical care construction program (administering agency: Public Health Service, Bureau of State Service, Division of Hospital and Medical Services).

The hospital and medical facilities construction program (Hill-Burton program) authorizes aid to assist in constructing and equipping hospitals of all types, public health centers, diagnostic and treatment centers, rehabilitation facilities, and nursing homes. The various types of facilities are defined further in Public Health Service Regulations, part 53 (title VI of the Public Health Service Act, as amended).

Statutory authority: Title VI of the PHS Act authorizes for each fiscal year ending with fiscal year 1964 appropriations in several categories for allotment by formula among the States to be used to meet from one-third to two-thirds the cost of construction of public or private, nonprofit, State or community medical facilities. The categories include $150 million for hospitals, public health centers, and related facilities; $20 million for diagnostic and treatment centers; $20 million for hospitals for the chronically ill and impaired; $10 million for rehabilitation facilities; and $20 million for nursing homes providing skilled nursing care and related medical services.

Section 636 of title VI also authorizes $10 million annually for research and demonstrations to promote the more effective use of hospitals and other medical facilities, including some experimental construction.

The eligibility of facilities for the mentally retarded is determined on the basis of the purpose and function of the facility. If the facility includes an active medical program and meets the definition of a hospital, diagnostic or treatment center, rehabilitation facility, or nursing home, and other eligibility requirements, it may qualify for aid.

Funds: 1962 appropriation: $220 million. (As of December 31, 1962, there were 37 projects at mental retardation facilities that have been approved under this program. The total cost of these projects is $30,888,967 with a Federal share of $12,358,321.)

The 1964 budget, $170 million. (It is not possible, at this time, to estimate the amount of funds to be used in 1964 for construction of mental retardation facilities.)

Relationship to provisions of S. 1576: There is some overlapping in the eligibility provisions for construction grants under the Hill-Burton program and for grants under parts B and C of title I of S. 1576. As stated above, only those portions of facilities for the mentally retarded as defined in S. 1576 which provide an active diagnostic, treatment, or nursing service are eligible for aid under the hospital and medical facilities construction program. Relatively few projects of this nature have received Hill-Burton aid, and this limited assistance does not help with the improvement and expansion of the educational, training, and residential services provided in these facilities.

Mr. HARRIS. I want copies of this made available, Mr. Chairman, to not only members of this subcommittee, but I want copies to this, Mr. Clerk, also delivered to the office of every member of this committee today for their information.

This obviously is a most important program. It has various reactions to it, some emotional. There is a great deal of sentiment involved. There is a great deal of concern involved. Therefore, I do not want any members of this committee to contend later on that we do not have, and have not developed, full and complete information on this subject as we take this matter under consideration when these hearings are concluded.

I believe that meets the request of the members of the committee who expressed a desire for additional information except one having to do with the States meeting their responsibility in the field, and the question, which has been discussed here this morning, as to whether or not this program would cause the States to hold off their progress and further programing in this field.

You have discussed that in your statement this morning, Mr. Jones, and no doubt there will be some other questions involved. I want to compliment you and the Department for getting together all of this detailed information which will be helpful to us in the consideration of this problem and to thank you for it. I also want to compliment you for your very fine and clarifying statement this morning with reference to title II of the bill and how you propose to set up these mental health centers, with the primary responsibility for the planning and the work to be conducted at the local level, and how you hope and expect to work it out. I think it is very commendable and I am glad to have this further explanation.

I will not pursue the matter with any further questions, but I did want to get this material in the record at this point in order to meet what I think certain members had in mind at the time it was suggested that we develop further information.

I do want to make it very clear that we will expect a complete and full description as to the needs and the program of title III when you get to that a little later on.

Thank you, Mr. Chairman.

Mr. ROBERTS. Thank you, Mr. Chairman.

I note the presence of the ranking minority member, the distinguished gentleman from Michigan, Mr. Bennett.

Mr. BENNETT. Thank you, Mr. Chairman.

Since I was one of those who raised some of the questions referred to by Mr. Harris, I would like to make a brief comment about my feelings on this legislation and then to ask a few questions, if I may. When I first came on the committee the only two members now on the committee were Mr. Harris and myself and we were here initially when these programs were first being considered. Our late departed friend, Percy Priest, who was a distinguished chairman of this committee, one of the leaders in the field of health legislation, not only mental but other forms of health legislation, was the sponsor of a bill which provided for the Health Institutes which now operate at Bethesda. I think we are all for this program. Certainly there is nothing that has more appeal and more sympathy from the average person than an effort expended in the area of helping people who are mentally sick or mentally retarded. I don't believe there is any member of this committee or any Member of the House of Representatives or any Member of Congress who doesn't want the Federal Government to do its share in this area and I personally would like to support

this bill or support a bill which would do something additional in the field of mental health, but I have some concern about the approach here and one of my concerns is the fact that your Department has grown over the last decade from a relatively small operation into a multibillion dollar operation spread all over the United States and other parts of the world. Before we embark on a new program, or a program that is called new—I get the impression that this is something that is regarded as a new program—I would like to find out what can be done that is authorized under existing law.

For example, I would like to know why we can't, by expanding the provisions of the Hill-Burton Act, take care of the construction of the mentally retarded facilities which you have in mind under title I of the bill, and also take care of the construction of mental health centers under the Hill-Burton Act, and I raise that question recognizing that not too much emphasis has been placed in the Hill-Burton program on mental health. Whose fault that is I do not know, whether it is the fault of Congress, or this committee, or whether it is the fault of your agency, but apparently—I think admittedly—not enough emphasis has been placed on the mental health program so far as the Hill-Burton Act is concerned. I don't know how much has been spent, but relatively a small amount, millions of dollars, compared to the amount spent on general hospitals.

Let me ask you this question to point this up. Why can't you construct the mental retardation facilities that you have in mind here under title I under the Hill-Burton Act if you were given additional funds to do so?

Mr. JONES. Mr. Bennett, I think there are several ways one might approach a new program, and we do think it is a new program in the concept that we have described. That might be one way to do it. We haven't felt that it was the best way. There has been spent since 1947, as I recall the figures, about $1.8 billion under the Hill-Burton program. About $59 million of this $1.8 billion has gone into beds and facilities for the mentally ill.

This has happened, in our judgment, because the program was directed primarily at providing general hospital beds for communities that did not have them. The whole focus of the Hill-Burton program was in terms of the care of the physically ill in general hospitals. Only 3 percent of the funds spent under the Hill-Burton program found their way into facilities for the mentally ill. The Hill-Burton program is still needed. It is still moving on. We are still, with Federal dollars, stimulating a great deal more for essential general hospital requirements in local communities.

We think that the Congress should have the opportunity, as it has in this legislation, to take a look at mental illness and at mental retardation as programs that require special attention, because they have not been adequately taken care of previously. To do so it was our feeling, and still is, that a new legislative proposal for a new program was an important aspect. And it is a new program in the sense that I have undertaken to describe this morning. It has been a matter of record in your previous hearings. We feel it is important to develop in the community a sense of responsibility for the mentally ill which they haven't had. We feel that this is an important aspect of the presentation.

The material that Mr. Harris has referred to will be available to you. It may be helpful to you in relating this authorization to existing authorities. We will be glad to amplify it for you, Mr. Bennett, as you may wish.

Mr. NELSEN. Would the gentleman yield?

Mr. BENNETT. Yes.

Mr. NELSEN. I have a letter in my file, Mr. Jones, from a nonprofit mental health center in Duluth, Minn. They are presently operating and they have been denied Hill-Burton funds because they don't meet the requirements or specifications for the disbursement of Hill-Burton funds. Whether it be by regulation or law I am not sure, but they have been denied funds. They are doing exactly what you propose to do under this bill and they have been denied Federal assistance, which is recognized as a needed thing. Yet they haven't been able to get the funds, but now the Hill-Burton Act could have been expanded, could it not, so that they would qualify for Federal assistance to do what they are now doing?

Mr. JONES. Mental health facilities in hospitals are eligible under the Hill-Burton Act. But a particular project has to relate to a State plan as developed by State authorities. This plan is then approved by our agency. We don't make the decisions as to which projects are to be included. The States make this decision.

Mr. NELSEN. This is a nonprofit facility?

Mr. JONES. A nonprofit institution is eligible.

Mr. BENNETT. Mr. Jones, the States will make the same kind of a plan under this bill, will they not?

Mr. JONES. But it will be limited, Mr. Bennett, to mental health and mental retardation facilities. Therefore, they will not be in conflict or in competition.

Mr. BENNETT. That may be true. I assume that under this new proposal you are going to place more emphasis on mental health, but I get back to the question of why you can't do it under existing programs, and your answer is that the Hill-Burton Act was directed primarily toward general hospitals, and I agree that that was the case, but now we have built general hospitals under this program all over the United States, very fine hospitals. I want to compliment your agency for the good work you have done under the Hill-Burton program so far as general hospitals are concerned. I think it is one of the best programs the Congress ever authorized. However, you have these hospitals built now. You have them built in my district. We have hospitals up in my area we never would have had without the Hill-Burton Act, but they are perfectly set up so that additions can be made to existing hospitals. One hospital in my district now, a very fine hospital, is adding a psychiatric wing and they are doing it under the Hill-Burton Act. Why can't you do that in every other place around the country where you feel these mental retardation facilities or mental health centers are needed, if you have the money to do it?

Mr. JONES. You are quite right, Mr. Bennett, under the Hill-Burton program inpatient facilities can be built, but the comprehensive mental health program that we have been discussing and which is the subject of this legislation includes facilities beyond inpatient care. The addition of outpatient facilities, rehabilitation facilities, half-

way houses, day and night care programs—it is these additional authorizations, additional facilities, which together go to make up a comprehensive community mental health program.

Mr. BENNETT. Yes, but shouldn't the mental health center be attached to an existing hospital?

Mr. JONES. It may or may not.

Mr. BENNETT. Pardon me?

Mr. JONES. It may or may not.

Mr. BENNETT. I realize that, but shouldn't it be?

Mr. JONES. We feel that most of them will be an extension of a general hospital but not exclusively.

Mr. BENNETT. But generally speaking you would attach either a mental health center or a mental retardation facility to an already existing general hospital, would you not?

Mr. JONES. This would be an expectation. Most of the projects will develop from a general hospital arrangement. Some will not.

Mr. BENNETT. And you will provide grants on the same basis, or essentially the same basis, but maybe a different matching formula, as you are presently doing under the Hill-Burton Act. My point is this, Mr. Jones: Why should we just name a new program and pass another law to start another program if you have the tools and facilities and the authorization? I doubt that there is another agency in the Federal Government that has so many different laws authorizing you to do things as HEW.

Mr. JONES. Mr. Bennett, we have undertaken in the document that Mr. Harris has introduced into the record to clarify the problem of duplication or overlap. We would have to have new authorization, Mr. Bennett, to utilize the Hill-Burton mechanism to develop the comprehensive community mental health centers.

Mr. BENNETT. Why?

Mr. JONES. Because we do not have it now for some of these facilities I have mentioned. I can give you the details on this, if you like.

Mr. BENNETT. I have not read your statement or this material you have just submitted to the committee. I of course don't know what is in it, but it just seems to me that we are starting an unnecessary program, a program to do something that we have already authority to do and that you could do just as well under Hill-Burton.

Mr. JONES. We can't build facilities for the mentally retarded under the present authorization of Hill-Burton.

Mr. BENNETT. It would merely take an amendment to a Hill-Burton Act, a very simple amendment, to accomplish that, would it not?

Mr. JONES. This would be legislation you would have to consider, just as you are doing now. As I indicated, there are several ways to accomplish these purposes, but this would not be a simple amendment, Mr. Bennett. It would have to have the same kind of consideration, I should think, that you are giving to the proposal under discussions.

Mr. BENNETT. Getting away from that for a moment——

Mr. HARRIS. Before you leave that, will the gentleman permit an interruption in order to make the record fully complete, if the gentleman will yield.

Mr. BENNETT. Yes, sir.

Mr. HARRIS. Is it not a fact that you would have to revise the whole administrative process from top to bottom if this were to be done?

Mr. JONES. Yes. Our major problem, Mr. Chairman, is that the Hill-Burton program relates for the most part to inservice facilities for the care of the physically ill.

Mr. HARRIS. Yes, I know, but you would have to revise your administrative process all the way up and down.

Mr. JONES. That is quite correct.

Mr. HARRIS. Isn't it true that every State in the Union has a State plan under the Hill-Burton program that already over the years has been worked out, the advisory group and the administrative group in the States involved connected with general hospital programs and not mental institutions at all?

Mr. JONES. That is correct.

Mr. HARRIS. That would all have to be revised, would it not?

Mr. JONES. That is correct.

Mr. HARRIS. To show that that does entail a lot of problems, is it not true that you had the same difficulty in a much lesser way, because it was a much smaller program, with these other categories that were extended in connection with the Hill-Burton program when our beloved and distinguished former member and chairman of this committee, Mr. Wolverton, was here, when under his leadership these other categories were added to Hill-Burton, and it is not a fact that you had a lot of trouble working out the administrative program with each of the additional categories except possibly the nursing homes.

Mr. JONES. That is correct, and then, Mr. Chairman, if we undertake this new program, and it is new, Mr. Bennett, in the sense that it is something that we are not now doing, by amendment to Hill-Burton we will force States into a pattern of administration within the State into which they may not want to be forced. That is, the same agency within the State which handles Hill-Burton would be required, if we amended Hill-Burton, to administer this program. Some States may not wish to do that and it would provide for lack of flexibility at the State and local levels.

Mr. BENNETT. But the fact is that you are building mental facilities under the Hill-Burton Act.

Mr. JONES. We are building mostly in-patient hospital facilities under the Hill-Burton Act.

We are building facilities for the mentally ill to the extent of about 3 percent of the Hill-Burton program.

Mr. BENNETT. And you could build community mental health centers.

Mr. JONES. We do not build community mental health centers or centers for the mentally retarded under existing legislation.

Mr. BENNETT. Rather than do this, you want a new program.

Mr. JONES. We want new authorization for a new program.

Mr. BENNETT. You are not satisfied to be able to do it; you want to have a new program to do it with. That is about the sum and substance of it, as I see it.

Mr. JONES. It is a new program, whether it is an amendment to Hill-Burton or new legislation, Mr. Bennett.

Mr. BENNETT. You can do it under present law, and I don't want to keep arguing this point with you, but you have it in one case that I know of and you have already said you have spent millions of dollars in building mental facilities under the Hill-Burton Act.

Mr. JONES. Three percent of the Hill-Burton funds have gone into facilities for care of the mentally ill, mostly for hospital beds.

Mr. BENNETT. Three percent, but it amounts to quite a few million dollars.

Mr. JONES. $59 million out of $1.8 billion.

Mr. BENNETT. And the reason you have not done more, you said a little while ago, is because the States in their plans that they submit to you have concentrated on general hospitals as distinguished from mental health hospitals.

Mr. JONES. This is why this is a new program. The communities have not recognized their responsibilities for the care of the mentally ill. Now we want to help them recognize them.

Mr. BENNETT. Now you want to go into a State, set up another agency completely apart from the present Hill-Burton hospital groups, set up another State agency, to submit a plan for mental health.

Mr. JONES. Each State already has such an agency in existence, Mr. Bennett, and four representatives of such agencies are here to talk to you this morning, if you have time for them, Mr. Chairman. Dr. Felix would like to respond if you want him to do so.

Dr. FELIX. If I might respond, the States represented by about every member of this committee have a separate agency for mental health. Michigan, Colorado, Minnesota, Pennsylvania, and Ohio have a different agency for mental health than they have for public health generally.

Mr. BENNETT. You mean when they submit a mental health project under the Hill-Burton Act you have a different agency in the State submit it?

Mr. FELIX. At the present time, most of them do not submit these, and I should point out one other thing. There is apparently confusion here. The Hill-Burton authorization is not adequate for the needs of the people. This is only a small piece of what is needed. For instance, to give an example, in my State of Colorado they have at the Fort Logan Center some inpatient beds amounting to I think, Mr. Brotzman, about 25 beds per unit. This facility, including outpatient, halfway house, and other aspects of the program, handles at any one time nearly 200 patients. Only 25 of them are in beds. Beds alone won't get it. If we are restricted again, as we have been in the past, to just inpatient beds, we won't be much farther along than we were before. This is a small segment of the total illness of a mental patient and what we are pleading for is an opportunity to give the patient comprehensive care. This cannot be done under Hill-Burton authorization.

Mr. BENNETT. Can it be done in these psychiatric wings that are being built in general hospitals today?

Dr. FELIX. No sir.

Mr. BENNETT. Why not?

Dr. FELIX. Only a part of it; the inpatient part only.

Mr. BENNETT. Why not?

Dr. FELIX. Because it takes the rest of the program to do it and you cannot do this in inpatient beds. You have to have your day care, night care, outpatient service, emergency service, rehabilitation services, halfway houses, sheltered workshops, and all the rest of it and

you have to have these administratively sufficiently interdigitated so that once one is introduced into this system he can move without any folderol or redtape from one type of service to another. This can not be done in inpatient beds.

Mr. BENNETT. What is being done in your present hospitals where these psychiatric wings are being built is they take care of cases in their communities that need medical care and that cannot be transferred conveniently to some institution a long distance away.

Dr. FELIX. That is only partly true, sir.

Mr. BENNETT. With respect to these additions to general hospitals, as Mr. Jones pointed out, most of the construction contemplated under this program would be associated with general hospitals already in existence and you are merely adding on wings or additions, other buildings connected with it, to do the kind of thing that is now being neglected.

Dr. FELIX. This is a misapprehension, Mr. Bennett. You speak about these inpatient beds in hospitals. They can take care of a patient when he has to be in a hospital, but the great bulk of people don't have to go to hospitals. They can be taken care of in day care service or outpatient service. Once you put a patient in a hospital you tend to increase the time he is out of commission, and we are trying to prevent this.

Mr. BENNETT. There is no reason why an outpatient wing can't be added to a general hospital to take care of psychiatric patients and to take care of other patients. That is just arguing around the circle.

Dr. FELIX. Not under Hill-Burton.

Mr. BENNETT. The point I was making before is that you want to set up, and I think it is pretty clear, another group of State agencies having authority to submit separate plans in addition to what we already have under Hill-Burton to work out this new program, as you call it.

Dr. FELIX. I think, sir, when you hear the Commissioners from several of the States who will speak a little later you will have this clarified more. These gentlemen are struggling with this problem now.

Mr. BENNETT. I think they are struggling with it because of the Hill-Burton people who have been administering the Hill-Burton program and I think that is why HEW as well as the State agencies haven't given due recognition to mental hospitals.

Dr. FELIX. I could only compliment the Hill-Burton people.

Mr. BENNETT. If this has been such an urgent and neglected program as you indicated it has been, it seems strange to me that nobody has been in here from HEW advocating this kind of a thing until now.

Mr. JONES. Mr. Bennett, the Congress set up a mental health study in 1955. Its report was presented about a year ago. This program is in response to this well-documented study which took about 4 to 5 years to complete. The chairman of that study group is here to be heard this morning. This is in fact a new program, Mr. Bennett. This is why it has not been presented before. It is a result of a major undertaking that is a landmark in the study of mental health.

Mr. BENNETT. Let's leave that for a minute. I want to ask you a question or two about research. What are you going to do with the $36 million you are asking for under title I for research?

Mr. JONES. That is the mental retardation program. This would be, Mr. Bennett, a program for the financing of the construction of research facilities at medical centers which would be designed especially, for the interdisciplinary study of problems related to mental retardation and human development.

Mr. BENNETT. You mean to tell this committee that you are short of funds for research in the field of mental health right now?

Mr. JONES. That is not what I said, Mr. Bennett. I said this program is to authorize funds for construction of special facilities, that are not now in existence, for the interdisciplinary study of mental retardation and human development.

Mr. BENNETT. Do you want to spread those out around the country?

Mr. JONES. It was contemplated that there would be about 10 under the administration's original proposal.

Mr. BENNETT. We are speaking about research now?

Mr. JONES. These are funds for construction of 10 research centers. It will not support research, but will develop facilities at medical centers. About 10 of them.

Mr. BENNETT. Can you spend any money now for the construction of research facilities for mental health?

Mr. JONES. We are spending money for health research facilities at the rate authorized, about $50 million a year.

Mr. BENNETT. You have authority now to do so?

Dr. FELIX. I think the gentleman asked if we were spending this money for construction of facilities and I believe Mr. Jones said that we were spending this much money in support of research, but not in construction of facilities.

Mr. BENNETT. I asked you if you had authority to do this. That is my question.

Mr. JONES. We have authority for health research facilities construction.

Mr. BENNETT. Then why are you asking for it in this bill?

Mr. JONES. This is a special facility, Mr. Bennett, under a different formula, that will provide what institutions themselves are not now able to provide under our existing program. This has been developed in this regard because the existing program is not adequate to provide for this type of facility to meet our problems of mental retardation.

Mr. BENNETT. You have money now available for expenditure and authority to go out and build a mental retardation facility, a research facility, out in the city of Chicago, or Philadelphia, or whatnot, wherever you want to go, do you not?

Mr. JONES. Not under these conditions, no, sir.

Mr. BENNETT. What are the conditions that are different here? What new authority does this give you that you do not already have?

Mr. JONES. This authority would give us the opportunity——

Mr. BENNETT. I don't mean opportunity. What authority does this give you to spend money on research facilities that you do not have now?

Mr. JONES. It would provide for a larger share of the cost to be borne by the Federal Government than is now true of existing research facility authorization, plus the fact that this would be earmarked for this special purpose as a part of a total mental retardation program.

Mr. BENNETT. The only difference then is one of matching formula?

Mr. JONES. Plus the fact that it is earmarked for this particular purpose, for which there has been too little done heretofore and we are trying to catch up.

Mr. BENNETT. You are not saying that you are short on money for research?

Mr. JONES. Yes, sir; we are, for construction of research facilities. We are quite short.

Mr. BENNETT. You are?

Mr. JONES. Yes, sir.

Mr. BENNETT. I can suggest that you take some of the money that you are spending on some of these other projects, which I won't characterize as ridiculous because maybe that is only my opinion, but I suggest you take the money that you are spending on why a monkey loves its mother, and other similar things, which have no tangible benefits, so far as I can see, and devote it to something that is related to human beings, particularly in this area we are talking about now.

Mr. JONES. Mr Bennett, Dr. Felix would like to answer you. So would I, but I will let him.

Dr. FELIX. I would very much like to answer that because you have touched on one of the most important and significant pieces of research that has been done in this decade to understand the underpinnings of mental illness in children and also some of the underpinnings of one of the metabolic diseases causing mental retardation. This was a study carried on at the University of Wisconsin in which baby monkeys were taken from the mother and raised apart from the mother. These monkeys turned out to be, as had been expected, very bizzarre behaving animals. When it came time for these animals to raise their own young, the young had to be taken from them to prevent the mothers from killing them. We have exactly this same picture of maternal neglect over and over again in human society and we can relate this back to problems of juvenile delinquency, schizophrenia in children, one of the most common problems among the mental illnesses today. We had thought for a long time that this was related to the deprivation of a proper mother-child relationship. We now have this demonstrated. Thank God for that experiment.

As another part of this experiment we overfed some of these baby monkeys certain substances—the name of the substance is phenylalanine—so that the body could not handle it, with the result that the monkeys turned out to have phenylpyruvic acid mental deficiency. PKU, they call it. This is one kind of mental retardation. This is one piece of research about which we have been asked questions for 2 or 3 years. I will stand on both my feet on top of the Empire State Building and shout with pride that we put the money into that one. You picked the wrong one, Mr. Bennett.

Mr. BENNETT. This is something like the Darwin theory of evolution. I wouldn't want to get into that area. It probably has some relationship to what you are talking about.

Dr. FELIX. Direct relationship.

Mr. BENNETT. I am not qualified to argue about it, but to the average layman spending hundreds of thousands of dollar to determine whether a baby monkey can be adjusted to the limb of a tree as well as he can to the arm of his mother——

Dr. FELIX. I am not aware of that experiment.

Mr. BENNETT. There is a project at the University of Wisconsin.

Dr. FELIX. Of course we could, I suppose, if Congress would authorize it, take human babies from their mothers and do the same thing. I wouldn't want to administer such a project, but we can only understand and learn how to prevent and cure these tragic conditions by experimentation and if we don't do it on babies we have to do it on other animals and the monkey is the nearest thing.

Mr. BENNETT. I do know for sure—this doesn't require medical degrees, so I think I am qualified to make this statement without any fear of contradiction—that the HEW has money running out of its ears for research, not only research of mental health, but research in every possible field that you wish to such an extent that you have agency representatives running all over the country contacting universities and contacting private physicians trying to look up projects to get this money spent, and I think Congress, frankly, ought to take a more careful look than it has ever taken before at this multibillion-dollar research program that you fellows have been engaged in for some years. I have serious doubt that the taxpayers are getting their dollars worth of value out of the money you are spending.

I have some other questions, Mr. Chairman, but I have taken more time than I should.

Dr. TERRY. Mr. Chairman, if I may, I certainly would like to respond to this, at least briefly, because I cannot agree at all with what you have said, Mr. Bennett.

Mr. BENNETT. I did not expect you to.

Dr. TERRY. It is true that in certain categories, funds have been made available to us for research that we have not spent and these funds have been returned to the U.S. Treasury. On the other hand, I think one of the greatest developments in the United States in the last few decades has been the development of the medical research program which Congress has authorized and which has been carried out through the National Institutes of Health. I have nothing to apologize for. We have made some mistakes, but the mistakes have been minimal in comparison to the amount of good which has been done. I think it is one of the greatest developments in American history, sir.

Mr. BENNETT. I had in mind the report that was made by a subcommittee of the Government Operations Committee a year or two ago on what you were doing out there in the field of research. I don't have that report before me, but it was not, I must say, a very complimentary report about your activities in this area. While I voted for practically every dollar that has been appropriated for your research activities, I do think I as a Member of Congress have the right to reserve my judgment as to whether it is being properly spent, and I have some serious doubts as to whether it is being properly spent. I don't mean that you are not doing good work out there, but I am just saying in my judgment, you have too much money. You have more than you know what to do with or more than you can adequately or properly or beneficially spend. That is my judgment.

Mr. JONES. Mr. Bennett, I hope you will read other reports than just that particular one, and I hope you can read that one in the context of its intention to review the actual mechanisms. It has been

very useful. The program is absolutely sound in our judgment and in the judgment of many professional groups that have reviewed its activities.

Mr. BENNETT. I say again I would like to support this kind of program, an additional program for mental health. I think perhaps that additional money could well be spent by the Federal Government in this field, but I would just like to see some of these loose ends gathered up and tightened up and tied down instead of going out willy-nilly into a great sprawling type program which duplicates in many areas what you are already doing and in many areas duplicates the authority and compounds the authority that you already have to do these very things. If we could get down to that kind of a program I certainly would favor spending some more money in the field of mental health.

Mr. JONES. I think we are at that point. It is a question of giving you the information you need for you to understand that this is exactly what the program proposes, Mr. Bennett.

Mr. BENNETT. That is all, Mr. Chairman.

Mr. HARRIS. Mr. Rogers.

Mr. ROGERS of Florida. Thank you, Mr. Chairman.

I might say that I feel, just since being on this subcommittee, that the work that has been done in this line has been effective. I agree that we all want to tighten up wherever we can and I think we are beginning to do this. I think some of the changes in procedures that have already been instituted in the last year or two have tended toward this and that the American people really are the beneficiaries of a tremendous program that is going to do untold good over the next number of years. Certainly the new concepts that are now coming out, and this is one, are going to be most beneficial to the American people.

I think generally the American people support this program very strongly, but I agree with my colleague that we do want to keep as close a control on money expenditures as possible. I wanted to know just a little bit about your mental health centers. You estimated the average cost would be what—just as an average—$1.6 million? Is that the figure?

Mr. JONES. $1.3 million.

Mr. ROGERS of Florida. About $1.3 million?

Mr. JONES. Yes.

Mr. ROGERS of Florida. Do you envision a particular number of beds, or would there be a minimum or a maximum number that you have in mind?

Mr. JONES. Mr. Rogers, we undertook to describe what would be an average center serving 100,000 people and we undertook to describe what the center would look like. Actually, we suggest 25 inservice beds and then related outpatient and other facilities. I think we have put in the record already what one of these facilities would look like.

Mr. ROGERS of Florida. It gives the number of beds.

Mr. JONES. For inpatients, 25 beds, for day and night care, 50 beds, and all the supportive services, it would cost, on the average, about $1.3 million. With an outpatient clinic at about $150,000, rehabilitation facilities at $190,000, emergency service, research and evaluation

at about $60,000, the total cost, including all of this, would be about $1.7 million.

Mr. ROGERS of Florida. They would be both public and private in various parts of the country, nonprofit?

Mr. JONES. That is correct.

Mr. ROGERS of Florida. How will the public and private facilities treat indigents?

Mr. JONES. They would be treated under a variety of patterns, Mr. Rogers, comparable to the way indigents are treated for physical illness. In some instances there would be a public operated facility as is true now for the physically ill. There would be payments by State, Federal, and local agencies to the facility for services rendered to welfare recipients. We would envision a combination of payments for persons treated in these facilities. Some would be by public funds under various programs, some would be by private individuals through fee for service payments, just as is true in general hospitals. Then we are quite hopeful and the indications are quite strong that voluntary insurance plans will move rapidly toward inclusion of mental illness in coverage under various insurance plans.

Mr. ROGERS of Florida. Do you have any staffing for mental retardation centers?

Mr. JONES. We have not proposed a staffing pattern, Mr. Rogers, for a mental retardation center. We do not have the experience nor do we have standard pattern that would make us feel assured in suggesting a staffing pattern for a mental retardation center. The problems are somewhat different. We do have full confidence, by virtue of experience already secured, as to a staffing pattern for a comprehensive mental health center program.

Mr. ROGERS of Florida. Do you think some thought should be given to see if we could get some experts together as to what should be suggested for the staffing pattern here?

Mr. JONES. I would hope, Mr. Rogers, that this could come at a later time after we move forward with the current program a little bit further. I think we would have a little better basis for coming back to your committee and suggesting a reasonable staffing pattern for mental retardation centers after some experience has been gained.

Mr. ROGERS of Florida. Do you feel we are putting sufficient emphasis on the solution and care of mental retardation in this bill?

Mr. JONES. I think this is a good program, Mr. Rogers. It is based on the study by the President's Advisory Panel on Mental Retardation. It is a practical approach to the problems of mental retardation. I can't say that this is all that could be done, but we think it is a very good, sound, practical, reasonable, workable program.

Mr. ROGERS of Florida. How much research would you say is now being done on mental retardation in the public health program? Could you supply that for the record if you don't have it available now?

Mr. JONES. I could supply the figure for the record. Much of the research that goes on relates to problems of mental retardation, although they are not labeled precisely under this category.

Mr. ROGERS of Florida. And where this work is being done, if you would let us have that for the record.

Mr. JONES. We will be glad to supply that for the record. The new National Institute of Child Health and Human Development will have a strong program directed toward the problems of mental retardation.

Mr. ROGERS of Florida. Thank you.

Thank you very much, Mr. Chairman.

(The following information was submitted for the record:)

Program for mental retardation

[In thousands]

Public Health Service:	1963
National Institute of Mental Health	$7,288
National Institute of Neurological Diseases and Blindness	15,839
Chronic diseases and health of the aged	290
Dental services and resources	143
Total	23,560

Mr. HARRIS. Mr. Nelsen.

Mr. NELSEN. I would like to refer, Mr. Jones, to page 427 in the hearings, and in the record is the letter that I referred to from Duluth, Minn., the Duluth Mental Hygiene Clinic, which is a nonprofit clinic, and they state that:

> We are informed that ineligibility for funds applies to all mental health clinics in the Nation which are organized and operated as private nonprofit corporations. The ineligibility stems from—

It goes on and explains why they are ineligible.

As I understand your statement, funds have been appropriated for community mental health centers in the past.

Mr. JONES. No, sir.

Mr. NELSEN. Did you not say that?

Mr. JONES. No, sir. I was quite specific, Mr. Nelsen, in saying that for the most part the funds have been limited under the Hill-Burton program to inpatient facilities.

Mr. NELSEN. I see. Would you examine the letter to be sure that they have the right information and advise me?

Mr. JONES. I will be very happy to have it examined by those that administer the program, Mr. Nelsen, and give you a report.

Mr. NELSEN. Your testimony that you gave today deals entirely with the mental health part of it and the community health centers, does it not?

Mr. JONES. Yes, it was primarily concerned with the staffing pattern.

Mr. NELSEN. You mentioned that this is an entirely new approach. I would like to call your attention to the fact that in 1957 in Minnesota we set up a program for community health centers and we have them now in operation. Have you any information which I could get advising me as to how extensively this program has been applied in other parts of the country, including Minnesota? How extensive has this gone? How extensively has this been applied?

Mr. JONES. Yes, we can provide that for you, Mr. Nelsen.

Mr. NELSEN. It really isn't new.

Mr. JONES. Well, it is new in the sense that the comprehensive community mental health concept has not been widely utilized as yet in the country. There are parts of it, such as a psychiatric unit in a general hospital. This, of course, is a step forward. This has been going on. This is where the bulk of the 3 percent of the Hill-Burton money

has been utilized. There are mental health clinics of the kind that you referred to in Minnesota. There are intensive treatment centers sponsored by State mental health programs in other localities in the country. There are relatively few communities that have the whole range of services that relate to the needs of the mentally ill, both for prevention and for treatment, cure, and rehabilitation. The total concept is relatively new. The new term is relative. There are communities that have done a great deal in Minnesota, Illinois, and other States. Dr. Felix can give you illustrations if you would like at this point.

Dr. FELIX. Yes, there are several. Minnesota has done a great deal. However, they are not completely comprehensive in Minnesota. Both Dr. Cameron and following him Dr. Vail worked very hard to do this. Illinois with their regional centers will be very close to it. You will hear about that later today. California at San Mateo; Fort Logan in Colorado; Kansas City, Mo.; and St. Louis, Mo.; the psychiatric receiving center at Kansas City, the Malcolm Bliss Center in St. Louis, are not quite comprehensive, but they come rather close. Moccasin Bend Hospital in Tennessee is another one. There are some more, but those are some examples, Mr. Nelsen.

Mr. NELSEN. That will be sufficient in the interest of time. Where would you get the staff people? Where would you get them?

Mr. JONES. This is the point to which I directed much of my statement earlier, Mr. Nelsen. There are about 1,000 new psychiatrists finishing their training each year. We would require, I think, as I indicated, about 2,900 for the approximately 290 centers that will be constructed over a period of 4 to 5 years. We would be providing the facilities in which the psychiatrists who will be finishing their training can practice their specialty. We would provide facilities which would require slightly more than half of the psychiatrists who will complete their training in the next few years. And if you take into account the numbers that are available now in communities, we think it is quite realistic to believe that the professional staff for these centers will be available when the centers are ready.

Mr. NELSEN. One of the reasons why I asked the question—is the staffing—is one of the controversial things about the bill, and I think we all recognize the merit of the community health centers. We all recognize the very dire need in the mental retardation field. I think that is a tragic need there. However, in view of the fact that the staffing provision is so controversial it also would appear from all the testimony that I have heard that one of the crying needs is title III of the act to train those who want to move in this field, and it would seem to me if we provide the bricks and mortar and the assistance to the States for the research centers, and the mental retardation, and facilities for community health centers that maybe we should proceed on what we are sure we can do and not get too many controversial proposals involved in the bill. I realize our time is running out, Mr. Chairman, but it would seem to me that we might give some thought to some modified approach on the staffing because it is very controversial.

Dr. FELIX. Mr. Nelsen, on the staffing, one thing that might be of interest to you is that the number of psychiatrists in the country is increasing at the rate of about 11 percent per year. This has been true for the last 5 years. This is because of the assistance the Congress

through this committee gave originally through the legislation enacted in the days of Congressman Priest, Mr. Chairman, to authorize training. If we only have an increase of 5 percent per year, which is less than half, we would have in 1965 around 17,800 psychiatrists as contrasted to about 14,000 now. By 1970 when this program would be more fully developed we would have around 24,000 to 25,000 phychiatrists. We need about 2,900 of these for these centers. We feel that this is a very realistic, very achievable, goal. Further than that, we have repeated evidence which demonstrates that once a facility is provided in a community, psychiatrists come in to locate because there is a facility there. As a physician I don't want to treat people if I can't give them proper and full treatment, hospital, outpatient, or whatever is needed. We can cite instance after instance in which there have been additional facilities put in a community, and in the course of 2 or 3 years, 4, 10, depending on the size of the community, additional psychiatrists come into the community, so we know that facilities act as a drawing card and we know the psychiatrists will be produced so we will have them available.

Mr. NELSEN. My feeling is that the No. 1 thing is to train personnel for staffing and, if they are available, that the States will do their own staffing. That is a possibility. The bill provides for no staffing at a later date. I think it is very difficult to assume that your plan will work, because I have never seen a temporary government program that didn't become permanent and I see no way that you can terminate this financing of staffing in the future.

It seems to me the very reason that you propose it be terminated at a future date is an admission of the fact that it shouldn't continue, and if it shouldn't continue, why start? It seems to me, if you provide adequate funds for the facilities and adequate training, that the staffing will automatically take care of itself. I might also add while we are talking about this program, I refer to the point that Mr. Bennett makes, the idea that many of us are very disturbed about more and more programs, one overlapping another. Therefore, I am concerned because we want to be very careful that we don't duplicate, and I am sure that you would agree that extreme care should be exercised.

Now with regard to this program of mental health and mental retardation, I was in the Minnesota Legislature back there when we passed our act, and it has been effective. It has been a very worthwhile program and we do have these community centers out there, and I think we all recognize we must learn to crawl before we walk.

Dr. FELIX. Mr. Nelsen, one of the problems, as Mr. Jones pointed out earlier, is being able to provide the funds immediately to staff fully a facility which has been constructed. We have an example on the edge of Washington here in Montgomery County, a hospital built I think on Hill-Burton funds, of which the top two floors remain vacant because they could not go ahead and get the staff to fill out the full seven floors of the hospital. All we say is if we can give help to overcome this immediate shock of putting on full staff the community can pick it up and will take it from there. This is an old story, not only in the Federal Government, but in private foundations. The Rockefeller Foundation used this for many years in developing programs both here and in other countries over the world in which they would start in with a certain large percentage, around 75

percent of the total cost, and reduce that rapidly over 3, 4, or 5 years and pull out of the picture entirely, and part of the agreement was that the locality would pick up the difference as the Rockefeller Foundation withdrew. This is how some of the really fine educational institutions in other countries as well as some in this country were developed and have been staffed.

Mr. NELSEN. Thank you. No more questions, Mr. Chairman.

Mr. HARRIS. Mr. Brotzman.

Mr. BROTZMAN. Thank you, Mr. Chairman. The hour being what it is, I will make my remarks very brief and also my questions.

First of all, I would like to thank the chairman for giving us the opportunity to learn some more about a very complicated area. I think that some of the information that you have provided for us in this supplemental hearing will be most helpful. I know it will be to me, particularly in the area of mental retardation, for example. One short question that I am most interested in, and I hope I can pronounce the word correctly, is you mentioned phenylalanine, I believe, a moment ago, Dr. Felix. It is my understanding that this is a physiological manifestation, that the presence of this or the presence of some physiological factor can be detected at a very early moment after birth. Is this not correct?

Dr. FELIX. This is correct, the presence of an abnormal substance known as phenylalanine, which is due, incidentally, to the absence of a certain substance in the body which breaks down some elements of the food into a more simple kind of chemical compound.

Mr. BROTZMAN. This can be determined by checking the urine of the newborn child, is that right?

Dr. FELIX. Yes, sir.

Mr. BROTZMAN. I understand a very simple test would permit this fact to be discovered.

Dr. FELIX. That is correct, yes, sir.

Mr. BROTZMAN. What percentage of mental retardation attributable to this particular physiological factor that could be determined so early?

Dr. FELIX. A relatively small amount. I think about one in a hundred, about 1 percent of institutionalized retardates. I think it is either 200 or 400 born a year, something like that. I forgot the exact figure, but it is a relatively small percentage.

Mr. BROTZMAN. But there are quite a few young children across the country born with it, is that not correct?

Dr. FELIX. Yes; probably out of any one year's corp of babies somewhere between 200 and 500. It is around 200 or 500 a year, a substantial umber.

Mr. BROTZMAN. My question is this: Why isn't that check made now in every hospital? Is there not legislation to authorize a simple test like this which would contribute to solving this mental retardation problem in this country?

Dr. FELIX. It doesn't take legislation, Mr. Brotzman. It is perfectly legal to do it and in a number of communities it is being done now, particularly in the larger centers. There is a field study going on, through the departments of health and mental health in the State of Virginia in which they are checking newborn in the State who get to well-baby clinics to detect how many of these are found, and then to institute proper diet.

There has also been a study carried on in the State of Maryland. Colorado has done this in Denver, but it is one thing to do it in Denver and it is another thing to do it in Telluride, or Silver Cliff, or maybe even Central City, or Aspen, or something of this nature because of the few number of children. However, it is the intention of health officials as rapidly as they can to make this part of a standard set of examinations of a child shortly after birth.

Mr. JONES. Mr. Brotzman, the Children's Bureau of our Department is actively promoting the utilization of this new research knowledge to prevent mental retardation from this cause.

Mr. BROTZMAN. How new is the knowledge?

Dr. FELIX. I was going to say it is not quite 10 years, 1955, I believe, or somewhere around that. 1955 to 1957 was when this method was developed so it could be applied on a mass basis.

Mr. BROTZMAN. And that represents a lot of kids.

Dr. FELIX. Yes, it does.

Mr. BROTZMAN. That physiological factor could be determined at an early point; isn't that right?

Dr. FELIX. Yes, sir.

Mr. BROTZMAN. I am wondering, where is the breakdown? Why isn't there an incentive to do this?

Dr. FELIX. While the test was known and the children could be identified, and in a number of areas, as I said, they were identified, it wasn't until about 3 or 4 years ago that a definitive treatment was developed which could be instituted to prevent the retardation occurring once the condition was found. Now they find by giving the appropriate diet, till the child is about 5 years of age, the child apparently can go on a full, regular diet and be all right from there on. What you bring up is really important though for something else. Every time a child who would have been a Phenylpyruvic retarded child is saved from this fate, he grows up to have normal intelligence. He bears this defect in his own chromosomes and can pass it on. We begin to get a larger and larger number in the population who are going to be potentially PKU's. And we are going to have to give more and more attention on a broader and broader basis to screen all children in order to apply this early enough. We have done one more thing. We now can identify in adults whether or not one carries this defect even though one doesn't himself manifest it. We can then counsel him that when he marries he should be very sure, particularly sure, that when his children are born they be carefully checked for a long enough period of time to be sure that they either do or do not have this condition and where necessary the proper diet can be instituted.

In other words, if in this condition, Mr. Brotzman, and this is a good example of how public health operates, we now can identify the people who can pass this on, we can institute detection methods for picking it up within a couple of weeks after birth then we can institute the proper treatment, knowing about the length of time the treatment will have to be carried on. This is primarily prevention.

Mr. BROTZMAN. I picked this example out because it looks to me like you can find the defect at an early moment and also there is an opportunity to cure, to correct?

Does the information go out to the various States so that they can start a program on this, or how does a program result that will imple-

ment the discovery that has been made by the expenditure of dollars?

Dr. FELIX. There are three or four different ways this gets out. It is probably usually first communicated to the professionals in the field at their scientific meetings each year. Somebody reports in a paper that he has done this and he has found these things or he has instituted this procedure and it seems to work. Usually after that it is picked up and given a field trial, in which a whole State or community is covered to see whether or not the condition can be identified with a high percentage of accuracy and then institute proper treatment. When it has reached this point, this information is then communicated to the doctors, all doctors, particularly health officers and pediatricians. The Department of Health, Education, and Welfare, like the other departments in the Government, has Regional Offices over the United States. We have one of the Regional Offices in Denver. There are specialists there in the various health fields in the case of the Public Health Service, which is a part of the HEW. In the case of our Denver office there are five States for which they are responsible. They communicate directly, go visit the health officers and physicians and others, and communicate this information. They are available for consultation at any time to assist the States in getting this program off the ground.

So through scientific communication, through demonstrations, through consultation, and through health education, in which the information is broadcast across the States through the proper media, you get the people motivated. You get the information to the appropriate people to give the treatment and you get on top of the problem.

Does that answer your question?

Mr. BROTZMAN. Yes, I appreciate your answer, Doctor, but with a known cause for which we have a corrective means, I don't understand why all this time has elapsed that we don't have a program that is operative.

Mr. JONES. May I speak to that question, Mr. Brotzman?

This is a problem across the board. As we develop new techniques of therapy we get new knowledge about how to treat disease. Why do some children still have diseases which could be prevented by vaccination? They are not vaccinated. There are problems of this kind. This whole mental health program that we are discussing and you are considering today is an effort to stimulate the utilization of new knowledge and new techniques to prevent and to cure mental illness. Your illustration is an excellent one in this particular regard. You are talking about hundreds of children. We are talking about thousands of children and adults who are not being treated now but who could be if the facilities and the manpower were just made available.

Mr. HARRIS. The real answer to the problem is that the hospitals and the doctors have not pursued it. They are the ones responsible because they are the ones responsible for the child when the child comes into the world.

Dr. FELIX. They are now pursuing it, and as far as the Federal Government is concerned, it has no direct responsibility, but is promoting the utilization of new knowledge for the benefit in this disease of children. As I say, the Children's Bureau is actively working in this field to promote the utilization of this new technique.

Mr. BROTZMAN. I think we have to go to the House, Mr. Chairman. I withhold any further questions.

Mr. HARRIS. Mr. Jones, Dr. Terry, and Dr. Felix, we want to thank you for your testimony this morning. You will return in the morning at 10 o'clock.

The committee will be in recess until 2 o'clock this afternoon or just as soon thereafter as the House concludes the legislation that we have, and we will meet for the purpose of hearing these people from the various States who are here who must return to their responsibilities.

Mr. JONES. Thank you.

(Whereupon, at 12:20 p.m., the hearing was recessed.)

AFTER RECESS

(The subcommittee reconvened at 2 p.m.)

Mr. ROBERTS. The subcommittee will please be in order.

I call next Jack R. Ewalt, former commissioner, department of mental hygiene, State of Massachusetts, and presently president of the American Psychiatric Association and superintendent of Massachusetts Mental Health Center.

STATEMENT OF JACK R. EWALT, M.D., FORMER COMMISSIONER, DEPARTMENT OF MENTAL HYGIENE, STATE OF MASSACHUSETTS, AND PRESENTLY PRESIDENT OF THE AMERICAN PSYCHIATRIC ASSOCIATION AND SUPERINTENDENT OF MASSACHUSETTS MENTAL HEALTH CENTER

Dr. EWALT. I testified about 2 months ago, on the preceding bill, and I will not repeat myself. It might be useful to the committee, with regard to some of the questions raised this morning, if I talked a bit about the experience we had in establishing community mental health centers in Massachusetts.

Because I directed the joint commission, I knew what the recommendations were, and we began to experiment to see whether or not these were practical ideas.

I left the commissionership in Massachusetts and took the chair at Harvard when it was offered, in order to run this experimental unit. (We have also gone into the community and set up some new ones.) I will give you two or three examples, and then answer questions.

The original one had been a mental hospital called the Boston Psychopathic, rather famous as a teaching and training institution. At one time it cared for about 2,000 patients a year in the hospital and about 700 in the clinic. It is a small hospital, with about 200 places for patients. People were coming in and being processed and sent on to the big State hospital. We reversed this completely so that now the hospital is seeing, via the clinic, over 4,000 cases a year. These are people who stay home, work, and so forth, and only about 700 enter the hospital.

I don't have the figures for last year, but the year before last we sent only 40 patients on to big State hospitals. We didn't cure all the rest, you understand: Some of them are still under treatment, but

they are home keeping house, working, and living outside the hospital. Many of them are students.

The Department of Mental Health then decided that, since this unit is in Boston and part of a medical school, we should experiment with some centers out in the community where there are staffing problems that would be typical of hospitals in more distant and sparsely populated areas.

One of the first ones was in Fall River, Mass., to serve the Fall River-New Bedford area. These are two small cities—the total population may be something in excess of 150,000 for the district. It is served by a hospital called the Taunton State Hospital, a typical large State hospital about an hour's drive from these two cities.

After the Department of Mental Health surveyed the community, the best plan seemed to be to establish the unit in collaboration with a general hospital in Fall River called the Union Hospital. This hospital had some unused space and was willing to make other space available. The legislature appropriated money for a building of 40 beds, but rather than waiting until the building was completed they decided they would open the clinic and the day hospital facilities first.

They are now constructing the building. The Taunton State Hospital has been running the clinic and the day hospital program for about 2 years. I think we have learned some very interesting things from this operation. In the first place, there are more than 200 patients in attendance at the center, and 158 are being discharged back into the community in the first year; the second year has not quite finished.

We also learned another thing. When the physician who is in charge of the center was running it, the emergency admissions to the Taunton Hospital dropped off to almost nothing. This physician was then taken with an acute illness and did not work for about 3 months. During the time he was ill the emergency admissions from that district shot right back up in spite of the fact that the nurses and the social workers were still on duty; while the hospital general medical staff tried to support them, they could not quite bring it off. Now this physician has returned to duty. They are allowing him to work only 2 days a week, but his being there 2 days a week is sufficient to allow the rest of the staff to carry on, and the emergency admissions from Fall River and New Bedford have again decreased. In other words, they are taking care of the emergencies in the community hospital.

I think the lesson we learn here, in times of shortage of personnel, is that one doctor could cover two centers, going to one place, and then traveling to a second one. If you gave him a supporting staff, this plan would help with the manpower problem.

Now, to illustrate how important it is that you individualize these centers for a community, I will take another community centering around Quincy, Mass. We have had in Massachusetts, as you have in Minnesota and other places, so-called area mental health centers. The word "center" is confusing as it is used here. These centers basically were child guidance clinics offering consultation and advice to teachers, school people, the juvenile courts, and similar services for adults in the community. They contain no beds, and no rehabilitation service; the centers are mainly outpatient diagnostic and treatment clinics.

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However, the center in Quincy is a very active one. The State hospitals that served that district had a followup clinic there, and a team from the hospital came to Quincy periodically to see new cases. So we combined these two services with the court clinic the State ran there. This became the nucleus, to which was added a rehabilitation service, services to retarded children, and so forth.

Here, too, they have not constructed a hospital but a small inpatient units is in the planning stage. They are taking care of a large number of patients who don't need to go to the hospital; they are integrating their rehabilitation services and their treatment services, and successfully.

In the Massachusetts Mental Health Center, we have had some experience with withdrawal of Federal funds; our experience may answer a question asked this morning. We had one of these title V or project demonstrations to see whether we could provide emergency service and keep patients out of the hospital and at home. We had the grant for 3 years. We found out some of the things we could do and some of the things we could not do. It was so obviously effective that the State picked up the tab, and we now have what we call the walk-in clinic.

Our experimental sample during 3 yeras we were working on the research was about 150 cases a year. The first year we ran it by ourselves; 600 cases were served. We are now into the second year. I believe I indicated previously previously that the record would show that the second year was running at the rate of 1,700 a year. I am not sure whether I put that in the record, but that is what it was for the first few months. I checked the figures yesterday: actually there are now 10 or 12 patients coming each day. They come 24 hours a day and weekends and holidays. This will be at the rtae of more than 3,000 a year if the cost load continues at the level.

The interesting thing is that since we started this program the waiting list for our out-patient clinic for definitive treatment has disappeared—a waiting list that had existed for 50 years. Now about half of these patients can be cared for at home, about half of them come just once and are not seen again, and a few do have to go into another hospital.

I think my colleagues might be able to also offer information about another hospital in Massachusetts where we were building the clinics on the hospital grounds, where we moved the Worcester child guidance clinic to the grounds of Worcester Hospital.

We were able after a while to close down part of the hospital, but, you see, it is necessary to have support for staffing it first. When one of these new centers is ready to go you can't transfer money from the big State hospital to support it in the first year because the big State hospital has to continue to take care of its cases until the new facility is functioning. It is possible that some States (certainly not Massachusetts) would be foresighted enough to provide an adequate budget so that the center could be put into operation first. There is no understanding of the number of people it takes. I think you have to look upon the 75 percent staffing and subsequent decrease as a demonstration, as you do under title V where you must demonstrate the need to the community. Otherwise, I think you will never get them off the ground.

Now, as to this one I mentioned in Fall River, we had to make appropriation to open that, but as it gets going we will close part of Taunton; we can then perhaps begin to drop that appropriation and run it from the old appropriations for Taunton. I don't know if this is clear.

That is all I want to say. We have been into this now for about 4 yeras, and I will try to answer questions.

Mr. ROBERTS. Doctor, you served, I believe, as Director of the Mental Health and Study Commission that was set up under the act of 1955, did you not?

Dr. EWALT. That is right.

Mr. ROBERTS. And I look back at the statement you made on page 240 of the hearings, and I think it is significant to recall what you had to say about Federal stimulation. You reported that you provide a program for national institutes of mental health from eight States. I am quoting from your statement now:

> At the time you appropriated the first $3 million, the States were spending less than a million dollars a year in total on their community mental health programs. This current year—

I think this points up what you say—

> the States are spending more than $100 million of their own State and local money, principally stimulated by your action.

Dr. EWALT. That is right. I could give you other examples.

Mr. ROBERTS. Now you also mention that you were president of the American Psychiatric Association. Has the association taken an official position on this legislation?

Dr. EWALT. Yes. I want to point out that the American Psychiatric Association, the oldest organized association in America, older than AMA, has consistently devoted its effort and attention to the care of the mentally ill. It was along with the AMA, one of the sponsors of this study; it endorsed this study, it counseled. The association has had a special committee review not only the President's mental health message, but these bills—your two, which were 3688 and 3689, and the two Senate bills, which were combined later in 1576—and they have gone on record; I believe your record contains official statements from them endorsing these bills and urging their passage. As their president, I am authorized to speak for them. We do endorse the bills and we do urge their passage.

Mr. ROBERTS. Now considering the selection of the personnel in the staffing, would the qualified people that would be paid on the Federal staffing program, that is under the contributions which are to be matched, would these people be selected by the private or public nonprofit groups in the community already in existence or to be organized?

Dr. EWALT. That is the way it is contemplated in the bill. I don't see how else it would work. I think what would happen, if I may cite Massachusetts again, in most areas is that you would have a committee or a board, much like the ones hospitals have, with representatives from various groups in the community—business, labor, industry, law, medicine, and so forth. They would undoubtedly select a qualified director, and receive advice and collaboration from the mental health and authorities in the State. I presume that the director would then himself select the remainder of the staff.

Mr. ROBERTS. Now would it be true that when we change the picture to a community picture that a large percentage of the patients would be paying patients?

Dr. EWALT. Well, I think this would vary within the community. For example, consider the city of Boston. The hospital I run is out in a better part of town, and takes patients from all over. We get a lot of patients from the colleges and universities. Most of those patients reimburse the State. On the other hand, we get a lot of patients from Roxbury and South Boston and most of those do not.

The State plans on building another one of these centers in South Boston because our hospital is small. I would presume that they will collect very little on that one.

On the other hand, they are building one in Cambridge, Mass., which is just barely getting underway. It has not started taking patients yet, but I presume that they will get a great deal of money back on that; Cambridge is basically a prosperous community.

Mr. ROBERTS. This is not in your line, but I think you might be familiar with it. Do any of the hospitalization insurance plans that are now in effect cover mental illness?

Dr. EWALT. Yes; there is a great variation. I am happy to say that due to a good deal of discussion and pressure, there is an increasing tendency for those hospitalization plans like Blue Cross and Metropolitan policies, and so forth, to pay for mental illness. There is great variation among the States. Years ago when I was at the University of Texas, for example, and ran their mental hospital and their general hospital, we collected from Blue Cross on all the psychiatric patients that came in there just as we did for the surgical patients. When I went to Massachusetts, I found that their Blue Cross program had different rules and would not pay a cent. Now they have begun to pay a little bit, and they will pay longer under the so-called catastrophic illness clause. So there is a great variation, but the trend is for more and more of these insurance agencies to cover, particularly when in private or nonprofit hospitals. But they still drag their feet and squawk like the blazes about paying State hospitals.

Mr. ROBERTS. You would believe then that both the amount of expense and the length of time usually required for the treatment of a mentally ill patient would be considerably reduced with this new program?

Dr. EWALT. I am confident it will. We have had experience, I think, that shows that. The reason is that you get the patient while he is still acutely ill, before the illness has gotten set, let's say. Furthermore, you are able to treat him just as much as he needs. Too often the only thing available to the patient is these general hospital units, and he has to go into the hospital. And if you have been in the hospital yourself, you know that they tend to infantilize you, begin to think for you and move for you, and so forth. I think the Army experience, our own experience, and so forth, has shown that hospitalization prolongs illness unless it is absolutely necessary. The facilities under proposal will greatly cut down the amount and type of treatment and the amount and duration of treatment.

Mr. ROBERTS. Thank you very much, Doctor.

Mr. Nelsen?

Mr. NELSEN. No questions.

Mr. ROBERTS. Mr. O'Brien?

Mr. O'BRIEN. No questions.

Mr. ROBERTS. Mr. Brotzman?

Mr. BROTZMAN. I have a question.

I was just referring to your testimony, Doctor, here on page 240 of the hearings. I believe you stated that—

At the time you—

You referring to the Congress—

appropriated the first $3 million, the States were spending less than a million dollars a year in total on their community mental health programs. This current year the States are spending more than $100 million of their own State and local money, principally stimulated by your action.

The question I am asking: How do you arrive at the conclusion that the expenditure of the Federal moneys stimulated the activity by the States?

Dr. EWALT. Well, that is a very fair question, and I will answer to the best of my ability. In the first place, many of the States had no such program at all, and were not spending anything. The Federal money became available. They began to use it to begin to set up some clinics. I think you will find that, except for two clinics run by the University of Colorado, this was generally true in Colorado, my home State and your home State. The Public Health Service used this money and pushed the idea in certain communities that there be a clinic; those that were receptive took it. For the mast part, these clinics worked. They all got too busy; how did they manage to increase the staff? Either the State or the local community or both had to augment the staff because the Federal grant was very little more money. You will find if you look it up, that you are getting very little more in Colorado than you got in 1948.

Other communities saw what was going on, they wanted to get on board, so they went to the legislature and got them to make an appropriation and then began to match that. I think we have some evidence that this was the case.

Now, if we can go over to the area of training of doctors, this committee again originated institutes of health; at the time there were very few residents being trained in this country. For instance, in Massachusetts, the whole Harvard setup was training 36 in 1947. I just happened to be counting them up for another reason yesterday, and there are now 136 in the Harvard program alone. Originally, with the first 36, the State was paying for 4, the Commonwealth Fund for 4, and the others were paid small sums by private hospitals. Now, in my hospital, the Federal Government is paying for 12 trainees, and the State is paying for 48.

I am sure that other factors are at work, for example, the general public's wish for these things, but I am confident that these demonstrations of usefulness made by the Federal Government played the major role in stimulating this. I think this is good evidence.

Mr. BROTZMAN. The reason I raise the point, I do think the vox populi is speaking in this area, and is stimulating at least some part of the activity. I am confident that this has occurred in Colorado. I think others in the room from Colorado would have to agree that in part there is an increasing and growing local interest in trying to do something about this problem.

Dr. EWALT. Mr. Brotzman, I don't want to belabor the issue, but I know a lot about Colorado. Dr. Eagan started the first of those clinics in 1924 or 1925. At first there were four, but neither the communities nor the legislature persisted enough, so they finally decreased to two, Creede and Grand Junction. That state of affairs remained, and Boulder followed. They really didn't get underway until the Federal aid program began to come through after the war in 1946–47. A great deal of the voice of the people demanding these things resulted from experience with the clinics set up under this program: people became aware that this is a service that you can buy, which you can spend money and establish, but I don't think we would have had any more success than Dr. Eagan—as you know, he can talk money out of me. But he could not sell this to the public until there was money to demonstrate these things in an adequate way.

I agree the vox populi was there, but I think the appropriations from the Congress had a lot to do with stimulating the vox populi, however you pronounce it; I am not a scholar.

Mr. BROTZMAN. Your Latin is as good as mine.

I had one other question. In your Massachusetts program, do you have the mental health or the mental illness program working in conjunction with the mentally retarded program?

Dr. EWALT. Yes, it is all in one department, called the department of mental health.

Mr. BROTZMAN. But they are two separate things, isn't that correct, in a sense?

Dr. EWALT. Well, yes and no, sir. I am sorry I can't answer it precisely. I can answer it, but not with yes or no. The residential schools for the retarded children, of which there are four, are quite separate from the mental hospitals. The laws for sending patients, committing them, and so forth, are separate. They are under the same chapter 123 of the general law but they are different sections.

On the other hand, the community clinics examine and manage the retarded children who can stay at home. So in the outpatient program they are handling the same agency, in the institutional program it is separate.

Mr. BROTZMAN. These two aspects, mental illness and mental health, and the mentally retarded, what is your concept as to how those will be handled under the legislation we are considering here?

Dr. EWALT. Well, I would think, as I read the legislation, that emphasis is on our current knowledge. You note that the mental retardation part of this emphasizes research because, except for the phenylpyruvic acid, we don't really know how to cure any form of mental retardation. Now we have got great breakthroughs on one of the commonest forms of mongolism. We know it has a chromosome, but we don't know how it gets that way. This raises hope. This program does not envision taking over the States' custodial function for the severely retarded. It does not, as I remember, envision taking over the public school or other school programs for training and education. It emphasizes research.

The mental health aspect emphasizes a great deal of treatment, rehabilitation, as well as prevention. There is not much research mentioned in that as I recall, but we already have a very large research program through the institutes of health and mental illness.

I would say that in some communities these mental health centers will serve both groups, diagnostically and therapeutically, up to the point where they have to be sent to a school, but a retarded child who must go to a special school requires a different facility than does a psychotic child who must go somewhere for treatment.

Whether they decide to build on the same campus will depend on the States and even on the communities within the States. I am not sure if I answered your question.

Mr. BROTZMAN. That is pretty good. I am trying to visualize how it might work there at the local level, because I can see the related problems, but I can also see that the method of handling a psychotic child would be markedly different from a child that was mentally retarded.

Dr. EWALT. Can I interject a sentence about Massachusetts again?

Mr. BROTZMAN. Surely.

Dr. EWALT. In the center I run we now have a very active program for treating psychotic children, psychotic adolescents, delinquent adolescents. We have a very active program for diagnosis of mentally retarded children and for treating the emotional aspects of it. We are planning to build a research facility where we will work further with the Children's Medical Center in studying the causes of these. We are going to build whether this is passed or not. I don't think we will be far enough along to benefit from it financially.

The children who come to this center will then go to the public schools. If they are so severely retarded that they cannot go to the training and public school programs, which are two different programs, but must go to an institutional school, I think that they would go to one of the State's residential schools or one of the private residential schools. But up to that point, as long as they can be cared for at home and go to the public school, as long as it is a matter of treating the emotional components, that is, the emotional reaction to being retarded, we would treat them in the same center.

I am sure other areas even within Massachusetts might draw the line a little bit differently. It must be made flexible. That is how I look at it.

Mr. BROTZMAN. I will just mention one more point, and I will quit. You talk about the mongoloid.

Dr. EWALT. Yes.

Mr. BROTZMAN. Is something being done in this particular area?

Dr. EWALT. Well, of course, they have discovered there is an aberrant chromosome in these mongoloid children, but I don't think it is at all clear at the moment. These people back here are probably more expert in retardation than I am. I intend to work the other way. At least as far as I am aware, we don't know why the aberrant chromosome shows up.

We are sure mongolism is very severe, but it is encouraging when you can make one little definitive step forward.

Mr. BROTZMAN. Thank you very much.

Mr. ROBERTS. Doctor, I didn't mean to get into this—as you say, you worked in the opposite direction from the mentally retarded—but I had hoped somewhere along the line some outstanding man in your profession would come up with a term that would take the place of the term mongolism. That seems to be a horrible way to describe these children.

Dr. EWALT. I agree.

Mr. ROBERTS. I wanted to ask this one question. A few days ago someone brought to my attention that many of these children that they would discover in time were victims of some type of upset in the metabolism, and with proper nutrition that perhaps as many as 3 to 5 percent of these children would be almost totally restored. Is there anything you have to say on that?

Dr. EWALT. Not the mongoloid, sir. Periodically people come up with various kinds of pituitary and pineal juice, little organs at the base of the brain, which they have injected in these youngsters, and they give rise to false hope in parents. I have seen some of this work and I have seen some of the youngsters supposedly improve. These kids are sort of cute, and they grow a little bit smarter. I think the parents have been victimized, and I don't mind having the record show I said this.

If the phenylpyruvic deficiency cases, the phenylalanine type of deficiency, are detected very early and the child is put on a phenylalanine-free diet—the pediatubous followed some of these youngsters for about 5 or 8 years—after 5 or 6 years—that is, at the age of 5 or 6 years—something is changed; he can then eat a regular diet and the deficiency does not develop, but it is crucial that he be treated before the symptoms of mental retardation appear, before the brain damage occurs. This is what all this bit about the urine tests, and all, this morning was. You have to test them at birth or very shortly thereafter and start the diet very early while they are still newborns for it to work as a preventive. It is not only preventative, it is curative.

Mr. ROBERTS. Would it be a fair statement to say that even families that are financially secure have a very difficult time in this country in finding adequate treatment for mentally retarded children?

Dr. EWALT. I don't think there is a single community in the country, even in Boston, where we have the facilities to treat adequately all the mentally retarded children or all the mentally ill persons that require treatment. We have never given enough time, money, effort, or attention to this problem.

Mr. ROBERTS. For a family of modest or low income, there is just not much hope under the present system, would that be true?

Dr. EWALT. That is right, sir. For the most part they are sent away to institutions. A few can get into the schools.

Mr. ROBERTS. Mr. O'Brien?

Mr. O'BRIEN. No questions.

Mr. ROBERTS. Thank you very much.

Dr. EWALT. Thank you, sir.

Mr. ROBERTS. Next I would like to call Dr. George Ulett and Dr. Harold Visotsky, and Dr. George Jackson, and ask that these three gentlemen organize themselves into a panel. That way I think we can expedite the hearing and accommodate you gentlemen, too.

Now, Dr. Ulett is director of the Division of Mental Diseases, Department of the Public Health and Welfare, State of Missouri; Dr. Visotsky is director of the Department of Mental Health, State of Illinois; and Dr. Jackson is State director, Little Rock, Ark.

I suppose the best way is to just let each one of you gentlemen make your statements and then we will reserve questions until the end.

STATEMENT OF DR. GEORGE ULETT, DIRECTOR, DIVISION OF MENTAL DISEASES, DEPARTMENT OF PUBLIC HEALTH AND WELFARE, STATE OF MISSOURI

Dr. ULETT. Mr. Chairman, members of the committee, I have a prepared statement which I will give you and just briefly review what is in this statement.

I am George Ulett, a professor of psychiatry at Washington University School of Medicine in St. Louis and a graduate of the University of Oregon Medical School.

Presently, I am director of the Division of Mental Diseases of the State of Missouri. I appear before you to give our full support to this bill 1576 and particularly title II, section B of what I feel is extremely vital legislation for our country.

The concepts here are embraced in full by our Governor, John M. Dalton, who previously sent you a message in support of this bill, and I am pleased to come as his personal emissary today and again reaffirm his support in favor of this legislation.

I am very happy to be able to report to you today that it was only last week that the house of representatives of our 72d general assembly in Missouri gave a unanimous endorsement to the already unanimous endorsement of our State senate of a bill authorizing the setting up of community mental health centers across the State of Missouri. I think this is particularly important. Our State is known as the Show Me State. This means that our people have a certain rational conservatism and like to know the facts before they buy a program.

I think it is also important that in testimony given to your committee previously Missouri turned out to be somewhat behind the other States in their mental health program. There are 32 that give more funds per capita for care of the mentally ill.

I think these two facts make it particularly significant that our State did review the facts and voted in favor of setting up community mental health centers such as are being discussed under this bill.

I am new to my position as a State director. Previous to this, I was director of a community mental health center in St. Louis. At this center we were quite familiar with patients entering and 90 percent of them returning back to work and back to their community after a stay with us of only a few weeks. Therefore, I was tremendously distressed when I became responsible for a State hospital program, which is similar to State hospital programs throughout the other States.

We have five large hospitals averaging over 2,000 patients in each. Here we found patients spending needless months and years. I saw this to be true yet did not have the facts to bring this convincingly to the legislators of Missouri so we conducted a study. Within our own State we had two community mental health centers, one in Kansas City and one in St. Louis and were able to compare what happened to patients when they entered these community mental health centers as against when they entered one of our State hospitals. We found that when the same kinds of patients entered a community mental health center there was accomplished there in a matter of a month at about half the cost what was done for the same type of patients when they entered a State hospital and there required 9 months of treatment.

We, thus, studied two groups of patients—all of the first admitted patients to these two types of hospitals that existed in our State. We found the average patient stay for a man coming for the first time to a community mental health center was 32 days. The same kind of patient in a State hospital stayed 255 days.

Now, the cost is higher in the mental health center, primarily because of the cost of staffing. We found the cost there was $24 a day as compared to $5 in our State hospitals. When you compare the total cost of treatment taking into account the shorter stay, we found that it was indeed a saving of a considerable amount of money to hospitalize a man in the community mental health center. You can also add to that the fact that there is a saving in productive income and in taxes to the State.

The question arises as to why is the treatment so much better in the community mental health center. There are a number of reasons but the main reason is the high ratio of staff to patient. In our State hospitals in Missouri we average 1 psychiatrist for 220 patients and 1 nurse for 90 patients, and in the community mental health centers in our State we average 1 psychiatrist for 8 patients and 1 nurse for 5 patients. Staffing, then, is the keynote to the success of the operation of the community mental health center. Therefore, I feel that this initial staffing section of title II, part B, is the important part of this legislation.

Now, it is, I think, very important that there is a buildup period (4½ years) in which the Federal assistance is available because it does take time to build up the staff, it takes time to build up the community support for financing this kind of operation. Yet, we know that unless we have access to the financial means to have a good staff at the begining, we are going to fail in our purpose. If the operation is a failure, we are not going to be able to interest the community in continuing its support.

I think it is very important that there is a stepwise decrease in the Federal assistance over the years because this then allows the local community to assume an increasingly greater responsibility as each year progresses until finally they take over the full responsibility of operation.

Now, because staff is the key to this whole problem, we give major consideration to this in our plan for these community mental health centers in the State of Missouri.

We were not going to place ourselves in the position of building schoolhouses without having teachers, and the location these centers is therefore tremendously important. We have tried in our State for years to get professional people out into the rural areas into our State hospitals, and if we had succeeded we would not be here talking about this problem today.

We did a manpower study of professional workers in the State of Missouri and we found they were located in three locations. I think it is no surprise to any of us that these were the places where we had medical centers, medical schools, and training programs for psychiatrists, social workers, and psychologists.

We, therefore, decided that initially in our program this is where we would place our community mental health centers. It may be of interest to this committee to know that in these three locations we

have today 70 young residents in training in psychiatry. This is twice as many psychiatrists as we need to staff these units that we intend to build.

Now, the Joint Commission on Mental Illness and Health has said that the problem is that there are far too few psychiatrists today going into public service. We feel that if we can have Federal funds available we can immediately recruit such people as are in training in these centers into these exciting new programs of community mental health that everybody is looking at and watching across the country and we can indeed reverse the trend and bring people into the field of public service psychiatry.

I speak from personal experience in this. In the community mental health center in which I worked for 10 years, we had a lack of money as we were supported by a municipality, and I am sure you all know of the financial problems of municipalities. So we could not obtain the money that we needed.

We had a very active training program with many doctors being trained yet when these young men reached the point of graduation, we did not have the money available to recruit them. These men who would have liked to have stayed and spent another year or two in public service went off into private practice and with loss to this great cause. In my own training I was for a time a fellow under our National Institutes of Mental Health program and thus was enabled to spend my time in teaching and research, finally moving into this area of public service. I think that the "initial staffing" portion of S. 1576 will create opportunities of this kind for other young men as they come along.

Missouri has very few mental health workers and that is why we feel that in the beginning of our community mental health center program we must start at these three locations that I have mentioned. With Federal assistance coming in, we will have ability to train more and more people and will then be able to move ahead in a few years to a second step of our Missouri program, namely, bringing this program out into the grassroots, into the smaller towns in the great rural areas of our State.

I believe that each State has unique needs. Each State must start from where it is and must face its own individual problems. Our problems in Missouri concern making available this adequate type of treatment early in the course of mental illness to all persons in each of the 114 counties in our State. If we cannot bring these centers close to the homes of each of the people in the 114 counties because we cannot bring the staff out to these rural areas, then the least we can do is make this kind of treatment available to all patients at centers where the staff is available. Later we can train more staff and spread out across the State.

We feel that the concept of having these units close to the patient's home is an extremely important one; we recognize this is what we must all strive for. We think it is even more important, however, at this stage that at least we adequately staff the units that we build. Some States are more fortunate than Missouri in the number of mental health workers they have. In some of our States here on the eastern seaboard, for example, you can bring these units close to the patient's home. In Missouri we have a good highway system and we

are concerned more with nearness in terms of hours of travel than we are in the geographical nearness. I would say we measure our nearness in minutes rather than in miles.

I would, therefore, hope that there would be a liberal interpretation of the word "near" in paragraph 3 in section 222 as regards the authorization of assistance for this kind of unit.

I would like to draw your attention to a provision in S. 1576 stating that Federal assistance for construction is a prerequisite for requesting "initial staffing" funds.

I am very pleased to note, therefore, that this bill is now authorized to begin in July of 1963, because we have a tremendous momentum in our State for improvement of mental health, and I would hesitate to delay our program even for 1 year. We do feel that Federal funds can be of assistance to us, but also feel that the sooner we can get this program underway, the greater the amount of money we will save our State in terms of a more effective and economical treatment program in these community mental health centers. Thus, not only State dollars will be saved, but also citizens will be able to return to their useful, productive lives in the community.

Gentlemen, it has been a pleasure and an honor to discuss S. 1576 with you here today. I feel this is a great step forward in the field of mental health. I believe the provisions of this bill, particularly the part that relates to funds for initial staffing of these new community mental health centers, can be of the greatest assistance to improve care for the mentally ill of Missouri and of the Nation.

Thank you.

Mr. ROBERTS. Thank you, Dr. Ulett, for a very fine statement. I think I have changed my mind. Instead of waiting until each one of the doctors completes his statement, I will go ahead and have some questions now because we might lose the trend and the impact of your statement if we do that.

Mr. Chairman.

Mr. HARRIS. No; let the others proceed.

Mr. ROBERTS. The gentleman from Minnesota.

Mr. NELSEN. Do you find that the staffing personnel is readily available to you in the event that you need members staffing in these hospitals at this point?

Dr. ULETT. I would answer the question, Mr. Nelsen, this way—that we feel, in our State, we must be very careful where we place these units if we are going to obtain staff. It is the old adage of "Should you move the mountain to Mohammed, or does Mohammed come to the mountain?" In Missouri, we have been waiting a long time with our large mental hospitals and their problems in out-State areas, and Mohammed has decided not to come there. Now we plan small community mental health centers located near these scarce mental health people—and we found that they like to stay in medical centers, they like to be near the medical schools—this is where these young people are in training.

As I point out, we do have, in Missouri, at the three points where we hope to start this program, twice as many young psychiatrists in training as we actually need, if we opened the doors of these three hospitals tomorrow. At Columbia, where we are planning one of these units, they are initiating a new resident training program this

year. There is another residency program in psychiatry opening next June at the St. Louis University Medical School in St. Louis. We are looking to these new training programs and the training programs that exist to find the staff for these units and we are very sure of assistance, because the number of psychiatrists now in training is in excess of our needs. We will thus, indeed, be able to find the people necessary for these units that we plan.

Mr. NELSEN. In the event of a shortage of staffing personnel, title III of the bill, where the Federal Government would provide assistance for the training of the proper professional assistance for the units, that would be a very important part of this bill; would you not think so?

Dr. ULETT. We feel that any money that will assist with training is tremendously important. It does not show its effects immediately. It requires a year or two to train these people, but we must look to the future. The more we train the more adequate care we give in the future.

Mr. NELSEN. The thing that some of us have been struggling with is that some seem to oppose the staffing feature, and you are trying to figure out which is the most important to provide training—we have the people available, or which is the most important? I think title III seems to be quite important. It may be necessary to use some staffing in earlier stages of the operation of these units.

Dr. ULETT. Well, if I could speak to that again, Mr. Nelsen, from Missouri—and I can speak only from our own experience—we will need funds to assist us in staffing immediately. That is, we will wish to hire some people who are already in training. Now, some of these people are on Public Health stipends in their training, others are being paid directly from universities and others from State funds. These men will be completing their training courses and we need money to hire them for these new service units.

In order to get these young men, we have to pay fairly good salaries, even though we cannot compete with private practice. On the other hand, there is a reticence of some of these young men, once they have completed their first 3 years of training, to plunge into the cold waters of private practice. They prefer to stay in the institutional setting for another year or two to acquire more experience before they are eligible for their official certification as psychiatrist by passing a test for their American boards. During that period of time we must be able to offer them a decent salary to compete with private practice and yet again we do not have to offer them an exorbitant amount. I think it is very important that we do have the Federal funds made available to us.

These funds can also assist us with training, because if we hire a young man as a staff psychiatrist in one of these centers in Missouri where there will also be training programs, the staffman will become an integral part of the training program. He is thus both a worker and a teacher and it is difficult, in my own mind, to separate the two functions for the use of funds that would come into staffing one of these units as to how much of this is service and how much is teaching, because all three of these hospitals will be combined teaching and service hospitals.

As you know, in the field of medicine, when a man is working on a patient, he is also learning. This is the way we train our people. I would say that any funds available for staffing, at this point, are extremely important to us in our program.

Mr. NELSEN. Do you anticipate we can face it up as the bill proposes at the end of the period set forth?

Dr. ULETT. Yes, I do. However, I feel that we are going to have to prove the worth of the program to the State legislature and to the local communities. If we don't have adequate staff initially, we are not going to do the job because if one of these centers is only partially staffed, it is not going to do the job of treatment.

As we pointed out in our statement here, the efficiency of these units from the study we conducted in Missouri is primarily dependent upon the ratio of mental health workers to patients. If we start out with these units poorly staffed, we are not going to demonstrate a good job. If we don't demonstrate a good job, I don't think we have a salable product for the community. So these units must spring into existence almost fully staffed.

Then when they demonstrate an efficient job, we can phase into increasing funds from the State and local communities to support this program.

Mr. NELSEN. Thank you.

Mr. ROBERTS. Mr. O'Brien.

Mr. O'BRIEN. Doctor, I would like to congratulate you also on your statement. I think it is very pertinent to one of the problems we might face along the way with this legislation.

You state that the Legislature of Missouri unanimously has voted to establish these three community mental health centers. Presumably when you did it you were determined to proceed with that program regardless of what might happen to this legislation. Is that correct?

Dr. ULETT. That is correct.

Mr. O'BRIEN. Now, do you think that Federal aid in staffing of those centers and other centers that may be established would slow down or accelerate State initiative in that field?

Dr. ULETT. I believe it would accelerate it. It would help us get these units functioning at a more effective level than we can function now with the money allocated. We have a certain definite amount of money that has been allocated for this program. Missouri appropriates on the biennial system. Within this 2-year period, we hope to get two of these units in operation. The third unit is not going to be operating until the next biennial period. We will then need more funds from the legislature. If I know the tenor of the State legislature, I feel that they will be pleased if we have some outside money coming in. It will show that the Federal Government thinks this is a good program, and the State legislature will not have to appropriate quite so much in this biennium and can look forward to a graduated program by adding more in the following legislative session.

I had a chart I used in presenting this to the legislature made up from figures on the cost of operating our division of mental diseases over the last 10 years, and the increase in funds into the mental health program was a line that goes up toward the corner of the ceiling. We

were able to make an estimate of the kind of cost increase of community mental health centers and it was a line that was much flatter. This is because the community mental health centers are small units and unless they are almost completely staffed at the beginning, they don't do the job they should do. It is almost a fixed cost program instead of a program of rapidly rising costs.

I think this is something that improves economy, and that a legislature can see putting money into this at an increasing rate as the years go by.

Mr. O'BRIEN. Then you feel that these three centers will not achieve the full purpose that the legislature had in mind unless there is some help and quick in staffing?

Dr. ULETT. I believe that the Federal help would let us achieve our goal more rapidly and more effectively.

Mr. O'BRIEN. Yes; and also would permit the eventual establishment of smaller, perhaps, centers outside the heavily populated areas.

Dr. ULETT. That is correct. That is a further phase of our program that of course would depend upon the availability of staff. Again, these three units will be partly for training with the goal of providing more staff.

Mr. BROTZMAN. Will the gentleman yield for one question?

Mr. O'BRIEN. Yes.

Mr. BROTZMAN. I must have understood something you said before, Doctor. I thought you said you had twice as many psychiatrists now as was needed to staff these particular three centers in your State. Did I understand your testimony correctly?

Dr. ULETT. No, that is not quite correct. We have twice as many young psychiatrists in training programs at the points where these three units are going to be built. If we look back in history, these doctors in training will, almost wthout exception, leave Missouri or go off into private practice and will not be available to help with this very grave problem of public psychiatry unless these three units have positions and funds to recruit these men.

Now, my own experience at a community mental health center in one of our cities was that as these men finished training, they would have stayed with us if we had had the funds for hiring them. Many young doctors would come to me and say, "What will I do next year?" And unfortunately, because I had a limited budget, I could not hire these men and they were forced to go elsewhere. On the basis of this experience, we predict that we will have an excellent chance of recruiting from the pool of trainees enough psychiatrists to feed into these programs when these units come into existence.

Mr. BROTZMAN. I don't want to take more of my colleague's time. This program will be operative in other areas of the United States so that competition is going to be just as great after the enactment of the program as it is now, it would seem to me.

Dr. ULETT. Of course, but other States also have training programs.

Mr. BROTZMAN. Right.

Dr. ULETT. So I imagine each State will try to recruit for their own program first from their own State. We would rather try to recruit from people already in Missouri and would have a better chance than in trying to steal from another State.

Mr. O'BRIEN. After four and a half years you are going to have to carry the whole burden anyway.

Dr. ULETT. Yes.

Mr. O'BRIEN. You mention that you have five large State hospitals in Missouri, is that correct?

Dr. ULETT. That is true.

Mr. O'BRIEN. In earlier testimony we have heard mentioned a billion-dollar-a-year cost of operating these somewhat archaic State hospitals. Is not there another factor in there? If we do not reverse the trend, if we do not get back to the local level, would it not be necessary in Missouri and in other States to build additional large State hospitals perpetuating the system we have now? Is that correct?

Dr. ULETT. This is correct and I might give you an interesting figure. In Missouri last year—well, 1961 was the year of our study—there were approximately 5,500 patients admitted to all public hospitals in the State. Our five State hospitals have some 11,000 beds. Now—40 percent of all of the people who were admitted across the State were admitted to two community mental health centers that had a total of only 252 beds. We feel the way to reverse the trend of chronic hospitalization is to put a greater number of people through these small hospitals and prevent an increased number of patients in the large ones. I would agree exactly to what you said.

Mr. O'BRIEN. While there might be a question of time in diverting the operating costs from these large institutions to the local level because you would still need them, you would arrive in many States at a point where instead of building another large State hospital that enormous cost could be diverted to the local level; is that correct?

Dr. ULETT. That is correct.

Mr. O'BRIEN. Thank you.

Mr. ROBERTS. The gentleman from Colorado.

Mr. BROTZMAN. Thank you.

Doctor, what was your overall appropriation for this fiscal year for mental health in your State?

Dr. ULETT. The last biennial appropriation was approximately $60 million.

Mr. BROTZMAN. That would be $60 million. When you say the last, would that have been last year for a 2-year period?

Dr. ULETT. Yes, that is correct.

Mr. BROTZMAN. And I would assume that out of that total, part would be allocated to capital improvement or construction, part would be for operational expenses, is that correct?

Dr. ULETT. That is correct.

Mr. BROTZMAN. Do you know roughly how your budget breaks down as between those two items?

Dr. ULETT. The majority is for operations. We did not have very much money for capital expenditures. I do not have the figures with me but the majority of that was not for capital expenditures.

Mr. BROTZMAN. You say majority, something over 50 percent was for operation?

Dr. ULETT. That is correct.

Mr. BROTZMAN. Now, turning your attention to the question of staffing just for a moment. I am not sure this has even been spelled

out. What kind of a staff are we talking about? What kind of personnel, what kind of qualifications are you looking for?

Dr. ULETT. Well, let me tell you about the community mental health center where I worked for 10 years in the city of St. Louis. This was a 200-bed hospital and we had at that hospital 22 psychiatrists including the residents in training. We had eight psychologists.

Mr. BROTZMAN. How many psychiatrists?

Dr. ULETT. Twenty-two.

Mr. BROTZMAN. Twenty-two psychiatrists?

Dr. ULETT. We had 8 psychologists, 35 nurses, and 85 attendants.

Mr. BROTZMAN. Pardon me, are these 35 registered nurses?

Dr. ULETT. They are registered nurses.

Mr. BROTZMAN. All right.

Dr. ULETT. We had 85 attendants, 6 social workers, and the remainder of the 227 were supporting, ancillary workers such as housekeeping, personnel, etc.

This hospital in a year would process approximately 1,800 to 2,000 patients.

Mr. BROTZMAN. Now, when you say 200-bed, I assume there was no outpatient treatment?

Dr. ULETT. There is an outpatient clinic that handled last year around 9,000 patient visits. There is also a ward specializing in the treatment of alcoholic patients.

Mr. BROTZMAN. I was not quite clear on one bit of your prior testimony. Maybe you can spell it out a little better for me. You indicated with your arm going up the increase. Now, what was the expenditure that went up rapidly in the legislature?

Dr. ULETT. The 10-year record of appropriations for the division of mental diseases, the custodial care program.

Mr. BROTZMAN. And the one that was more level, which did this indicate?

Dr. ULETT. This was our projected costs of the community mental health centers and the flat curve of projected cost was based on the fact that these were small units. We are planning to staff them almost completely when they come into operation, and because they are small units and there will be no intention and no ability to increase major capital expenditures, you could not crowd more staff into these small hospitals and thus this would be a relatively fixed-cost operation over a projection of the next four or five biennial periods.

Mr. BROTZMAN. In your State is there quite a bit of impetus in the area of mental health among the people? Are they interested in doing something about it?

Dr. ULETT. Yes, we have a tremendous momentum in our State's interest in the mental health area. I think the good support of our program by our Governor, our endorsement by more than 25 State professional organizations, and, finally, the unanimous vote of both the senate and the house for a new improved program in mental health gives you some idea of Missouri's interest in improving the mental health program for its citizens.

Mr. BROTZMAN. If the Federal Government provided the facility, do you think your State legislature would appropriate the moneys to staff them?

Dr. ULETT. Well, they have appropriated money for partial staff for two of these units, but they appropriated the money for building the three units. I think they will certainly do all they can to give us the staff that we need.

Again, I can't read the crystal ball and know whether they will appropriate entirely for this. I do feel if there were some Federal assistance in getting this program underway we would certainly have greater assurance of the successful operation of these centers. I think that if they were operating successfully, and as Mr. O'Brien pointed out, reducing the overcrowding in the State hospitals, then we would have a tremendous amount of support for the State taking over the operation entirely as this stages out over a 4½-year period. I think the Federal money would be of tremendous assistance to us in selling this program and in producing a successful operation.

Mr. BROTZMAN. I appreciate your comments but I think you made a very true statement a moment ago that each State has a unique problem and has unique problems. It is obvious, too, that the money all comes from the same basic source to staff a hospital of this type. I say the same source, the same people are paying the bill whether they pay it to the Federal Government and we distribute the money or they accept the responsibility for or maintain their initiative at the local level.

If the structures and so forth were provided, would the people of your State just as soon assume the responsibility there as to pay it to the Federal Government and have the money come back.

Dr. ULETT. May I give you an example?

Mr. BROTZMAN. Surely.

Dr. ULETT. We have at the Malcolm Bliss Mental Health Center in St. Louis an alcoholic ward. I was at this hospital for 10 years and I tried unsuccessfully for the first 6 years I was there to develop a program for the treatment of alcoholic patients. The community was not willing to buy this and the State was not interested in the treatment of the alcoholic. We were able to get from the National Institutes of Health some funds to assist in setting up a demonstration project. It has now been in operation for a year and a half. It has been highly successful and the State will take this over as part of its own operation. It will then become entirely State supported and the Federal Government will phase out of the project. I think this is an example of the kind of thing the Federal Government can do in coming in and sponsoring something across the Nation as a program demonstration. The project draws it to the attention of the State and then the State picks it up.

Mr. BROTZMAN. If I understand your point correctly you think that by initiating this program it will be an educational proposition for your State legislature, is that right, so that they will assume the responsibility in 4½ years?

Dr. ULETT. I think it will be educational for the people of Missouri, the people of the State. I think ultimately we would bring these into successful operation but I think we could do it more rapidly with Federal aid. I think the sooner these become successful the more chance there is of the State picking this up as its total operation.

Mr. BROTZMAN. All right.

Mr. ROBERTS. Mr. Rogers of Florida.

Mr. ROGERS of Florida. Thank you, Mr. Chairman.

I want to commend Missouri on their advanced progress in this field. It sounds like a very excellent program that you have initiated. As I understand it you have three such centers.

Dr. ULETT. They were just authorized as of last week so they are not as yet in existence.

Mr. ROGERS of Florida. Not as yet in existence?

Dr. ULETT. That is right.

Mr. ROGERS of Florida. Do you plan to staff them to the extent as you have previously staffed them where you worked in St. Louis?

Dr. ULETT. Yes.

Mr. ROGERS of Florida. On the same proportion?

Dr. ULETT. Yes, that is right.

Mr. ROGERS of Florida. How much would you pay a psychiatrist for instance?

Dr. ULETT. We would pay a man who has finished his residency training, that is, I believe, 3 years of training, $14,000.

Mr. ROGERS of Florida. $14,000.

Dr. ULETT. Yes.

Mr. ROGERS of Florida. Now, how many would be on the staff at this rate of $14,000?

Dr. ULETT. Well, at our units, we plan to have 120 beds and we would hope to have probably 10 psychiatrists for one of these units.

Mr. ROGERS of Florida. All at $14,000.

Dr. ULETT. Yes, all begin at $14,000 but can advance to higher salaries.

Mr. ROGERS of Florida. Now, would these all be devoting their full time, these 10?

Dr. ULETT. Yes, all of the people that we have in our State division are full-time employees and we do not permit private practice in addition to the employment in our division.

Mr. ROGERS of Florida. Under the proposal here that we have now I believe it would allow private practice. Would this make a change in the staffing if that were allowed?

Dr. ULETT. Well, these would be part-time people and I assume they would be paid differently but if they were employees of our division, and our division will be operating these centers, these men would give full-time service.

Mr. ROGERS of Florida. Like you operate a hospital. I presume you allow private physicians to use the facilities and perhaps to pull certain duty on call, is this normal or not?

Dr. ULETT. Well, this would be considered a part-time man for us, if someone came in from private practice on the outside and could give a percentage of time to us. We do have part time, we have consultants in private practice and they are paid according to the number of hours they give service to the State.

Mr. ROGERS of Florida. If you allow them to use the facilities there, do they have to make any payment for the use of these facilities?

Dr. ULETT. This practice has not been put into effect in Missouri. Missouri does not have private men having private patients in public facilities. Some States do this. We do not.

Mr. ROGERS of Florida. What is the common practice with people that do it?

Dr. ULETT. I am not familiar with this situation.

Mr. ROGERS of Florida. Your experience is wholly limited to Missouri?

Dr. ULETT. That is correct.

Mr. ROGERS of Florida. Now, I believe you stated that you would have, I believe it was, eight patients assigned to one psychiatrist, is that true, in your hospital?

Dr. ULETT. That is our ratio in units run by the cities, yes.

Mr. ROGERS of Florida. And is this the percentage that it should be? Is this the ideal percentage?

Dr. ULETT. In our new units we are planning 1 psychiatrist for 10 or 12 patients.

Mr. ROGERS of Florida. You have no trouble staffing your facilities?

Dr. ULETT. The facilities, the two that are in operation run by the cities are completely staffed for their full operation and we do not anticipate difficulty in obtaining the staff for these three units we are planning as they will phase into operation over the next 3-year period.

Mr. ROGERS of Florida. I see. How many psychiatrists are hired by the State of Missouri, do you know?

Dr. ULETT. At the present time in our State hospital system, we have, I believe, about 45 or 46 psychiatrists.

Mr. ROGERS of Florida. How many would you say exist in the State of Missouri?

Dr. ULETT. There are today 195 psychiatrists in the State of Missouri.

Mr. ROGERS of Florida. And the population of your State is what?

Dr. ULETT. Four and one-half million. We would not be recruiting for these units from these 195. There are in addition to this 70 young men in training to be psychiatrists and we would place all of our recruiting efforts on these young men who have not yet determined whether they will go into public service or private practice. Our feeling is that by building this program, which is indeed a new and exciting program for psychiatrists across the country, that these young men can be induced to come into this program, so we would be recruiting from a pool of 70 young men who as yet are undecided as to what direction they would move. We feel that we would be quite successful in getting enough from this training program and the new training programs opening in our State as these men graduate over the next few years.

Mr. ROGERS of Florida. Yes, now, you have 70 graduating?

Dr. ULETT. Seventy in the total 3-year program, first-, second-, and third-year residents.

Mr. ROGERS of Florida. I see.

Dr. ULETT. Approximately a third would be graduating each year.

Mr. ROGERS of Florida. I see. As of what year does this begin?

Dr. ULETT. That would be starting next year for us.

Mr. ROGERS of Florida. Now, next year—1964?

Dr. ULETT. That is correct.

Mr. ROGERS of Florida. In 1965 and 1966, then, you would have a little over 20 coming out each year?

Dr. ULETT. That is correct. Then there are two new training programs opening in our State that will be underway in the next year, which will add more to that pool.

Mr. ROGERS of Florida. Now, in this training program, how much of Federal funds would you say are involved in this?

Dr. ULETT. I could not actually say because I don't operate these programs; they are not State programs but are from the universities and centers across the State.

Mr. ROGERS of Florida. Do you suppose it would be possible for you to furnish that information to the committee?

Dr. ULETT. Yes; I can find that out or possibly the National Institutes of Health would have it here available.

Mr. ROGERS of Florida. Do you feel there are funds in that program?

Dr. ULETT. Yes; I know that most training programs have some Federal support.

Mr. ROGERS of Florida. Training funds?

Dr. ULETT. Yes.

Mr. ROGERS of Florida. Do you feel this needs to be enlarged, the training programs?

Dr. ULETT. I don't know from personal experience what the number of resident applicants for training in these units is. As I see it, the need as we face it is for funds to hire these men once they have completed their training.

Mr. ROGERS of Florida. In other words, you see no difficulty, you think you will be able to produce enough in Missouri under the present training program to now staff your immediate needs, your immediate forseeable needs.

Dr. ULETT. My answer is yes if we can successfully recruit and to do that we must have funds.

Mr. ROGERS of Florida. How many must you recruit from these 70 in the next 3 years?

Dr. ULETT. Approximately 30 or 40, about half of them.

Mr. ROGERS of Florida. Now, are there any other people trying to also recruit these psychiatrists other than just from private practice?

Dr. ULETT. Not that I know of.

Mr. ROGERS of Florida. It would only be in your State?

Dr. ULETT. That is correct.

Mr. ROGERS of Florida. All of these State students?

Dr. ULETT. No.

Mr. ROGERS of Florida. Is your training program resricted to residents of your State?

Dr. ULETT. No; they come from all over the world.

Mr. ROGERS of Florida. It is possible they might go back to other areas?

Dr. ULETT. That is right. I might point out, however, that the University of Missouri at Columbia is opening its training program next year and it does primarily draw from the State of Missouri.

Mr. ROGERS of Florida. How many beds in your alcoholic ward? I notice you mentioned that.

Dr. ULETT. The alcoholic ward is designed for, I think, 26 beds.

Mr. ROGERS of Florida. Twenty-six beds?

Dr. ULETT. Yes.

Mr. ROGERS of Florida. What is the largest ward in the hospital?

Dr. ULETT. In the mental health center in St. Louis?

Mr. ROGERS of Florida. Yes.

Dr. ULETT. Twenty-eight beds.

Mr. ROGERS of Florida. And that is for what?

Dr. ULETT. In this hospital there are six 28-bed wards for general psychiatry and this one 26-bed ward for the alcoholics.

Mr. ROGERS of Florida. You have no experience at all at working with private physicians, psychiatrists in private practice?

Dr. ULETT. No.

Mr. ROGERS of Florida. You have no experience?

Dr. ULETT. No. They in no way associate with the Division of Mental Diseases.

Mr. ROGERS of Florida. Thank you very much. You are most helpful.

Mr. ROBERTS. Mr. Harris.

Mr. HARRIS. Doctor, do you think you can get qualified personnel for $14,000 a year?

Dr. ULETT. Yes; these are young men who are finishing their residency training program and come with us and they move on the way up. Our top salary for psychiatrists is $23,000 in Missouri so these men can look to an increment in salary as they stay with our program all the way up to becoming superintendents at $23,000.

Mr. HARRIS. What percentage would you have of senior psychiatrists in your hospital?

Dr. ULETT. Well, we would hire these men at whatever level they could come in. A man who has had his 3 years of training is the man who starts at $14,000. He is, at that point, a trained and qualified psychiatrist for the purposes for which we would be using him. Now, the senior people are those who have stayed longer in our program.

Mr. HARRIS. Unfortunately, you have given Mr. Rogers the impression that you get your personnel at $14,000. Now he is not here. Now you have given me the information that that is the starting salary and in a short time that you increase that. I think that is most important. I hope you seek an opportunity to clear that up for Mr. Rogers before you leave.

The reason I brought that up is because under the scheduled program here we have been led to believe that in order to obtain qualified personnel, it would take approximately $19,000.

Dr. ULETT. Well, that would be for a man who had completed all of his training.

Mr. HARRIS. Is there a difference?

Dr. ULETT. The man who takes the examination for his psychiatric boards has in addition to the 3 years in the training program, 2 years of experience in hospital work, and at that time he has had 5 years in the field of psychiatry and goes for his board examination.

Now in Missouri, a man who starts at $14,000 is eligible for $16,000 to $17,000 in his fifth year when he finishes his residency training program plus 2 years of experience. When he passes his boards he is eligible to have $2,000 added on to that. So he increases his salary over the years.

Again we feel that many of these people as they spend 1 or 2 or 3 years with us will then go off into private practice and would be replaced by men coming in at the $14,000 level.

Mr. HARRIS. You think the greater number of personnel are going to be people just out of training?

Dr. ULETT. I would believe this would be our greatest source of supply.

Mr. HARRIS. What percentage of your total do you expect to remain in that category?

Dr. ULETT. Without having had experience, this is difficult to say. I would feel that the larger percentage of the people would probably be these younger people coming in.

Mr. HARRIS. Did I understand you earlier to say that the legislature provided for the staffing of two of the hospitals but not the third one?

Dr. ULETT. Partial staffing of two of the hospitals.

Mr. HARRIS. Partial staffing?

Dr. ULETT. That is correct.

Mr. HARRIS. What percentage would you say of the total need that they provide for the staffing?

Dr. ULETT. Well, this again is difficult to answer because we do not know our time schedule for completion of the units. They gave us a sum of money for staffing, but with no clear knowledge of the exact month in which the unit would be placed in operation, and that is why I say it is a partial amount.

Mr. HARRIS. So if you are convinced that after 4 years the staffing can be adequately taken care of through the State and local funds, I will ask the same question that has been asked by other members of the committee. Could it not be assumed that they take care of the staffing to start with?

Dr. ULETT. All I can say is that we do not at the moment have sufficient funds to staff our units that are planned. We feel that if more money were available these units could be staffed more completely and earlier. I feel that the earlier they are staffed and the more completely they are staffed, the more effective will be their operation and hence they will be able to better prove their effectiveness.

Mr. HARRIS. You have five hospitals now, State hospitals?

Dr. ULETT. That is correct.

Mr. HARRIS. You have three centers that have been projected for the next 3 years.

Dr. ULETT. That is correct.

Mr. HARRIS. With the three centers and the five hospitals, how many people will be accommodated?

Dr. ULETT. The five hospitals have a present bed capacity of between 10,000 and 11,000, and the three centers that we are planning will have a total bed capacity of between 500 and 600.

Mr. HARRIS. How will these centers take from the State hospitals and relieve them of the patients?

Dr. ULETT. When these three centers are in complete operation and fully staffed, it is our intention that all patients admitted to the division of mental diseases will go through these three hospitals. There will be no direct admission to State hospitals.

Mr. HARRIS. In other words, the patients will first enter the centers before going to the State hospitals.

Dr. ULETT. That is correct.

Mr. HARRIS. And they will not go from the State hospitals to the centers?

Dr. ULETT. That is right.

Mr. HARRIS. Now, did I undertand you to say that it costs more to keep patients in the State hospital than you anticipate the costs will be in the center?

Dr. ULETT. The answer is "Yes." We conducted a study of first admitted patients and we studied those who went to the centers with the average cost of $24 a day and those who went directly to the State hospitals at the average cost of $5 a day. When we looked at the same kinds of patients who were admitted to these two kinds of facilities solely because of where they lived, both having the same kinds of illness, those who went to small centers were discharged with an average stay of 32 days. Those same kinds of patients who went to the State hospitals were discharged with an average stay of 255 days. At the cost figures given above, it was cheaper for the patient to have his illness treated from day of entrance to day of discharge at the smaller center.

Mr. HARRIS. That leads me to make this comment that I cannot help. Why don't we do away with State hospitals and make them all centers, then?

Dr. ULETT. The problem that we would face in Missouri is what do we then do with the 11,000 patients that we have in these 5 State hospitals now? We would hope ultimately to reduce the population in these five hospitals.

Mr. HARRIS. Well, I cannot understand why you would keep a man who has a mental condition in a center on an average of 32 days but that same man, if you sent him to the State hospital would be there on an average of 255 days. That just does not seem reasonable to me although I am certainly a neophyte and know nothing about these problems at all except what I have heard just now. It just does not seem reasonable.

Dr. ULETT. I can tell you, Mr. Harris, that it distressed me greatly when I first bumped into the problem because I had spent all of my professional life working in one of these small centers where we returned 90 percent of the patients back home and back into the community. When I came into the State hospital system and saw the same kind of patients I had been treating over the years and sending them back to their families and work getting lost at the State hospital and spending many months there, it was indeed most distressing. I felt as you do and asked "Why do we have these State hospitals?"

Then I found we were trapped. These large hospitals were built a hundred years ago when we didn't have modern treatments and now in Missouri we have on our hands 11,000 patients. Some of these patients have been in these hospitals all of their lives. The average stay in these hospitals in Missouri is 13 years. If we could do it over again and admit these people to small centers rather than having them get lost in these large hospitals, I am sure that is the way we would do it. Again, each State has to start from where they are at this time.

We know in Missouri that the longer you stay in a State hospital the less chance you have of getting out. Our study shows us if you spend 4 years in one of Missouri's hospitals you have only 1 chance in 20 of ever leaving that hospital.

Yet look at the small intensive treatment centers. We know that a man entering this type of center has 9 chances out of 10 of leaving. Today we know that the earlier you treat the patient and the more

the staff concentrates on this man, he sooner you get him out and the less chance his illness has of becoming long term and chronic. The longer he stays in the State hospital, the longer he is going to stay there. That is why we feel everybody in our State should have a chance of being treated in a small mental health center. This then gives him a good chance of not ever being admitted in one of our large State hospitals.

We feel the only way we have of reducing or eliminating the large State hospital population in Missouri is by giving the people a chance for treatment at the community level in these comprehensive community health centers. The key to their operation is good staffing and that is why we feel the staffing provision is indeed the most important part of this bill. Without the staff in these little hospitals, there is no program. There is nothing magic about having a smaller number of beds rather than a larger number; the magic, however, is in the number of professional workers you have per number of patients in these small units.

Mr. HARRIS. Then what you hope to do with this program has not been brought home to me heretofore. That is no reflection on the Department witness and those in favor of this bill. What you ultimately hope to accomplish by this program is to reduce the number of patients in the big State hospitals to a minimum, and ultimately down the line to more adequately take care of the patients in the local center, and thereby increase the opportunities or possibility of that patient then getting back into society instead of being sent to the State hospital where he becomes a life patient?

Dr. ULETT. Yes; that is a very excellent summary of what we hope to do with this program.

Mr. HARRIS. That is the most revealing information I have had about this whole problem. I only wish that every member of this committee could have heard this comment that you have just given about this program, and what we might ultimately expect or hope from it. If we have any vision or farsightedness in us at all, it seems to me we should lean over backward to try to see if we cannot do something about it. I am waiting for Dr. Jackson to get here—you would not think so the way I am asking you these questions—because I know something about the sad story in my own State as you have given in the State of Missouri—11,000 people in your State; how many do we have, Doctor?

Dr. JACKSON. 3,500.

Mr. HARRIS. You have thousands and thousands in State after State. It seems to me it is really a problem that we should tackle. I don't care if it is from the Federal level or the local level. I think that is all. Thank you very much for your interesting testimony.

Mr. ROBERTS. Doctor, I have no questions, just one comment I would like to make.

While a student at the university, and I do not know why this happened but our campus adjoined that of a State institution, some of us were on the borderline there for several years. I majored in psychology and I used to go out there quite a bit and knew the wonderful doctor who was in charge out there for many years. Then later, after I began the study of law and the practice of economy, I observed that a lot of these cases in the State institution were sent

there under the commitment by court. Once they were in that institution there was a tendency on the part of their relatives and families not to want them back once they had become incarcerated and they just did not seem to get any better.

Now, I have know some who were brought back but invariably those who brought back were problem cases from then on, I mean they were never fully accepted by the society that they left. It seemed to me that it was, as I think you said, that they were just really trapped there, and I think there is a lot of truth in that. I think these people become a number and a name in a State institution and that is it. In the lower sociologic economic groups the chances are even less than these people are going to be returned and lead useful lives.

Is that the way you see the problem?

Dr. ULETT. Yes, that is correct. I think this whole proposed program is designed to keep people out of custodial institutions and we would like to turn our custodial care institutions into rehabilitation hospitals for the long-term patient.

Mr. ROBERTS. To bring this out in the open and remove the stigma that is placed on the person who is a victim of the mental illness?

Dr. ULETT. That is correct.

Mr. ROBERTS. Mr. Brotzman.

Mr. BROTZMAN. The chairman refreshes my recollection on a question I intended to ask before.

How are you handling your alcoholic problem, Doctor?

Dr. ULETT. Well, again, I am new to the State job and we are just getting some things underway. Our Governor appointed a commission on alcoholism which is working with me to develop a program for the State of Missouri. Just as in every other State of the Union this is indeed a grave problem in our State. We have some estimated 100,000 alcoholics in the State of Missouri. Our first step has been the establishment at this municipally operated community mental health center of a ward devoted entirely to the treatment of alcoholics with a very broad therapeutic approach to the problem. It is our plan now as we go forward and establish three new centers across the State to have a specialized unit for the treatment of alcoholics at each of these community centers.

Now, the other thing that we are doing is we are working in conjunction with the division of health to bring people from all over the small towns in Missouri and the counties and the rural areas to study at this unit and see how we go about treating the alcoholic. One of our big problems is that so many of our professional people, particularly in the smaller communities, don't know what to do when they come across an alcoholic. They have no concept of the treatment program. We are bringing them in now to study and spend a few weeks in this unit and go back to their hometowns with some knowledge in alcoholism. We plan to have these three units with this broad treatment program made available for the whole State of Missouri.

Mr. BROTZMAN. When you have very seriously affected alcoholics, do you commit them? Do you still have to commit them under the laws of your State?

Dr. ULETT. Yes. We have a judge on this commission and we hope to do an overhaul for the next legislative session on legislation regarding to the alcoholic. Some of them are committed to our State hospitals.

Mr. ROGERS of Florida. Mr. Chairman, may I ask one question?

Mr. ROBERTS. Yes.

Mr. ROGERS of Florida. What is the extent of your program for mental retardation?

Dr. ULETT. We have two units in our State which we call school-hospitals, one being in the eastern part of our State and one in the midwestern, and they house some 2,800 mentally retarded individuals. We have not as yet developed our new program for the mentally retarded. However, in January of this year, we did set up a section on retardation within our division, and my deputy director is in charge of this section. During the next 6 to 8 months we hope to actively plan a program with modern concepts in the field of the retarded, but as I say, this is in the planning state and I have nothing that I can tell you more at this time.

Mr. ROGERS of Florida. Would your three centers envision any efforts in the mental retardation field?

Dr. ULETT. As presently planned I would say minimal. Certainly we are planning a unit for children in each of these centers. There are some children who come in when it is a question of diagnosis; "Is this an emotional problem, mental retardation, or mixed?" We will certainly have some diagnostic facilities for the retarded. Where they will be located depends upon our planning in the next 6 to 8 months.

Mr. ROGERS of Florida. What is the estimated mental retarded population in your State?

Dr. ULETT. In our State the number of retarded, if you use the public health classification, is something over 100,000. Many of these, of course, are now involved in the special school program for handicapped and are not those that would come to institutions for care.

We have a waiting list at the present time of 560 children. Our school-hospitals are filled to capacity and I think this is probably not unlike the problems of many other States.

Mr. ROGERS of Florida. What is the staff on your mental retarded institutions?

Dr. ULETT. These school-hospitals have staff that consists of physicians, nurses, social workers, and attendants.

Mr. ROGERS of Florida. Any psychiatrists?

Dr. ULETT. One of our units has two psychiatrists and the other has no psychiatrists.

Mr. ROGERS of Florida. No psychiatrists?

Dr. ULETT. That is correct.

Mr. ROGERS of Florida. How large is the one that has no psychiatrists?

Dr. ULETT. It is the larger of the units. It has a total of about 1,800 patients. We have a consultant psychiatrist but no resident psychiatrist. The smaller unit has two psychiatrists and this is not by design, this is by location of unit. Again I feel the geographical location is tremendously important in obtaining a staff.

Mr. ROGERS of Florida. I am sorry, I thought that you said you did not use any private physicians.

Dr. ULETT. These are not private physicians.

Mr. ROGERS of Florida. Consultant?

Dr. ULETT. The consultant is in our division office.

Mr. ROGERS of Florida. But he is not assigned to that hospital?
Dr. ULETT. No.
Mr. ROGERS of Florida. He is a State employee?
Dr. ULETT. Yes.
Mr. ROGERS of Florida. Thank you.
Mr. ROBERTS. Doctor, I am sure you want your formal statement made part of the record of the hearing?
Dr. ULETT. Yes, please, Mr. Chairman.
Mr. ROBERTS. Without objection it will be filed. Thank you again.
Mr. ROBERTS. Our next witness is Dr. Visotsky, director of the Department of Mental Health, the State of Illinois.

STATEMENT OF DR. HAROLD VISOTSKY, DIRECTOR OF DEPARTMENT OF MENTAL HEALTH, STATE OF ILLINOIS

Dr. VISOTSKY. Mr. Chairman and members of the committee, I am Harold Visotsky, director of the Department of Mental Health for Illinois.

I am a graduate of the University of Illinois, College of Medicine, and the Illinois Neuropsychiatric Institute. I am a member of the faculty at the University of Illinois and was director of residency training in the department of psychiatry for 4 years.

Currently I am the cochairman of the AMA Congress on Mental Health Planning for region 13 (Illinois).

I appear before you in full support of Senate bill 1576, a most important legislative development toward aiding our crucial efforts in combating, treating, and preventing mental illness and mental retardation.

Furthermore, Mr. Chairman and members, I appear before you as the personal representative of our Governor, Otto Kerner. He has communicated to members of this committee on two occasions (March 5 and 26, 1963) his strong support and interest in such legislation.

This legislation particularly encourages and reinforces my strong hopes for continued progress in the Illinois program, in that I have only recently succeeded Dr. Francis J. Gerty as director. Prior to this I served as the director of mental health services for the city of Chicago.

Programs for the mentally ill in our State for many years past have been oriented toward humane but custodial care in institutions. Measures of the program's progress have been assessed in the numbers of beds available. Staffing for treatment has unfortunately assumed a secondary priority. This resulted in a pattern that reinforced the concept of the hospital as the end of a one-way street.

There are 50,000 mentally ill and mentally retarded patients in our hospitals in Illinois today.

On the basis of this, programs currently under planning and in progress are planned to reverse these patterns. Institutions that are remote from the community have difficulty in staff recruitment. This produces a limited treatment program which perpetuates chronic hospitalization.

To meet this problem Illinois has planned for six zone centers. These centers will provide 280 in-patient beds, day hospital facilities, night hospital facilities, out-patient facilities, rehabilitation, occupational, and vocational facilities.

It is a comprehensive mental health center.

Of the 280 beds we will have 20 for mental retardation, 20 for treatment of emotionally disturbed children, 20 for treatment of emotionally disturbed adolescents, 20 for geriatric patients, 20 for patients with alcoholism and addiction problems.

These facilities will be located geographically within each zone so that persons in the zone will have the zone centers accessible within a maximum of 1½ hours drive of their home. The zone centers are planned to interrelate with the resources of each community. The underlying principle of these centers is to provide comprehensive care as early as needed to patients in distress.

My experience in the Chicago program has indicated that early intensive treatment as close to the precipitating crisis as possible provided the optimum therapeutic results.

We operated what was called a crisis oriented program. When I first started I found we needed beds for patients in crisis. When I began to talk with both the staffs of public and private facilities in the city of Chicago they asked me how many beds I needed. I said I would need at least 100 beds to start an acute and emergency oriented treatment program. Because of lack of funds and lack of staff we never got the 100 beds but just prior to my leaving the program I again was asked how many beds I would need because the beds were now available. I said, "I think I can use 10 beds and keep them filled" because in those intervening 4 years we learned how to deal with the treatment of patients in acute distress without putting them away in a bed.

I sometimes think we get misled when we think of the treatment of mental illness tied irrevocably to a bed. There are many ways of treating patients without putting them in a bed and stripping them of their dignity. Many of these patients do not need bed care. So that our community centered programs must take advantage of varied local manpower resources; local physicians, pastors, teachers, lawyers, and workers of all kinds who have service contacts with emotionally distressed people. These programs with such community breadth are more attractive to mental health professionals.

Throughout the State we implemented the community centered program in a number of ways. One was through the community grant-in-aid program. Through a combination of Federal (NIMR), State, and local funds, communities have been aided in initiating mental health clinics (outpatient only). This combination of Federal and State funds used as seeding money primarily for staffing has started clinics in communities where none were previously possible. As these clinics stabilize, funds are gradually withdrawn to seed and encourage other communities. Currently 42 such clinics are in operation.

Now, I do not want you to misunderstand this program. These are primarily outpatient clinics with no inpatient beds and without the full range of comprehensive services. The progress is tedious and is helped only through patient encouragement, education, and the ultimate results which are visible to the community. This is how we get involved with the community.

This year a similar grant-in-aid program was undertaken on behalf of the community day-care centers for the mentally retarded.

Secondly, the Illinois legislature has just enacted bills which provide that any municipalities, or legally constituted taxing bodies may provide by a referendum vote a tax not to exceed one mill to be used for mental health and mental retardation services. We have also revised our mental health code so that patients in need of mental treatment have easier access to State facilities and so that the patients' broad range of civil rights are explicitly protected.

Lastly, our recently accepted Proposal for Comprehensive Mental Health Planning calls for the creation of local planning committees throughout the State. Among the major tasks for these committees are staff recruitment and training.

In reviewing the comprehensive plan for mental health it becomes apparent that staffing is the key to its eventual success. This means that—

(1) We must keep in public service areas more of the graduates we train in our medical schools and colleges.

(2) We must staff our comprehensive treatment centers as broadly as possible so that these may be used for training as well as service.

(3) The staff must present breadth and variation in experience as well as in numbers in order to initiate new techniques, and multiple approaches to complex problems of mental illness in our society.

(NOTE.—I believe the comprehensive treatment program can only be successful if it is adequately and fully staffed. Furthermore, the staffing should be initiated as soon as possible, in that it is not only the service force but also serves to educate and orient the communities to their responsibilities and roles. If this is not done in the early phasing of the community centers, then most often the community will abrogate its responsibilities, leaving them to State or Federal agencies.)

I believe comprehensive services must not be confused with total services. These units are not all things to all people in the community. They are to be used by integrating and interrelating with the community resources and services. For those services which the zone centers cannot supply, the community must be encouraged to provide, by exchanging services or by contract. We can exchange services using the services and resources already in the community, whether they be teachers, police officers, courts, or other members of the community.

We are in essence selling the product to the community and if you see before you some enthusiastic psychiatrists it is because we have seen for once a total project, not a piece, not a fragment of an approach but a total approach.

If we can get our foot in the door with the community we can sell this product to communities and they will support it as they have in certain areas in Chicago and in other communities in our State. The receptivity was good for outpatient clinics, and is even more so for the comprehensive centers. This requires the initial priming for service in order to show the total effectiveness and eventually an economy of such progress.

Now, it seems to me that the States are doing about all they can. Our mental health budgets are going up but remember that we are

maintaining old programs with one hand while we are trying to build new ones with the other.

In addition to this, our population keeps growing. In Illinois for the 1961–62 biennium our budget went up 10.1 percent for the mental health funding. That is for the Department of Mental Health. This biennium went up 20.9 percent and we will have to have it up 20 percent for the next four bienniums merely to stay ahead and move to that which Chairman Harris summarized so well in his last statement. We need this financial aid in order to do away with the old custodial hospitals and set up comprehensive community centered programs which will get these people back to their communities and in a functional state as early as possible.

We have to make this a two-way street, not the one-way street it has been in the past.

In summary, I would like to tell you that we, too, have set up staffing patterns for the zone hospitals which are in many ways similar to Dr. Ulett's. We will have problems starting trained psychiatrists out at $14,000. I think in our region we probably will consider a range of $16,000 to $22,000 for our psychiatrists.

I wish therefore to thank you gentlemen for the pleasure and honor of appearing before you. One of my lectures to psychiatric residents for some years was "The Team Concept in Mental Health Programs." I am pleased to serve on the mental health team with all of you.

Thank you.

Mr. ROBERTS. Thank you, Doctor.

I do not think I have seen any estimates or percentages or figures on this particular concept but do you have any opinion as to how many patients, and this would probably be mostly outpatients I would assume, continue to work and pay taxes? Would it be a large percentage of these people that you treat, say, for various periods during the day or during the week, a good many of those people continue working?

Dr. VISTOSKY. Well, I can't answer that question directly. I can answer it by saying this, that about 30 to 40 percent of the patients in our clinics requested evening appointments so that we had to open our clinics on Saturdays and on evenings during the week. I am talking about the city of Chicago and I am sure this follows in other areas because these people work and wanted to continue work and get their treatment at a time other than taking off from work. This does not include housewives who could make daytime appointments.

We have another study which might be interesting to you. In the city of Chicago we tabulated our costs for treatment of patients in a comprehensive outpatient unit, that is for the most part trying not to hospitalize them. We found that for $600 to $800 per year we can treat and return a patient to effective working relationship, whereas to put this patient in one of our State hospitals just for custodial care costs us somewhere between $2,000 and $2,500, and this provided no treatment.

So I found, and as Dr. Ulett has found, that as public health psychiatrists we naturally followed the road to the State mental health program trying to rework our State mental health programs to follow the course that we found so successful in our own experience with comprehensive mental health programs in the cities.

Mr. ROBERTS. In other words, there are three factors where the patient, if he becomes a member of the State institution, you have got the outlay for his board, room, keep, treatment, clothes, and then you have got his loss as a wage earner and as a taxpayer; and third, in most cases if he is a breadwinner you have got to consider whether or not his family has to be kept up on the public welfare rolls while he is a patient.

Dr. VISOTSKY. That is correct, sir; most correct.

Mr. ROBERTS. Mr. O'Brien.

Mr. O'BRIEN. I have only one question. I asked this of Dr. Ulett. Do you believe that Federal help in staffing will reduce the State and local efforts in that directions?

Dr. VISOTSKY. By interpolating our program of seeding which we have done on this small basis throughout the State to start "outpatient clinics," this is not true. What happens is primarily this: When we begin to set up a program where we give them the initial start, we give them the bulk of the money to start, whether it is 75 or 80 percent and sometimes as high as 90 percent to some of the small clinics in depressed areas, the minute we set up such a program the community begins to set up a board, the board members begin to pick other people to work with them, and an educational process goes on. This constitutes responsibility and eventually leads to the acceptance of financial support as well as other support.

When we finally say to this board "You are now established and we are going to have to cut you down to 30 percent and maybe 20 percent" this does not come as a shock, since it was noted as part of the "contract" in accepting the seeding money. We have found that the community has educated itself during those intervening years. Speaking also as a community member, when we see the problem and its solution I think most of the people that we have dealt with are willing to accept this responsibility.

Mr. O'BRIEN. One final question. You have already demonstrated you can affect more cures at the local level for the many reasons you cited but do you now also believe that over a period of time, a long period of time, that for every State in the Union that maintains the present custodial institutions that there will be a saving running into billions of dollars? I do not mean actually back in the taxpayers' pocket but I mean avoiding wasteful expenditure, throwing it down a rattrap, concept of the madhouse. Is that correct?

Dr. VISOTSKY. I could not agree any more strongly. It is not only the economy of money, it is the economy of dignity, of returning people to the community, and the economy of getting people functional once again in the community setup. This is a vital economy for a nation.

Mr. O'BRIEN. If by some miracle overnight the money that is now being spent on an archaic system could be brought to a local level and properly spent curing people, you would not need a nickel of Federal money, would you?

Dr. VISOTSKY. No, I might even say "Amen."

Mr. BROTZMAN. When will your six zone centers be completed?

Dr. VISOTSKY. Mr. Brotzman, the ground-breaking ceremony for the first is on July 29. They are all scheduled to be bid and contracted for within the following 6 months. I should imagine they will be built within the next 2 years, that is 18 months, probably, give or take some 6 months.

However, I may say this: We cannot wait 2 years to begin staffing those facilities, or we will have magnificent and beautiful empty shells. We have to start staffing and recruiting for those facilities almost immediately, and this is what we are doing.

Mr. BROTZMAN. I would assume you would be planning for that now.

Dr. VISOTSKY. Yes, sir; we are planning for that now, and part of this plan is the staffing patterns for these clinics.

Mr. BROTZMAN. There is one rather small point, I want to be sure I understood it correctly.

On this crisis approach that you have, I would assume the idea of the zone concept is you should have the treatment center close, geographically, as well as having a short period of time within which to observe prospective patients; is that correct?

Dr. VISOTSKY. Yes, sir; it should be as close to the patient as possible. In Chicago we had some of our treatments centered in housing projects. We rented apartments close to the patients, and we found that the appointment failure rate went down. Remember that this a strange and debilitating illness at times in which the apathy of the patient cannot allow the patient to mobilize himself to get help from great distances. Often the staff time is wasted by appointment failures.

We want to be as close to the patients and their families as possible; it not only aids the educational process, but it also aids giving them care as close to the crisis as possible.

Mr. BROTZMAN. Now, drawing upon your experience it is my understanding that the knowledge of mental retardation is behind that of treating mental illness generally.

Would that be a fair statement?

Dr. VISOTSKY. You mean our knowledge about treatment? Yes, sir; I would agree.

Mr. BROTZMAN. Now what did you do in Chicago in the area of mental retardation?

Dr. VISOTSKY. We did a number of things. We provided counseling to the parents of children who are mentally retarded. We are interested not only in trying to cure the child who is mentally retarded, but we see the stress for the total family in dealing with this child. We found if we can offer them help through visiting nurse counseling, if we can offer them help through pediatricians' and physicians' counseling, that if the care for such a child was supplemented by education we might make the load on these parents and on this family and on the other normal children in the family, much easier. This is all we can do in this program at this time. As I said, we are now trying to set up day centers for the mentally retarded throughout the State in grant-in-aid programs.

The zone clinics will have the 20 beds available for diagnostic evaluations and for acute disturbance in mentally retarded children. Many of these families are able to deal with their children at home but they have no place to turn if there is a crisis except to commit a child to a State hospital.

We say, let us take care of this child during the crisis and when he recovers from his emotional or physical crisis we will return this child and then work again with you in the community.

Mr. BROTZMAN. Do you have a school system that is especially adapted or is this accommodated for within your public school system in your State?

Dr. VISOTSKY. It varies again from community to community, Mr. Brotzman. There are local county school boards and their regulations vary throughout the State of Illinois. Some of the schools take the educable and trainable retarded. Some of them take only the educable retarded. Most of them do not.

We have two facilities, two schools for mentally retarded and we are building two more. The contracts are let and the construction is going on in one.

Actually the State is divided into eight zones. The two southern zones have hospital schools for mentally retarded in lieu of the zone centers.

Mr. BROTZMAN. If a child lives in zone 1, does he or she have to move permanently to the other zone in order to go to school? Do they have to be away from home?

Dr. VISOTSKY. You mean under the present circumstances, sir?

Mr. BROTZMAN. Yes.

Dr. VISOTSKY. Yes, unfortunately that is true. We like to keep them as close to home as possible.

Mr. BROTZMAN. I would assume that it takes a specially trained teacher and perhaps additional equipment as an adjunct to the public schools in order to educate the mentally retarded child; is that correct?

Dr. VISOTSKY. That sounds like a fair assumption. I would agree.

Mr. BROTZMAN. But it is difficult to work into your public school setup?

Dr. VISOTSKY. It is difficult because they have their priorities too and this is the problem of the mentally retarded. They are at the bottom of everybody's priority. Now we are trying to give them an even chance with other people who are disabled; we are trying to reverse this unfair priority system.

Mr. BROTZMAN. Thank you.

Mr. ROBERTS. Mr. Rogers?

Mr. ROGERS of Florida. Thank you, Mr. Chairman.

How many mentally ill do you estimate you have in your State, sir?

Dr. VISOTSKY. You mean people who are walking around or are in the State hospitals?

Mr. ROGERS of Florida. Yes, the total population that you think might exist there in your State.

Dr. VISOTSKY. We would state pretty close to 10 percent.

Mr. ROGERS of Florida. Ten percent?

Dr. VISOTSKY. Yes.

Mr. ROGERS of Florida. And your State population is what?

Dr. VISOTSKY. It is about 10 million.

Mr. ROGERS of Florida. 10 million?

Dr. VISOTSKY. It is over 10 million.

Mr. ROGERS of Florida. So a little more than a million people you indicate as possible——

Dr. VISOTSKY. Candidates?

Mr. ROGERS of Florida. Candidates.

Mr. HARRIS. How many in institutions?

Dr. VISOTSKY. Fifteen State hospitals and two schools for the mentally retarded. They contain 50,000 patients. This includes the mentally ill and retarded.

Mr. ROGERS of Florida. About what is your mentally retarded population?

Dr. VISOTSKY. About 3 percent of the general population, I believe. National surveys give these figures and we would stick pretty close to them.

Mr. ROGERS of Florida. What percentage of that are actually in the hospital?

Dr. VISOTSKY. About 15,000, Mr. Rogers, and there is a waiting list of approximately 2,000, I believe.

Mr. ROGERS of Florida. 2,000. Now how many psychiatrists does the State employ?

Dr. VISOTSKY. We have 117 physicians practicing psychiatry.

Mr. ROGERS of Florida. 117 M.D.'s practicing psychiatry. Do you use private psychiatrists, psychiatrists who are in private practice?

Dr. VISOTSKY. Are you talking about part-time psychiatrists who are in private practice and work for us, too?

Mr. ROGERS of Florida. Yes, sir.

Dr. VISOTSKY. Yes.

Mr. ROGERS of Florida. Pretty extensively?

Dr. VISOTSKY. It depends on the urgency and the area and we are willing to make special arrangements in order to get help for the patients.

Mr. ROGERS of Florida. What about your centers?

Dr. VISOTSKY. In our centers we would also follow that format as closely as possible. We would hope to get full-time physicians. Every time you get a part-time person you increase the difficulties in communication but again we are willing to make compromises until the program takes on and goes full force. I am a full-time psychiatrist in the department of mental health and the point is that I presume if they hired me for nine-tenths or three-quarters time it would have been easier for me but since I have 100 percent responsibility I might as well devote full time.

This is what we are trying to impress on our psychiatrists in the State.

Mr. ROGERS of Florida. Yes. Now how many would you say are in training in your State?

Dr. VISOTSKY. I do not have the exact figures. The estimates currently run between 137 and 150 psychiatrists in training.

Mr. ROGERS of Florida. And they will be graduating in what proportion, would you say, over the next 3 years?

Dr. VISOTSKY. It is a 3-year program so that they will follow this proportion of which maybe a third will be coming out each year.

Mr. ROGERS. Fifty a year probably. How many do you anticipate that you will be able to recruit in your program from these graduates within your own State?

Dr. VISOTSKY. Well, I think we should recruit somewhere between 20 and 30.

Mr. ROGERS of Florida. Out of the 50?

Dr. VISOTSKY. Out of the 50.

Mr. ROGERS of Florida. Each year?

Dr. VISOTSKY. Right.

Mr. ROGERS of Florida. And you can start all of these men at a salary of what?

Dr. VISOTSKY. We have scheduled them at a salary range of $12,000 to $14,000. Now you are talking only about these men; these graduates?

Mr. ROGERS of Florida. The graduates are what I am talking about.

Dr. VISOTSKY. We are going to do recruiting for more than these men.

Mr. ROGERS of Florida. Where else will you recruit?

Dr. VISOTSKY. We will recruit from psychiatrists who are currently in practice, we will recruit from some hospital centers which we hope to put out of commission. That is, we have psychiatrists there and as the patient load drops out there we hope they will transfer to our centers. Our salary level will be somewhere between $14,000 and $22,000.

Mr. ROGERS of Florida. I see. Now I believe you said you would have 42 clinics.

Dr. VISOTSKY. No, sir. I said there are 42 outpatient clinics which have been seeded by grants throughout the State. That is, the Federal Government has contributed money to our State, and we added to it and matched funds have been provided by the communities to support these clinics.

Mr. ROGERS of Florida. They are now in operation?

Dr. VISOTSKY. Yes; these are not State clinics, these are community outpatient clinics supported by the community, for the most part.

Mr. ROGERS of Florida. What is the typical staffing in one of these, would you say?

Dr. VISOTSKY. A typical staffing is the equivalent of a full-time psychiatrist—I say equivalent because it may be two half-time people, one psychologist, one or two social workers, and some secretarial-clerical staff.

Mr. ROGERS of Florida. I see. One of these clinics now would serve what area or what population, would you say?

Dr. VISOTSKY. They vary somewhere from, maybe, 30,000 to maybe 90,000.

Mr. ROGERS of Florida. Yes.

Dr. VISOTSKY. And doing the job sometimes poorly, being overwhelmed by long waiting lists.

Mr. ROGERS of Florida. Yes. Now is this under your direction?

Dr. VISOTSKY. No, sir. This is under the direction of their own boards. They have to meet certain qualifications in order to get the combined Federal and State grants. They run their own programs for the most part except that they must meet certain qualifying conditions.

Mr. ROGERS of Florida. Now are these the clinics that you feel are helping to prevent the custodial care?

Dr. VISOTSKY. Yes, sir.

Mr. ROGERS of Florida. Are these the ones that you have referred to?

Dr. VISOTSKY. Yes. I was talking about the clinics in the city of Chicago but these, too, were granted aid by the State and Federal Government. Even when I was directing the centers for the board of

health in Chicago part of our budget came from the State and Federal seeding money.

Mr. ROGERS of Florida. Yes. Now your clinics in Chicago were run by the city, mainly, and it was under the control of the city, is that correct?

Dr. VISOTSKY. That is correct.

Mr. ROGERS of Florida. And how many clinics did you have in Chicago?

Dr. VISOTSKY. Well, the board of health itself provided four clinics.

Mr. ROGERS of Florida. Four?

Dr. VISOTSKY. Yes, sir.

Mr. ROGERS of Florida. And what was your staffing for the four clinics?

Dr. VISOTSKY. We had something like 12 psychiatrists, about 28 social workers.

Mr. ROGERS of Florida. Is that for all four or for each?

Dr. VISOTSKY. Yes, I am giving you the totals. There were 28 or 30 social workers, about 6 psychologists. We had a community mental health educator, we had community mental health organizers to supplement the staff, and the clerical staff.

In addition to this, we had professional consultants available.

Mr. ROGERS of Florida. I see. About what portion of the population would you say these four clinics served? I realize you may have different areas.

Dr. VISOTSKY. No, it was very specific and I can give you the population.

Mr. ROGERS of Florida. All right.

Dr. VISOTSKY. We limited the areas for this clinic. We knew we would be swamped if we tried to serve the city of Chicago which had 5 million people in the city, so we set up these communities really as small zone centers. They were primarily in housing centers and they served each population of about between 68,000 and 80,000, the smallest was 68,000 and the largest was 80,000.

Mr. ROGERS of Florida. 68,000 to 80,000?

Dr. VISOTSKY. Yes.

Mr. ROGERS of Florida. With an average of about three psychiatrists then, normally?

Dr. VISOTSKY. Yes, with the one exception that you must realize that these were out-patient facilities. They were not in-patient, they do not have the day or night hospital components that we would want for zone facilities so they were primarily out-patient clinics.

Mr. ROGERS of Florida. It is your theory now that if it is possible you want to avoid using treatment where it is necessary to confine them to bed?

Dr. VISOTSKY. That is true. But when I am talking about a treatment facility it means we can bring a person in for a whole day. Patients that we have in clinics, we treated only for a half hour or an hour, but we were not set up to bring groups of patients in for long periods of time or to send them to vocational rehab shops or training shops or occupational therapy or many services they needed.

Mr. ROGERS of Florida. Now in your zone clinics, what do you envision?

Dr. VISOTSKY. We envision a comprehensive range of service both in day hospital, night hospital, inpatient unit and as I pointed out, all the vocational rehab programs that have been mentioned earlier.

There would be the occupational therapy programs. We would have the day care facility for mentally retarded. In some areas we might run a school for the disturbed adolescents and children; we limited this to two zones to see how it works as a pilot project.

We initially thought of building them into all the six zone facilities but decided to use only two before we commit ourselves.

Mr. ROGERS of Florida. I see. Now how many beds would you have in the zone hospital?

Dr. VISOTSKY. 280 beds.

Mr. ROGERS of Florida. 280?

Dr. VISOTSKY. Yes.

Mr. ROGERS of Florida. What would be your staffing for that zone?

Dr. VISOTSKY. The rough estimates are something like 18 to 20 full-time psychiatrists, 12 full-time psychologists, 18 to 20 psychiatric social workers, 30 full-time registered nurses and then we have a group of somewhere between 150 and 175 of what we call aids.

These are child care workers, they are activity workers, recreational workers, psychiatric aids and so on.

Then there would be the community health workers, and three program analysts and supporting laboratory services.

Mr. ROGERS of Florida. Now what population would you plan for this facility to serve?

Dr. VISOTSKY. Well, let me give you an example. We have two of these centers for the Greater Metropolitan Chicago area. So if we just divide the Greater Metropolitan Chicago area we say somewhere around 2.5 million, but this is not true because there are other resources in the greater metropolitan area.

As for areas like Decatur, Rockford, Champaign, I would presume between 300,000 and 400,000 people would be served.

Mr. ROGERS of Florida. I see. Do you think this is sufficient for an area of three to four hundred thousand?

Dr. VISOTSKY. No, sir; I do not. I am not sure how sufficient it is. We are going to have to start this way and see how it goes.

Mr. ROGERS of Florida. I see. Now for mental retardation, what part of your funds are devoted to the care and research and training and teaching of the problems of the mentally retarded child?

Dr. VISOTSKY. The mental retardation program is part of our full department of mental health. I don't have an exact figure. Perhaps Dr. Brown could give it to me. For the biennium beginning July 1, 1963, we have appropriated $44,950,034 or 18.8 percent for mental retardation.

Mr. ROGERS of Florida. About 20 percent?

Dr. VISOTSKY. Yes, sir.

Mr. ROGERS of Florida. Do you divide the programs at all? Do you feel they are so related there should be no division between the mentally ill and mentally retarded?

Dr. VISOTSKY. Well, it depends on how you look at it. For example, when you are talking about zone facility, the zone facilities are responsible for comprehensive care for that zone. This is why we put

in a day care center for mentally retarded and 20 beds for mentally retarded.

That is, we did not divide it in that setting. However, we do have it divided in providing two school hospitals for mentally retarded.

We are building two more, one is a research facility primarily and one is a care and training facility. We have a pediatric institute which is a research and training institute, so there are five facilities which are in the division of mental retardation.

The research and training facility is a training institute to train people in the care and also in the research for mental retardation.

Mr. ROGERS of Florida. How many are training a year?

Dr. VISOTSKY. Well, the program has just opened. 300 to 325 medical students in their senior year at the University of Illinois and now at Northwestern and now at the University of Chicago will be rotating through the pediatric institute. In addition to these senior medical sudents we are giving training to about 12 to 14 pediatric residents, and about 4 to 5 child neurologists each year.

Unfortunately, it seems that the mentally retarded have not secured the interest of many physicians. We do find that we must now build an interest because we do have some hope for early detection and treatment. Physicians want to be successful and I think we might interest them. We also will give special training in mental retardation to clinical psychologists and social workers.

Mr. ROGERS of Florida. Now how many psychiatrists devote their time to the problem of mental retardation in your State program?

Dr. VISOTSKY. I would say no more than five.

Mr. ROGERS of Florida. About five?

Dr. VISOTSKY. Yes; however, in this instance we have had good success in working with pediatricians who are particularly interested in this problem.

Mr. ROGERS of Florida. When did you start the program at the pediatric institute?

Dr. VISOTSKY. The pediatric institute got its director and director of research training just this year.

Mr. ROGERS of Florida. I see.

Dr. VISOTSKY. The director came about 6 to 8 months ago.

Mr. ROGERS of Florida. Is he a psychiatrist?

Dr. VISOTSKY. He is a psychiatrist pediatrician neurologist.

Mr. ROGERS of Florida. How many of the private physicians or psychiatrists do you use in your program, would you estimate?

Dr. VISOTSKY. We have a consultant list, that is people who give a portion of their time, which numbers between 60 and 80.

Mr. ROGERS of Florida. I see. Do they make use of the facilities of your clinics or of your zone clinic?

Dr. VISOTSKY. You mean to bring private patients in, sir?

Mr. ROGERS of Florida. Yes, sir.

Dr. VISOTSKY. We have not worked out that kind of arrangement although I would be very interested in such a program. We find that when we allow physicians to use our facilities they will in return give care to our patients and I would be most interested in setting up such a program. We have projected one other program.

Mr. ROGERS of Florida. Let me pursue that just 1 minute, if you don't mind.

Now, if you were to allow a private psychiatrist to use your facility and then he offered some of his time, would you have to pay him out of your funds for that time?

Dr. VISOTSKY. If we are going to parallel the programs for medicine in general hospitals we would not pay for his care of our patients.

Mr. ROGERS of Florida. That would not be expected?

Dr. VISOTSKY. No; it would not be expected.

Mr. ROGERS of Florida. All right. Now you were going to something else?

Dr. VISOTSKY. I was going to comment on some projected plans because, as I told you before, we are just juggling this custodial program on the one hand while we are trying to build a new program on the other hand and it has at times nearly overwhelmed us. Some of the projected uses for the State hospitals, for the ones that will be put out of use for the most part, will be for rehabilitation. We will hope they, too, will become intensive treatment centers.

The very fact they have been a State hospital does not mean they cannot become comprehensive zone centers and we hope the physicians in the community will be allowed in as open staff to use those facilities under our supervising psychiatrists.

Mr. ROGERS of Florida. I see. Now, do you think it would be difficult to provide, say, 250 mental health community facilities, 250 basing it on a hundred population, 100,000 for each one say, to provide 10 psychiatrists for each of those facilities based on 100,000 population?

Would this be difficult or not?

Dr. VISOTSKY. It would be difficult but I think we have to face that challenge and we have to have the money available to hire the people as they become available, even if we have to turn some of that money back.

Mr. ROGERS of Florida. Thank you very much. I appreciate your testimony. It has been most helpful. Thank you.

Mr. O'BRIEN. Thank you very much, Doctor. I would like to say at this point in the record the number of mental patients in various States could become embarrassing as we go along, especially when we get to New York State. As I understand it there are more than a million persons treated annually in the United States for mental illness and more than half of all the hospital beds in the United States are occupied by mental patients. I think that was covered very neatly without giving the New York State figure.

Dr. VISOTSKY. Yes, sir.

Mr. O'BRIEN. Thank you very much, Doctor.

Dr. VISOTSKY. Yes, sir.

Mr. O'BRIEN. Our next witness is Dr. George Jackson, State director, mental hygiene, Little Rock, Ark.

The Chair at this time yields to the chairman of the full committee, Mr. Harris.

Mr. HARRIS. I would like to extend a cordial welcome to Dr. Jackson. Because of his years of experience in this field, I do not want to indicate that our State claims anything like all of the total success of Dr. Jackson.

We, I suppose you might say, have given him leave a few years ago and he went down to Texas and did not take very long to get the mental situation all straightened out in the State of Texas.

They let him go to Kansas and he stayed in Kansas for a while. Of course, you know the difficulties they had there but even so he took care of that situation. Now we have him back in Arkansas.

With that additional experience we hope on the second round in Arkansas to take care of our State.

That is facetious, of course, Doctor, but I am glad to see you here on this program.

STATEMENT OF DR. GEORGE JACKSON, STATE DIRECTOR OF MENTAL HYGIENE, LITTLE ROCK, ARK.

Dr. JACKSON. Thank you, Mr. Chairman. I am really happy to be here.

As you have mentioned, I am going to take a little different approach to this problem, since my experience has been in either State hospitals or State hospital systems.

My experience, as far as clinics, has been limited to those that we have operated as part of a State hospital program with the exception of only a few months in which I had the responsibility for the community mental health services in Kansas.

I would like to say that I am real happy to be back in Arkansas because we believe in Arkansas we are going to work out the answers to these problems that we know that everyone is struggling with.

We have taken a little different approach. Our approach is that wherever the patient is seen he needs adequate treatment, whether this be in a State hospital, a comprehensive mental health center, or a clinic.

There is no cheap way to do this. If the patient is to receive adequate treatment it takes just as adequate a staff in a State mental hospital as it does in any mental health center. The State mental hospitals with the same type of staff we believe can return home an equal number of mentally ill people, all of the services being comparable.

We believe that we are in a position to pretty well demonstrate this fact.

Arkansas has a population of about 1,800,000 people. We have two hospitals. We have one hospital located in Little Rock, which has a capacity of about 1,100 patients. This hospital has had a capacity as high as 2,200 patients. We have a hospital at Benton which is 30 miles south of Little Rock which presently has 2,400 patients which has had in excess of 3,200 patients.

Now over the years the Little Rock hospital has operated as the admitting hospital for the State, all patients come to the Little Rock hospital first.

Last year we admitted 4,200 patients. We discharged in excess of our admission. In fact, 24 months ago we had a total patient population of 4,700 and as of yesterday the population was 3,538.

Mr. HARRIS. That is in both Little Rock——

Dr. JACKSON. That is in both hospitals. I might state in Benton of these total patients 800 are adult mentally retarded people.

Now we are taking a little different approach to this. We feel that we have a little headstart on this program that is being planned and we are very strongly in favor of the proposed legislation.

I might say I am not too sure just how strong our people are to send more money to Washington but we are certainly very much in favor of getting some back from Washington to help promote this program.

Now we are starting this type of an approach to it. We are in the process of making our two mental hospitals into a series of comprehensive mental health treatment centers.

Here is what we have done: We take a section of that hospital, we assign it a district of counties in the State and we assign it a staff of personnel.

When a patient enters the hospital this patient is assigned in rotation to the doctors assigned to serve that district. So we will say Dr. Jones takes the first patient that comes in. This patient is Dr. Jones' patient as long as that patient needs hospitalization or unless Dr. Jones leaves the hospital.

He can transfer this patient anywhere in the service in which he is working but he cannot pass it on now as a chronic untreatable patient to someone else.

Now this is what was occurring at the Benton hospital. Any time there was a vacancy down there and we were overcrowded we would pick out some patients to move down there and you did not move the best prospects as a rule.

They usually moved the patient that made the staff most uncomfortable. Consequently, this hospital began to be known as the place where you go to stay. This we are now in the process of changing.

Just as of the first of this month, July 1, we sent 2 full teams of psychiatrists, psychologists, social workers, nurses, plus additional aid personnel—we completely vacated a building by somewhat overcrowding the other buildings and we set this up with a district of 15 counties. They will admit all patients from those 15 counties. They will have the responsibility for any outpatient followup of these patients and any followup in the community.

The doctors on this team can go to the community if they wish to hold a clinic to see patients prior to admission or to treat patients, but if they don't then any patients requiring hospitalization will be their responsibility.

If we find that the space allocated to them is not sufficient, we will add more space but they will have the responsibility for this district of counties.

We expect by the end of this year to establish a second section in this hospital which will take the southeast group of counties which are most adjacent to this hospital. In our plans for construction, we have underway three such centers as replacement for existing buildings which are quite old and out of date at the Little Rock hospital.

Now these three centers that will be built together with one very adequate facility we have now on the ground will convert the Little Rock hospital into four comprehensive intensive treatment sections.

This, then, will have our State divided into six districts.

Now we don't believe that this is the total answer and I will explain some of the problems that come along. We still need to replace about 400 additional beds to have all outmoded facilities replaced.

Now here is the problem as we see it.

Mr. HARRIS. Where will those replacements take place, at Little Rock or Benton?

Dr. JACKSON. We hope at neither place. You see, our problem is this: Can our staff with the distance involved between, we will say, Little Rock and Fayetteville carry on an adequate program to serve the area? We don't think so. It is too far for patients to commute, it is too far for staff to commute, and it is too far for the families to visit these patients as we think necessary.

What we hope to do would be to establish four centers, one in each of the four corners of the State which would take in the group of counties most distant from the Little Rock and Benton hospitals.

That would be one in the northeast corner of the State, one in the northwest and similar for the southeast and southwest.

We are proposing a 100-bed facility that would serve a population area of approximately 200,000 each. This would mean that the 6 centers which would occupy the present State hospital plus the 4 centers to be built would provide a total of 10 centers serving a population of roughly 200,000 or a little less each.

Now our idea is that these centers would carry out the total program for those people in commutable distance from the facility itself: that if additional space is necessary because of accumulation of patients, which we hope would not occur, that we would add additional beds to each center and leave the responsibility for serving the district in its own location.

In addition to increased personnel, now this has been mentioned, our personnel who serve the Little Rock hospital numbers about 850 employees for this 1,100 patients, but our length of stay, as I mentioned, has been appreciably reduced.

For example, if we can reduce the stay of each patient by 1 day, we save over 10 years of hospitalization and if we can reduce the stay of each patient by 1 week, we have saved the equivalent of more than 70 years, or the lifetime of one person.

Our emphasis up to now has been to improve the staff ratio, intensify the treatment of the patient, and utilize the services of all other existing agencies.

For example, we have a vocational rehabilitation unit on the grounds of each hospital. We work very closely and receive a lot of help from the Departments of Welfare. We receive a lot of help and provide a lot of service to nursing homes and nursing home operators.

The department of education, the State board of health, the visiting nurses, the volunteer groups have all played a part in the reduction that has occurred in our population. We believe and it is our feeling that the reason that we need some help from the type program that is being presented in this bill is for the service that we are not now giving.

For example, I can see the question being raised by my own board and members of our own legislature. Would it not be cheaper to build these 400 beds on the grounds of the Little Rock hospital?

I am sure it would. I am sure it would be cheaper to operate them there because they could utilize all other facilities; laundry, coal storage, laboratory, and so on.

It would mean those people that live too far to take advantage of these services would not be served. We are not serving these people now. We are only serving people who live 200 miles from our hospital, who are quite sick, and who need institutional care very seriously.

Many patients in that area need treatment but just are not receiving it.

Now here is where I believe that this initial staffing has importance. We know that if we are able to develop and construct a facility, we will say, at Federal, to serve that corner of the State, we can expect, from the experience of clinics, that we are going to appreciably increase the utilization of that service.

Now our experience has been that clinics, in their initial operation, do not decrease State hospitalization. The clinics that I have been associated with, when established, would more than double the number of patients admitted to the State hospital, and that within the first year.

They see patients that are brought to their attention that have been in the community, and they feel this is a person that is quite ill, and that he needs to be hospitalized.

It is only after a period of operation of around 3 to 5 years that we have been able to see a reduction in those patients actually coming to a hospital as a result of clinic services.

Now I can well see that by opening up a comprehensive treatment center to serve the district that that center will no doubt provide three to four times the service to the people in that area that the State hospital is now providing.

Now this, to me, is where some assistance in Federal financing to bridge this gap is very important to the local States. I believe that the States can assume and will assume the financial burden.

If they can bridge the gap between providing adequate service to all their needs and can reduce this backlog to a point where they are able to meet it, I feel that they will do so.

For that reason, I do believe that a period of financing, for a period of up to 5 years, would be very important.

Now, from the construction standpoint, I again would like to see some of this money down in Arkansas, because I believe that with 75 percent matching I might be able to talk them into providing the other 25 percent.

I do believe by having this financial assistance in the construction of possibly four of these centers that this might be quite an inducement for the State to take on a little extra expense in time by locating them in an area outside of the present State hospital.

Personally, I would like very much to see this pass, as I believe it is a tremendous step forward.

I am not interested, frankly, in seeing centers set up to keep passing on to the State hospitals those patients that they don't feel capable of treating.

I believe it is just as cheap to add to that center and keep adding to it until they learn how to successfully treat these patients.

I think this has been one of the problems over the years. We have gone through the phase of the acute psychopathic hospital, and such statements as this are going to clear the State hospital system but we have fallen far behind in providing an adequate State hospital staff. Only in recent years has it been possible to adequately staff, and then in only a few isolated places.

I do not believe there is a State, to my knowledge, unless it would be the Topeka State Hospital (which is the best staffed State hospital

in the United States), there is no State hospital that can compare with any of the staffing patterns that have been indicated for these comprehensive centers.

I do believe, that with the facilities and the staff, the State hospitals themselves, can carry much of this load if they can have help in providing service as close to home for those patients so they can receive adequate treatment, and, in many cases, remain on the job as an employee going for treatment rather than as a person being sent great distances to a State hospital, and then the person having to go back through the transition of fitting back into the community, hoping he can get employment back, will in time solve the problem.

Thank you.

Mr. O'BRIEN. Thank you very much, Dr. Jackson, for an excellent statement. I get the strong impression that you believe that without staffing the provision here that this bill would be much weaker and less effecive?

Dr. JACKSON. I believe this, Mr. Chairman. I believe that every State is trying to do everything that they can in this area. Now, just like in Federal Government, these hospitals are competing with all of the services in the States; increased enrollments in the colleges; the public school, the highways, and the States just are not in a position to give this much of an increased financing at the present time.

Mr. O'BRIEN. Mr. Harris?

Mr. HARRIS. I want to join in complimenting you, Doctor, on your very informative and interesting statement.

Personally, I am glad to have this rundown on our situation in Arkansas. I know the chairman of your State board, Senator Olin Hendrix, has done a magnificent job in his efforts to do something about this problem along with other members of the board for the last several years.

I am sure he and the others in our State were glad to see you return to this responsible position.

Do you feel that the staffing provision of this proposal is necessary then, not to provide staff for your State hospital, but to bridge a gap with these new centers that will be set up over the State, or around the State, decentralizing this program and ultimately placing more responsibility on the localities?

Mr. JACKSON. Yes, sir; I do. Actually I think this: That the States have as much of a load as they can carry right now in adequately financing their presently existing State hospitals. I don't believe that the States are able to finance, even though, on a long-term basis, this is the economical thing to do.

I do believe that if these are established, they will produce the results that will enable them to either decentralize the present existing State hospitals, or better utilize them as a part of the total program.

In other words, it might well be that a State hospital in existence might well be the center serving the district adjacent to it. I would not see us building another center, just 5 miles away, just to get out from under it. Why not use those buildings as a center for that district and then use the money that would normally be for additions to the State hospital as the State's part in helping provide the cost for the development of these centers?

Mr. HARRIS. Now, I was very much impressed with the program as explained by the Director from Missouri and also the Director from Illinois. They pointed out the possibility of providing greater service, improved service, with an ultimate objective of reducing the load and responsibility of the State and the Federal Government by establishing a program on a decentralized basis handled by local people, thereby providing better treatment to the patient, which is the ultimate objective and which seems to me a very sound objective.

I must make this comment: This is the first time I have seen a truly decentralized program that has been offered to us in a long time. I am very much impressed with it. I hope others will be too.

Now what about the training program? You have how many staff assistants in the State hospital?

Dr. JACKSON. You mean in training?

Mr. HARRIS. Well, first on active service.

Dr. JACKSON. We have 22 regular staff physicians and 18 residents in training. The regular staff consists of 12 psychiatrists full time, 3 psychiatrists part time, and 7 specialists in other specialties on part to one-half time.

Mr. HARRIS. Now those 22 are in Little Rock and Benton, sir?

Dr. JACKSON. No; in addition to that we have eight at Benton.

Mr. HARRIS. You have 8 at Benton and 22 at Little Rock?

Dr. JACKSON. Yes.

Mr. HARRIS. Then you have how many in residents?

Dr. JACKSON. Eighteen.

Mr. HARRIS. That is in training?

Dr. JACKSON. Yes, sir.

Mr. HARRIS. Now while we are there I want to ask some more information for my own edification. There are certain doctors in the State that have grants or fellowships or something who come to Little Rock and are in training with you?

Dr. JACKSON. Yes.

Mr. HARRIS. Under what program are they in training, Doctor?

Dr. JACKSON. Of our 18 we received 4 grants from the National Institutes of Mental Health for the training of general practitioners in psychiatry. The 14 others are paid for from State appropriations.

Now this is a good point. We encourage the man from general practice. Our main recruiting effort is to get the man who has been in practice for at least 5 years. Of the 18 that we have in training, 14 were recruited from within the State and we believe that we will have a good chance of keeping the majority of those in the State.

Mr. HARRIS. Now those that are recruited and paid for, the 14, are they paid for out of State funds?

Dr. JACKSON. Yes, sir.

Mr. HARRIS. Are they receiving the same benefits or remuneration as those who are in training under NIH funds?

Dr. JACKSON. Exactly the same.

Mr. HARRIS. In other words, the Federal Government then under the program which we have today put in this record, under that NIH program, is contributing 4 to this training program and our State of Arkansas is contributing 14.

Dr. JACKSON. That is right, sir.

Mr. HARRIS. I think that is a very good point to make. It should be revealing to the members of the committee; it is to me.

I think that is all, Mr. Chairman.

Again, I want to compliment Dr. Jackson for his contribution. Thank you, Mr. Chairman.

Mr. O'BRIEN. Mr. Nelsen.

Mr. NELSEN. I have no questions but I certainly wish to compliment this gentleman on his statement and testimony, very informative and very well done. Thank you.

Mr. ROGERS of Florida. I have a few questions, Mr. Chairman.

As I understand you have two institutions?

Dr. JACKSON. Yes, sir.

Mr. ROGERS of Florida. Do you have any clinics at all?

Dr. JACKSON. Not under our operation. They come under the mental health authority of the board of health.

Mr. ROGERS of Florida. How many clinics do you have?

Dr. JACKSON. Only three.

Mr. ROGERS of Florida. Three?

Dr. JACKSON. That is right.

Mr. ROGERS of Florida. How long have they been functioning, sir?

Dr. JACKSON. Well, the one there at the university, the medical center, has been in operation for, oh, years.

Mr. ROGERS of Florida. I see.

Dr. JACKSON. One has just opened there in the city of Little Rock within the last 3 months and the one at Fort Smith has been in operation now about a year and a half.

Mr. ROGERS of Florida. About how many psychiatrists are assigned to each of those clinics, would you know?

Dr. JACKSON. Well, the university hospital has about—oh, of course, they assign students there, they assign residents and they assign staff members. I would not be able to tell you.

Mr. ROGERS of Florida. Then your outclinics at Fort Smith, what would that be?

Dr. JACKSON. Fort Smith has two psychiatrists on part time but it is strictly outpatient.

Mr. ROGERS of Florida. And how many psychiatrists?

Dr. JACKSON. Has one full time.

Mr. ROGERS of Florida. One full time?

Dr. JACKSON. That is right.

Mr. ROGERS of Florida. What is the population of Little Rock?

Dr. JACKSON. 125,000.

Mr. ROGERS of Florida. And the population of your State, sir?

Dr. JACKSON. 1,800,000.

Mr. ROGERS of Florida. And you have how many psychiatrists on your State, 14?

Dr. JACKSON. Well, let's see. You are talking about just hospital, State hospital payroll.

Mr. ROGERS of Florida. Or State psychiatrists, paid for by the State.

Dr. JACKSON. The reason I say that the medical center employs about 8 psychiatrists in the department of psychiatry and we have 12 on our staff full time at Little Rock and Benton who are trained psychiatrists.

Mr. ROGERS of Florida. How many psychiatrists do you have in your State? Would you know off hand?

Dr. JACKSON. I am not sure because you see, we have two veterans hospitals there. I would guess probably we have a hundred.

Mr. ROGERS of Florida. About a hundred?

Dr. JACKSON. Yes.

Mr. ROGERS of Florida. That includes those at the veterans hospital?

Dr. JACKSON. Yes.

Mr. ROGERS of Florida. What do you pay your psychiatrists, Doctor?

Dr. JACKSON. Well, a man that has just completed 3 years of training we start him at $14,000, in 6 months we raise him $500 and in fact each 6 months up to $16,000.

At that time he is board eligible. If he takes his board and passes we give him an increase of $1,500 annually.

Mr. ROGERS of Florida. Is there any difficulty in recruiting psychiatrists for your program?

Dr. JACKSON. Well, right now if I had one come along I would not have funds to pay him.

Mr. ROGERS of Florida. I see. So you have had no difficulty?

Dr. JACKSON. Now they are not all trained, understand. Eighteen on my payroll are in training.

Mr. ROGERS of Florida. Yes.

Dr. JACKSON. Fourteen of them right out of my salary budget.

Mr. ROGERS of Florida. I see. Now what program do you have for the mentally retarded?

Dr. JACKSON. Actually, up until very recent years we have had a very limited program. The State opened an institution at Conway, I believe it started about 4 years ago and it is in the process of expansion there. They now have about 540 children. It is a very adequate facility, it just is not quite large enough yet.

Mr. ROGERS of Florida. Do you know what the mentally retarded population of your State is estimated at?

Dr. JACKSON. It is estimated around 20,000 to 30,000, sir.

Mr. ROGERS of Florida. I see.

Dr. JACKSON. Depending on whose estimates you use.

Mr. ROGERS of Florida. Yes. How many psychiatrists devote their time to the facility there?

Dr. JACKSON. The institution does not have a full-time psychiatrist. They have a full-time pediatrician and they use psychiatric consultants from Little Rock.

Mr. ROGERS of Florida. Do you use the psychiatrists in private practice a great deal in your State to work with your State program?

Dr. JACKSON. We do this. We have three that act as consultants and teach in our residency training prorgam on a part-time basis.

We do encourage the psychiatrist who will to come to see their patients in the State hospital.

I will admit that few of them do because they just don't have the time.

Mr. ROGERS of Florida. Do any of the private psychiatrists use the facilities of the clinics, do you know?

Dr. JACKSON. No, sir.

Mr. ROGERS of Florida. They do not. Are these clinics provided for indigents or do you have arrangement for payment for paying patients?

Dr. JACKSON. They have an arrangement but nobody is barred from being seen in the clinic on the basis of inability to pay.

Mr. ROGERS of Florida. What arrangements for paying do you have for those clinics?

Dr. JACKSON. Well, they have a sliding scale up to $10 an hour for treatment. They have a form that they use there that is approved by the local medical society for them to use.

People above a certain level are expected to go to a private psychiatrist if he is able to see them.

Mr. ROGERS of Florida. I see. What is that level, do you recall offhand?

Dr. JACKSON. Well, I could not tell you the exact formula. It is based on the number of dependents in the family, and the gross income. They also take into consideration whether he has any members of the family that are college students and other financial obligations.

Mr. ROGERS of Florida. I see. But basically this is provided for those of limited income.

Dr. JACKSON. Yes. Anybody above, we will say, a six to eight thousand income, is encouraged, unless they have some untoward expenses, to seek treatment privately.

Mr. ROGERS of Florida. I see.

Now, you don't have beds in this clinic, as I understand it?

Dr. JACKSON. No, sir.

Mr. ROGERS of Florida. Strictly outpatients?

Dr. JACKSON. That is right.

Mr. ROGERS of Florida. Now in your health State facilities where you do have the beds, do you allow any private patients at all?

Dr. JACKSON. Yes.

Mr. ROGERS of Florida. In other words, you allow the psychiatrist to place his patient in there?

Dr. JACKSON. Actually any physician in our State can refer a patient to our hospital without going through any legal proceedings.

He just writes a statement that he has examined this person and in his opinion this person is mentally ill and needs treatment in the mental hospital.

We can accept a patient on that.

Mr. ROGERS of Florida. I see.

Dr. JACKSON. That makes up about 54 percent of our admissions.

Mr. ROGERS of Florida. I presume a patient could not be kept there against his will under those conditions?

Dr. JACKSON. Well, he can only not be kept after a limited period of time. We can hold him up to 30 days even though they object.

Now we would not do that unless we thought it was really necessary.

Mr. ROGERS of Florida. You mean just one physician's statement?

Dr. JACKSON. One physician's statement. Just like you would refer a patient into any other local hospital.

Mr. BROTZMAN. Would the gentleman yield?

Mr. ROGERS of Florida. Yes.

Mr. BROTZMAN. Do I understand this could occur without any court order?

Dr. JACKSON. Yes.

Mr. BROTZMAN. Without any judicial process?

Dr. JACKSON. Yes.

Mr. BROTZMAN. Just on a physician's statement?

Dr. JACKSON. Yes. In other words a patient cannot walk into the Baptist Hospital and say "I want to be admitted."

Mr. ROGERS of Florida. But he can just walk out?

Dr. JACKSON. Well, he can walk out from us if we think he is all right to go.

Mr. ROGERS of Florida. You would not hold him there against his will simply because a doctor had asked to admit him, would you?

Dr. JACKSON. No, I would not, not without getting some legal action, but I can hold him up to 30 days.

Mr. ROGERS of Florida. Without his physician's approval?

Dr. JACKSON. No with his physician's approval.

Mr. ROGERS of Florida. Without a court order?

Dr. JACKSON. Yes.

Mr. ROGERS of Florida. Does the board have to meet if he were to request to get out?

Dr. JACKSON. What he can do, is this: He can write me a letter requesting his release and I can immediately turn him loose if I want to. Or if he is not believed to be dangerous to himself or to anyone else and the patient wants to leave, we will call his doctor and turn him loose.

Mr. ROGERS of Florida. I am sure that would be your normal practice but I just wondered.

Dr. JACKSON. Suppose he was a paranoid individual here that had ideas of people doing things to him and we thought he should not be loose. We would not wait 30 days to get a commitment. We would examine the man and send to the court a report of the examination and immediately ask for a commitment. We find this does not occur more than five or six times a year.

Mr. ROGERS of Florida. I would think so, too, but I wondered what procedure there would be for a man whose doctor had asked that he wanted to be committed and wanted to leave, would you take him to court immediately.

Dr. JACKSON. If he did and we thought he was safe to go, we would release him.

Mr. ROGERS of Florida. He can go to a court to determine whether he should remain?

Dr. JACKSON. Yes, he can do that.

Mr. ROGERS of Florida. You can do that immediately and you would not prevent that, would you?

Dr. JACKSON. No.

Mr. ROGERS of Florida. Fine.

Dr. JACKSON. What I am getting at is, we try to look at this as a sick person and he is referred in by his doctor.

Mr. ROGERS of Florida. Yes?

Dr. JACKSON. As I say, 54 percent of our patients come in on that and that is all that ever occurs. This way you never take away the civil rights of this person, and when this person is ready to leave he goes ahead about his business, he can drive his car, he can tend to his business. We try not to use the court commitment. We also try to pro-

tect his rights. I mean if this person has reason to believe he should not be there, we proceed to have him examined immediately.

Mr. ROGERS of Florida. Fine, that is what I wanted to see.

Dr. JACKSON. Yes. If the doctor that examined him said, "This man does not need to be restrained here," we turn him loose if he does not want to stay or we may just try to encourage him to stay.

Mr. ROGERS of Florida. Thank you very much, Dr. Jackson.

Mr. BROTZMAN. I will make mine very short. I understand we have one more witness.

I think we are very fortunate, Doctor, to have the benefit of your testimony, particularly in the view of the fact that you have had an opportunity to observe the operation of these programs in three States if I understand correctly.

Dr. JACKSON. Yes.

Mr. BROTZMAN. Your testimony today has been basically concerning that in Arkansas where I understand you presently are located?

Dr. JACKSON. Yes, sir.

Mr. BROTZMAN. Were you in Texas or in Kansas prior to going back to Arkansas?

Dr. JACKSON. I was in Kansas.

Mr. BROTZMAN. Kansas?

Dr. JACKSON. Yes, sir.

Mr. BROTZMAN. Generally, do you have a system in Kansas similar to the one you are promulgating in Arkansas?

Dr. JACKSON. They have this in two of the three hospitals and are in the process of setting it up in the third one.

Mr. BROTZMAN. Do they have any sort of community mental health centers in operation?

Dr. JACKSON. Only as outpatient. They don't have the comprehensive inpatient-outpatient type of operation.

I believe that there are approximately 18 clinics in operation right now which are State operated, State and locally operated.

The State supervises them but actually the State puts nothing other than just some little initial money into them. They are actually financed through a local millage tax levy and any county can levy up to 1 mill for this purpose or combination of counties can do this.

Since this was initiated I believe there has been an increase of about 10 or 12 clinics.

Mr. BROTZMAN. Do you know when their community mental health program was initiated over in Kansas?

Dr. JACKSON. You see, they had an operation there up until 3 years ago that—in which the mental health authority which handled the community mental health services was under the board of health, as a division of the board of health.

Three years ago they transferred it to the department of institutions. At the same time they passed this enabling legislation to raise funds for the establishment of such clinics. Since that transfer the clinics have increased from 6 up to I believe, 18.

Mr. BROTZMAN. I don't know how closely in touch you are with their program now but how would you say their program is working?

Dr. JACKSON. Well, it depends on whose rating you use.

Some people think it is close to first. It was 47th years ago, but now some people say it is first, some say it is second or third. Kansas would say it is first, I am sure.

I would say that this hospital program is reasonably adequate. I think that it could still make considerable improvement. I think the community services need to be extended beyond just outpatient services on to real operating centers.

Mr. BROTZMAN. Their outpatient program, has that been in operation for some time?

Dr. JACKSON. Well, actually the State hospitals each have operated an outpatient department for years. For example, at the Topeka State Hospital they operate a clinic there where they have 3 senior physicians and 12 residents on a full-time basis just serving the area there in that county. Well, the majority of the patients are from a radius of 25 to 30 miles. They see, I would say, between 600 and 800 patients in treatment a year. Each of the other hospitals operate similar outpatient departments in their area but not as heavily staffed.

The other two hospitals which are in small communities do well to have as many as two psychiatrists at any time on a full time basis serving those clinics.

Now the 18 that I am talking about, approximately 18 that I believe they have in operation now, really are community clinics and have their own board for administration.

They are only supervised by the State department who does establish regulations and as the State controlling agency must approve the opening of any new one.

That is for protection so an area that really should not have one would not try to finance and try to set up one if it was more feasible to combine and set up with another operation.

In other words, the State department states you should not operate one but if three of your counties go together we will approve it.

Mr. BROTZMAN. Is that done under a general State enabling type of legislation?

Dr. JACKSON. That is right.

Mr. BROTZMAN. Then they levy the 1 mill, I think you said, at the local level?

Dr. JACKSON. County level.

Mr. BROTZMAN. I think you said several counties.

Dr. JACKSON. It still has to be levied at the local level but each county may take their share and join with other counties to finance the operation. It is specifically earmarked for mental health purposes.

Mr. BROTZMAN. That is an ad valorem type tax?

Dr. JACKSON. That is right.

Mr. BROTZMAN. Just quickly now, I don't know if you are abreast of the situation in Texas. You probably have some continuing interest. Do they have anything similar to this in the State of Texas?

Dr. JACKSON. I am not familiar enough to tell you how much they have expanded in their outpatient services. I know they have some.

Mr. BROTZMAN. They do have some?

Dr. JACKSON. Yes.

Mr. BROTZMAN. Is this a relatively new program in the State of Texas, sir?

Dr. JACKSON. No. Texas and particularly the larger cities have had clinics over the years, there have been a number of them. In fact, the one I would say in Dallas is one of the oldest clinics in the country. It has been in operation probably 30 or 40 years.

Mr. BROTZMAN. Are you acquainted, Doctor, with the method of financing those clinics there?

Dr. JACKSON. No, sir; I am not.

Mr. BROTZMAN. I would like to thank you for your appearance here. You have been very helpful.

Dr. JACKSON. One other thing I did not mention. It was mentioned about having your hospital adjacent to medical centers.

In about 1948 in Arkansas, they moved the medical school on to the grounds of the State hospital so now their programs are right adjacent to each other which we have found to be very, very helpful.

Mr. O'BRIEN. Doctor, how many nurses do you have in your two hospitals?

Dr. JACKSON. Graduate nurses, I am somewhat understaffed. I have about 42 at Little Rock and 20 at Benton, sir.

Mr. O'BRIEN. Forty-eight psychiatrists, you say?

Dr. JACKSON. Well, we have a total of 48 either in training or men who have completed their training at the two hospitals on a full-time or part-time basis.

Mr. O'BRIEN. It occurred to me that your figures were quite significant in view of earlier testimony. I believe it was Missouri, where we had 1 psychiatrist to 200, 220 patients and 1 nurse to every 90 patients.

Dr. JACKSON. Actually, even though it may appear so, their testimony and mine really is not in conflict. I think we are all in favor of having an adequate staff in both areas. Our approach may be a little different.

Mr. O'BRIEN. I agree with you because I think your figures coupled with the rate of discharge which you have makes a very strong case for adequate staffing.

Dr. JACKSON. I think you must have both.

Mr. O'BRIEN. Thank you very much, Doctor. We are most grateful.

Our final witness today is Dr. Harold L. Friedenberg, Richmond, Va.

STATEMENT OF HAROLD L. FRIEDENBERG, O.C., RICHMOND, VA.

Dr. FRIEDENBERG. Mr. Chairman, members of the committee, I realize the hour is late and I am going to make my statement as brief as possible. I would like to speak on title III in this bill which has not been touched on today.

My name is Harold L. Friedenberg. I am an optometrist practicing my profession in Richmond, Va. In 1942 I graduated from Pennsylvania State College of Optometry.

I am a member and past president of the Richmond Optometric Society, the Virginia Optometric Association, Virginia Academy of Optometry, and the Virginia State Board of Examiners in Optometry. Currently I am the administrative secretary of that board and a fellow of the American Academy of Optometry.

My appearance here is on behalf of the American Optometric Association and particularly its Committee on Visual Problems of Children and Youth, of which I am a member.

My writings include articles published in the American Journal of Optometry and Archives of the American Academy of Optometry on such subjects as "Notes on the Application of Telescopic Spectacles With Reports on Three Cases," "Subnormal Vision Device Augmenting Palliative Treatment of Hypertension," "Case Report of Intracranial Tumor With Visual Complications," "Essential Optic Atrophy."

In February of this year one of my articles appeared in the Journal of the American Optometric Association entitled "A Discussion of Physical and Perceptual Environment in Visual Training of Mentally Retarded Children" and in May, in the Optomertic Weekly, "The Retarded Reader and Multidisciplinary Care.

Currently, I am a vision consultant to Ohio State University Research Foundation on a research project entitled "The Influence of Vision Training Upon the Subsequent Reading Achievement of Fourth Grade Children," and am an optometrist for a Child Guidance Clinic (Richmond, Va.) which cares for emotionally disturbed and mentally retarded children.

My practice includes cooperation with pediatricians, phychiatrists, psychologists, other optometrists and special education teachers working with emotionally disturbed and mentally retarded children with visual problems.

On behalf of the American Optometric Association, Dr. James Tramonti submitted a statement before this committee last March on H.R. 3688 and H.R. 3689. While I would like to think that the committee members remember Dr. Tramonti's testimony, I cannot quite bring myself to believe that all the members of the committee do.

However, I am confident that copies of it are readily available and, therefore, I shall not attempt to repeat it or even to summarize it.

Dr. Morton Davis submitted a statement to the Senate committee holding hearings on S. 755 and S. 756. It will be found on page 187 of the printed hearings.

These bills are identical with titles I and II of S. 1576, but title III, providing for the training of teachers of mentally retarded and other handicapped children, is new material.

My appearance is especially for the purpose of supporting the enactment of that portion of the bill and emphasizing the importance of the utilization of optometrists, both as members of the panels of experts and as members of special or technical committees as provided in section 302, subparagraphs (b) and (c) of the bill.

Not so long ago the vast majority of people associated visual problems with advancing years. There were a few children with obvious handicaps such as crossed eyes, squint, and similar afflictions which were readily recognizable.

It is only in recent years, through the pioneering work of optometrists in connection with such organizations as the Gesell Institute, that the public is beginning to realize that very young children may have vision problems which seriously affect their ability to learn, to engage in sports, and otherwise lead the normal life of a child, even though to the casual observer their eyesight is not impaired.

It is not enough to know if the child can see a ⅓-inch-high letter on a Snellen chart at a distance of 20 feet, with or without glasses. It must also be determined whether the child can focus on the printed words of a book held at 12 to 16 inches from him and maintain effortless binocular vision for a sustained period of time.

So many children with behavior problems have been discovered to be unable to accomplish this task without lenses and/or vision training, that their misbehavior may well have stemmed from a desperate effort to escape from an intolerable school situation.

Confusion exists in the minds of my individuals as to the difference between vision and acuity. Acuity is simply the ability of the individual to see a letter one-third of an inch high from a distance of 20 feet. Vision, on the other hand, is the individual's ability to correlate and integrate what his acuity tells him is there.

C-o-w may be seen by someone with 20/20 acuity, but only through the complex processes which make up vision can that person, on seeing these letters, conjure up a four-legged animal with a tail and two horns which eats grass, says moo, and gives milk.

Thousands of handicapped children have just such a problem. C-o-w are prefectly clear to them but the ability to visualize these three letters as cow, as we know it, is completely lacking. It is a complex task for any child and often an insurmountable one for a handicapped child.

Our profession has, as the result of research, developed the techniques and skills necessary to help children—handicapped or otherwise—to make the transition from the acuity level to the level of visualization.

The article entitled "Problems in Defining and Classifying Blindness" which appeared in the New Outlook for April 1962, written by John Walter Jones of the Office of Education, Department of Health, Education, and Welfare, states:

> It is widely recognized that visual acuity alone is not a reliable criterion for defining or placing of visually handicapped children. Reliance upon it as the most important single factor also is being challenged. In addition, many questions raised in connection with the use of present visual acuity designations center upon the fact that they do not correspond to the way children function in school. Yet in many instances administrators have used the visual acuity limitations as the determining factor for placement rather than as a guideline.

The child who has learned to visualize easily to obtain meaning from visual symbols without support from the other senses can spend his efforts and energy in learning what he is reading rather than the actual mechanics of seeing words.

The child with visual perceptual problems may find the symbols themselves such a succession of obstacles that he derives little or no meaning from the words, although he might see them with 20/20 or better acuity.

Many educators, psychologists, psychiatrists, and other individuals who work with children are aware of the relationship of visual perception, not just visual acuity, to scholastic achievement. Many more need to be informed of this relationship.

An emotionally disturbed or socially maladjusted child, by reason of these handicaps, finds great difficulty in coping with the everyday problems of living. Add the additionally frustrating factor of a vis-

ual problem, which appears more frequently among these children, and the handicaps appear to be insurmountable. However, by removing one of the frustrations, namely the visual problem, the child is frequently helped to adjust more rapidly to his problems.

One child psychiatrists has estimated that approximately 35 percent of the children seen by him have some impairment of binocular vision, with or without an accompanying reading disability.

Since vision, the ability of the child to understand things he cannot taste, touch, smell, or hear, is one of the major contacts with reality in the early experience of this child, it can readily be surmised that the emotionally disturbed child who cannot face reality has created for himself a situation of stress which involves vision. One authority has stated that the outcome of the future development of personality is to a great degree a function of the extent and quality of visual contact.

Permit me to call your attention to one statement which appeared in the American Optometric Association's report to the 1960 White House Conference on Children and Youth:

> Of great social import is the startling relationship which has been found to exist between vision difficulties and the baffling problem of juvenile delinquency. Statistics reveal that more than 80 percent of delinquent and predelinquent children have not achieved satisfactorily in reading. Research further reveals that in 50 percent of those encountering reading difficulty, vision is a contributing factor. Certainly this does not indicate that every child with a reading problem is a potential delinquent. Rather, it does indicate that such children should always be examined promptly for the existence of a vision difficulty, and particularly those children whom society has not been able to "reach."

There was a theory, which still prevails although it was long since exploded; namely, that children with limited vision would damage what little remained if they used it to full extent in school.

As a result, some students were routinely classified as blind children and taught to read by means of braille, whether or not they could see to read print. It is now recognized that children should be encouraged to develop to maximum use even slight amounts of residual vision. Our profession is entitled to great credit for what has been accomplished along these lines.

The article from which I previously quoted which appeared in the New Outlook, April 1962, lists a number of questions which remain to be answered; namely:

What factors other than visual acuity tested beyond the reading distance are important in determining the mode of reading performance of children with very low vision?

Does the average child whose visual loss is associated with a particular condition such as nystagamus tend to be a more likely candidate for special education than one with a different condition but a similar degree of visual acuity? Is he more likely to succeed in reading by means of braille or by means of print?

How extensively is large print material used by children with visual limitations? Which among them must rely upon it for their independent reading?

Does the introduction of braille as the first trial reading medium result in a loss of the opportunity for young children to develop print reading skills and use of residual vision at an age when the chance for this development is optimum? Or does the introduction of print

as the first trial reading medium to children with inadequate vision result in a loss of the opportunity for them to develop adequate skill in reading by means of braille?

What constitutes a good trial climate and an adequate trial period for most of these children?

Members of our profession stand ready, willing, and I believe able to make a substantial contribution to finding the answers to these questions.

On page 34, the bill provides that the Commissioner of Education—

is also authorized to make grants to public or other nonprofit institutions of higher learning to assist them in providing professional or advanced training for personnel engaged or preparing to engage in employment as teachers of handicapped children, as supervisors of such teachers, or as speech correctionists or other specialists providing special services for education of such children, or engaged or preparing to engage in research fields related to the education of such children.

Our profession is peculiarly well qualified to participate in this program insofar as it pertains to the visually handicapped child.

Our attention has been called to the case of the son of one of the secretaries employed by one of the House committees of Congress.

He had been classified as retarded, unable to learn, and uncooperative. She took the lad to an optometrist here in Washington who specializes in orthoptics and visual training. The result is that after several years of professional optometric care, he is an honor student, president of his class, and captain of the basketball team.

Recently an article appeared in the Saturday Evening Post of May 25, 1963, entitled, "Mom, Mom, I Can See." Much of the article describes the work of Dr. William Finebloom, an optometrist who has pioneered in subnormal vision aids.

It required legislation to secure for optometrists commissioned status in the Army and Air Force, to have their services made available in the aid to the blind program under title X of the social security law, and for veterans entitled to outpatient vision care to avail themselves of the services of an optometrist if they so desired.

We have never advocated legislation which would compel an American citizen with a vision problem to seek the services of an optometrist. We do believe that it is in accordance with the American tradition and the welfare of our fellow citizens that optometric services should be made available to all those in need of them. Unless Congress makes it crystal clear, however, that the services of members of our profession shall be availed of in connection with State plans provided in S. 1576, I feel confident that members of our profession will either be excluded or will have to "crawl under the tent."

Our association has published three manuals to provide the practicing optometrist with an up-to-date survey of the problem of caring for the partially sighted child. Copies of the three manuals are available for members of the committee and staff.

It has been a pleasure to appear before you and if I can be of service in answering any questions or providing additional information at a later date, I will be happy to do so.

Mr. O'BRIEN. Thank you very much, Doctor. I ask if title III, as it is now contained in the bill is satisfactory to you and people in your profession?

Dr. FRIEDENBERG. I would think it is, sir. It does not specifically mention optometry but it certainly gives authority to use optometry.

Mr. O'BRIEN. And it is obvious from your statement that there would be quite a serious handicap?

Dr. FRIEDENBERG. That is right.

Mr. O'BRIEN. I was quite interested from a personal angle.

I notice one of your papers concerned fourth grade children. I have a grandson who is going through that same problem right now.

Thank you very much for a very fine statement.

Do you have any questions, Mr. Brotzman?

Mr. BROTZMAN. I have no questions.

Mr. ROBERTS. The hearing will stand adjourned until 10 o'clock tomorrow morning.

(Whereupon, at 5:35 p.m., a recess was taken until 10 a.m., Thursday, July 11, 1963.)

MENTAL HEALTH

(Supplemental)

THURSDAY, JULY 11, 1963

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON PUBLIC HEALTH AND
SAFETY OF THE COMMITTEE ON
INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to recess, in room 1334, Longworth Building, Hon. Kenneth A. Roberts (chairman of the subcommittee) presiding.

Mr. ROBERTS. The subcommittee will please be in order.

I have received this morning from the Honorable John W. Reynolds, Governor of Wisconsin, a telegram which I would like to place in the record because of the fact that he was very anxious to be here.

Without objection, I would like to read the wire. It is addressed to me as chairman, Subcommittee on Public Health and Safety of the House Interstate and Foreign Commerce Committee.

It is a pleasure to have the opportunity to submit testimony to this committee. The mental retardation and mental health bill (S. 1576), which you are considering, is one about which I and many people in Wisconsin are urgently concerned.

The matter of care, treatment, and training of the mentally retarded and mentally ill is especially close to our hearts. When I took office as Governor of the State of Wisconsin, I was aware that one of the first tasks I would face was the development and presentation of an executive budget. Included in that budget would be requests for added millions of dollars for mental retardation and mental health services. The largest amounts of these would be for operation of our institutions.

In order that I could have as much knowledge as possible about these programs, I personally visited each of the State institutions in Wisconsin. At each of them I held a detailed budget hearing with officials of the State department of public welfare, the institution superintendent and his staff.

Perhaps the most unforgettable aspects of these visits was the opportunity to meet with patients in the wards and with the personnel who take care of them. I came away feeling that, despite the large sums of money that State and local governments have spent in these programs, much more is needed to provide a program of treatment and rehabilitation which will effectively raise the level of achievement of these unfortunate individuals more nearly to the maximum of their potential, and pave the way for their possible return to community and family life.

This is true in Wisconsin where our State institutions are among the best in the Nation and where our expenditures for treatment and training services are considerably higher than they are in some States.

The predicament of the mentally retarded person was particularly heartrending to me as I toured areas where there was a lack of qualified personnel to provide a program for their progressive development and rehabilitation, and a lack of sufficient facilities to allow for effective use of those services we already have.

I was told that even the unusual devotion and interest of personal working with these handicapped persons cannot have its greatest effect under such crowded circumstances.

In my own thinking about the problem of mental retardation and the services required, I have come to the conclusion that unusual special effort is now needed. It is most desperately needed in the area of research and the education of specialized personnel for the training of the mentally retarded. The State will need to depend on research and education programs to assist us in the development of future programs.

These programs must be directed at prevention of mental retardation wherever possible, and at the provision of multiple training and medical services to enable more of these afflicted persons to live a more natural life in their own home and community.

It seems to me that the combination of grants for construction of research centers, facilities for care and training of the mentally retarded and grants for training of teachers of the mentally retarded is a most important one since these training personnel are in urgent necessity if our facilities are to be used well and if the retarded child is to develop to his maximum potential.

It is only through this kind of effort that we can lessen the drain on public funds resulting from long-term care of the retarded person who does not get the proper training.

I am told that one of the most crucial problems in the care of the mentally handicapped child is the shortage of teachers with the special knowledge and at the present time it is not possible for a sufficient number of people, who would otherwise be interested, to receive this training.

The provisions of this bill would be of special importance in continued development of this group of very necessary skilled professionals.

In Wisconsin, over the last 10 years, we have invested $313,320,481 of State and local money in public facilities and programs for the mentally retarded and mentally ill.

Despite this strong effort on our part, we have not been able to provide a total treatment program sufficient to fully relieve human suffering, and to return afflicted persons to their own community responsibilities and to productive living.

Public responsibilities in care of the mentally retarded and mentally ill are unique and, of course, are not present in the care of most physical illnesses. That public responsibility has always been a local one. What we need now is enough help to gain a fuller benefit of the large investments which we have made over the years.

The provisions of this bill, which would provide assistance in the development of comprehensive mental health centers and support for initial staffing, are of special importance now.

In Wisconsin our communities are interested and anxious to assume more responsibilities in the care of the mentally ill. This, along with increased coverage of mental illness by health insurance and the increased availability of private services, places us on the brink of a new era in the business of providing such services.

The bill currently before you will make it possible to move in the direction of increased local services and increased services from the private sector of medicine much more rapidly than would be otherwise possible.

Assistance in staffing for a few years is essential if we are going to see the progress that is vital.

I am inclined to have more than the usual amount of feeling about this entire matter. This is because of my recent experience in visiting and talking with the people who need these services.

However, I have another reason, and that is because I also have had recent experiences with the serious problem which Wisconsin, as well as other States, faces in developing sufficient revenue resources to meet these needs.

I am confident the skilled people in our mental retardation and mental health services in Wisconsin will be able to increase the gains we have already made with the added assistance from this legislation.

We are now embarking on a comprehensive mental health planning effort which has been made possible by a grant of money from funds appropriated by Congress for that purpose.

Through this planning effort we are convinced that we will be able to mobilize our local communities and encourage their interest in assuming these responsibilities.

The impetus which will be provided by the provisions of this legislation will be important to take full advantage of the program that has already started.

I appreciate this opportunity to lend my support to legislation which serves the vital social purpose that S. 1576 does.

Thank you.

JOHN W. REYNOLDS,
Governor of the State of Wisconsin.

I call next Mr. Boisfeuillet Jones, who is accompanied by Dr. Terry and Dr. Felix.

Mr. Jones, you may proceed with your statement.

FURTHER STATEMENT OF BOISFEUILLET JONES, SPECIAL ASSISTANT TO THE SECRETARY (HEALTH AND MEDICAL AFFAIRS), DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY DR. LUTHER L. TERRY, SURGEON GENERAL, PUBLIC HEALTH SERVICE; AND DR. ROBERT H. FELIX, ASSISTANT SURGEON GENERAL, NATIONAL INSTITUTES OF HEALTH—Resumed

Mr. JONES. Thank you, Mr. Chairman and members of the committee. It is a pleasure to appear before this committee once again. As you have requested, Mr. Chairman, I shall, in this presentation, confine my remarks to the provisions of title III of S. 1576—"Training of Teachers of Mentally Retarded and Other Handicapped Children."

Title III would, essentially, amend and extend the provisions of Public Law 85-926, a graduate fellowship program in the education of mentally retarded children, by: (1) including preparation of educators of other types of handicapped children as well, and (2) providing funds for research and demonstration on problems related to the education of handicapped children.

It also extends the program for training teachers of the deaf under Public Law 87-276, authorized for 2 years in September of 1961, for another year, after which time that program would be included in the other provisions of title III.

Mr. Chairman, may I offer your committee a brief review of the operation of Public Law 85-926. This law was enacted in September of 1958 "to encourage expansion of teaching of mentally retarded children through grants to institutions of higher learning and to State educational agencies."

Under section 1 of this law, the Commissioner of Education is authorized to make grants to public and other nonprofit institutions of higher learning to assist them in providing training of college instructors in the area of mental retardation.

Under section 2 of the law, the Commissioner is authorized to make grants to State educational agencies to assist them in establishing and maintaining fellowships for supervisors and teachers of the mentally retarded.

Since the initiation of this program in fiscal year 1960, about 525 fellowships have been awarded to approximately 380 persons.

It is anticipated that by the end of 1963 about 690 fellowships will have been awarded to more than 475 individuals. The impact of the program under Public Law 85-926 is now being felt throughout the Nation.

Awards have been made to students in all but one State. Information available on 172 former fellows shows that almost 90 percent

are engaged in some type of education activity for handicapped children and over 70 percent are working specifically in the area of mental retardation.

The majority of the 172 former fellows are currently employed in leadership positions, such as directing State or local school programs, or conducting teacher preparation programs in colleges or universities. Not only has this program contributed to the alleviation of the shortage of personnel in this field but it has made a substantial contribution to the improvement of the quality of their preparation as well.

Thus far, the annual appropriation of $1 million for this program has been used only for the preparation of leadership personnel and college and university instructors.

The proposed amendment would provide additional funds so that a substantial number of teachers of mentally retarded children also could be prepared.

It has been estimated that perhaps as many as 50,000 additional teachers are needed for such children. Similar favorable effects have been observed in the program for training teachers of the deaf under Public Law 87–276.

Since its inception more than 940 scholarships have been awarded through 46 colleges and universities.

The program developed under the patterns of Public Law 85–926 in the field of mental retardation has been very successful and well received.

Title III of S. 1576 would help meet two of the most critical needs in the education of handicapped children. It would contribute to the alleviation of the severe shortage of special educators to instruct children, supervise and direct programs, and conduct college teaching; and stimulate the development of new knowledge.

The result would be a single, comprehensive, flexible piece of legislation to serve all handicapped children.

There is an urgent need for more and better qualified educators to instruct children with other types of handicapping conditions as well as those who are mentally retarded or deaf.

It is conservatively estimated, for instance, that at least 2 percent of the school-age population have serious mental health problems which interfere with their educational progress and general personal adjustment to such an extent that they require special school programs.

Large numbers of these children are in school but find themselves less and less able with each passing day to cope with inappropriate and inadequate home, school, and community surroundings. Many others have been excluded because they could not adjust to the general school program.

Increasing public awareness of the needs of these children is reflected in a flurry of activity by the schools and other agencies in recent years. The number of socially and emotionally maladjusted children and youth reported to the Office of Education as receiving special education in the public schools more than doubled between 1948 and 1958. This increase, however, represents only a very small beginning.

As in other areas of specialization, skilled teachers can rarely be found who understand the underlying causes of aggressive or withdrawn behavior and who can create a classroom climate which is conducive to learning for children with these problems. College and

university teacher preparation programs in this area are grossly inadequate.

The need for fundamental research into the effects of various types of emotional disturbances on learning is dramatically apparent. Demonstration projects also are needed if the successful solutions which have been found as a result of research are to be made known to the many States and communities which appear ready to proceed with program development but are still groping for answers.

It is gratifying to note that S. 1576 specifically mentions children who are emotionally disturbed or socially maladjusted, and would enable the Office of Education to make provisions to help close the large gap in school programs for them.

Another large group of children for whom the schools have been unable to make adequate provisions and who would benefit from the pending legislation are those handicapped by speech impairments or partial loss of hearing.

It is believed that as many as 2 million school-age children are handicapped by these impairments. Only about a fourth of them are receiving the speech correction, auditory training, or specialized instruction they need to progress satisfactorily in school and eventually achieve their full potential in our society.

The special needs of visually handicapped children also are recognized in this bill. Totally blind children and those with severe visual limitations are entering the Nation's schools in larger numbers than ever before.

The rate of visually disabling conditions in children has remained fairly constant since the turn of the century. The number of visually handicapped children has risen along with the child population. A new eye condition resulting in blindness and primarily affecting prematurely born infants swept the Nation between 1945 and 1955.

The major cause of this condition, known as retrolentil fibroplasia, has been isolated and effective preventive measures developed through medical research. But the thousands of children whose vision was lost or impaired during the period in which it was prevalent are now in our schools. This sudden surge in the number of children handicapped in school because of blindness or partial loss of vision has created an unprecedented demand for special educators.

In addition, there have been several recent and very basic changes in educational methodology in this field. The full implications of these and other developments need research exploration and demonstration which would be facilitated by this legislation.

The last group of handicapped children named in S. 1576 are those who are crippled or who have special health problems. It is estimated that there are approximately 1 million of these children of school age in the Nation at this time.

This group includes children with orthopedic and cardiac conditions, neurological impairments, or brain damage, and children diagnosed as having cerebral palsy, many of whom have complicated associated handicaps.

Advances in medical science have eliminated or sharply reduced some types of handicapping conditions which have plagued us in the past. Further advances are solely dependent on the success of medical

research. But the large number of crippled children now present in our society must be educated and trained to the highest level of achievement possible.

S. 1576 makes special provision for research and demonstration projects as well as grants-in-aid for training of professional personnel. The need for research and demonstration projects was recognized in the President's legislative proposals. This is especially necessary in a developing area as ramified and complex as that of education for the handicapped.

States and local communities have made considerable progress in providing educational opportunities for handicapped children. Despite their best efforts, however, it is estimated that only about one-fourth of the handicapped children in the Nation needing special education now have access to it.

If the present rate of program development continues, by 1968 States and local communities are likely to be making suitable educational provisions for only about one-third of the Nation's handicapped children.

Increased Federal participation as proposed in this bill should help close this gap at a much more desirable rate. A great amount of human suffering and public expense would be avoided by enabling these handicapped persons to live full and rewarding lives and to achieve their optimum potential as contributing members of our society.

That, Mr. Chairman, concludes my formal statement. I do have available a considerable amount of data relating to this program which, if the committee so desires, can be submitted for the record.

Mr. ROBERTS. I would like that to be sent up to the committee for examination, Mr. Jones. If it is important enough and not too voluminous we would certainly be glad to include it.

(The information to be furnished follows:)

TABLE OF CONTENTS OF SUPPORTING DOCUMENTS

1. Distribution map and list of awards granted under Public Law 85–926, the graduate fellowship program for the preparation of leadership personnel in the education of mentally retarded children, by State and institutions for fiscal years 1960–63.
2. Distribution maps and lists of (*a*) awards granted under Public Law 87–276, the program for training teachers of the deaf, by State and institution for fiscal years 1962 and 1963, and (*b*) distribution map of colleges and universities offering programs for training teachers of the deaf, 1961–62. (Prior to enactment of Public Law 87–276.)
3. Table showing number of colleges and universities reporting at least a minimum sequence of courses in the preparation of teachers of handicapped children for academic year 1961–62 by State and by region.
4. Maps showing comparison of the colleges and universities reporting at least a minimum sequence of courses in the preparation of (*a*) teachers of mentally retarded children for academic years 1953–54 and 1961–62, and (*b*) teachers of emotionally disturbed and/or socially maladjusted for academic years 1953–54 and 1961–62.
5. Table of preliminary estimates of the number of special education teachers needed in 1963 to instruct each type of handicapped child included in S. 1576.
6. Statement of some research and demonstration needs of the education of handicapped children.
7. List of research projects on the education of handicapped children completed or initiated under existing Office of Education research grant programs.

ATTACHMENT 1

List of awards granted under Public Law 85-926, fiscal years 1960-63

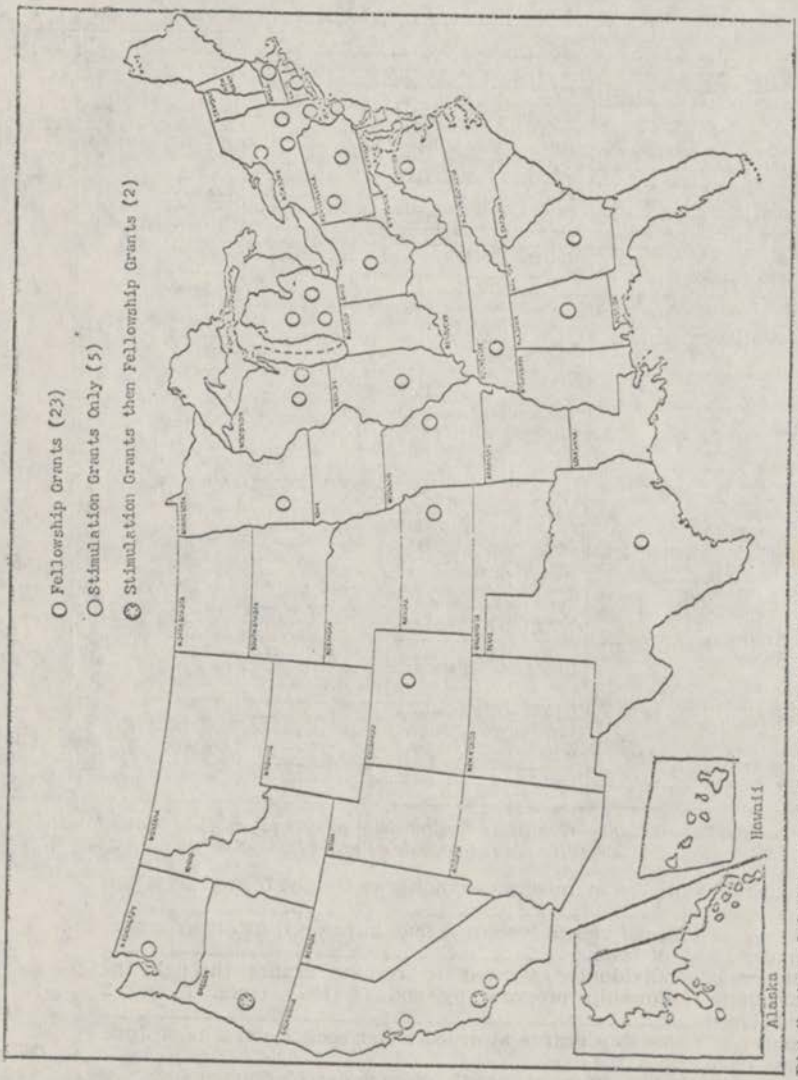
State	Section I		Section II (State education agency)	Total number of fellowships
	Institution	Number		
Total United States		275½	392	667½
Alabama			8	8
Alaska			7⅓	7⅓
Arizona			4	4
Arkansas			7	7
California	Los Angeles State College	8	9⅔	25⅔
	San Francisco State College	8		
Colorado	Colorado State College	18¾	10	28¾
Connecticut	Southern Connecticut State College	4	8	12
Delaware			3	3
Florida			11	11
Georgia	University of Georgia	15	8	23
Hawaii			10½	10½
Idaho			8	8
Illinois	University of Illinois	15½	9½	25
Indiana			6	6
Iowa			8	8
Kansas			9	9
Kentucky			9	9
Louisiana			8½	8½
Maine			8½	8½
Maryland			6	6
Massachusetts			8	8
Michigan	Wayne State University	17	8	29
	Western Michigan University	4		
Minnesota	University of Minnesota	18⅔	8⅓	27
Mississippi			6	6
Missouri			9	9
Montana			8	8
Nebraska			7	7
Nevada			8	8
New Hampshire			6	6
New Jersey	Newark State College	10	8½	18½
New Mexico			8⅔	8⅔
New York	New York University	6	9	55½
	Teachers College, Columbia University	16		
	Syracuse University	18		
	Yeshiva University	6½		
North Carolina			9	9
North Dakota			9	9
Ohio	Ohio State University	17⅔	9	26⅔
Oklahoma			6	6
Oregon			8⅔	8⅔
Pennsylvania	Penn State University	18	8	42
	University of Pittsburgh	16		
Rhode Island			10	10
South Carolina			4½	4½
South Dakota			7	7

Summary tabulations—Graduate fellowship program in the education of the mentally retarded under Public Law 85-926

Number of colleges and universities that have applied for participation in program	63
Number of colleges and universities that have been awarded grants under sec. 1 of law	30
Number of individuals expected to receive grants through the graduate fellowship program by end of 1963 (secs. 1 and 2 combined)	482
Number of fellowship grants awarded under secs. 1 and 2 as of June 30, 1963	667½
Number of stimulation grants of $10,500 each awarded under sec. 1	13

Total amount of Public Law 85-926 funds spent or obligated (as of June 30 of each fiscal year):

Fiscal year 1960	$985,222
Fiscal year 1961	993,433
Fiscal year 1962	997,000
Fiscal year 1963	996,433
Total	3,972,088



Distribution of Colleges and Universities Awarded Grants Under Public Law 85-926, Fellowship Program in the Education of Mentally Retarded.

ATTACHMENT 2

Total student awards program for training teachers of the deaf, Public Law 87–276, academic years 1962–63, 1963–64

	Number of awards
Alabama: University of Alabama	12
Arizona: University of Arizona	24
Arkansas: University of Arkansas	30
California:	
University of Southern California	23
Los Angeles State College	22
San Francisco State College	22
Colorado: Colorado State College	20
District of Columbia: Gallaudet College	68
Georgia: Emory University	11
Illinois:	
University of Illinois	18
DePaul University	12
MacMurray College	6
Northwestern University	20
Indiana: Ball State College	35
Iowa: State University of Iowa [1]	10
Kansas: University of Kansas	22
Massachusetts:	
Boston University	27
University of Massachusetts	9
Smith College	27
Michigan: Wayne State University	24
Minnesota: University of Minnesota	21
Missouri:	
Fontbonne College	14
Washington University	45
Nebraska: Municipal University of Omaha	12
New Hampshire: University of New Hampshire	10
New Jersey: Trenton State College	12
New Mexico: Eastern New Mexico	16
New York:	
Teachers College	50
Syracuse University	14
Canisius College [1]	13
University of Buffalo [2]	15
New York University	20
North Carolina: Lenoir Rhyne College	8
North Dakota: Minot State Teachers College [2]	7
Ohio:	
University of Cincinnati	16
Kent State University	23
Ohio State University [1]	8
Oklahoma: University of Oklahoma	8
Oregon:	
Oregon College of Education	22
Lewis & Clark College	18
Pennsylvania:	
University of Pittsburgh	28
Pennsylvania State University [1]	8
South Dakota: Augustana College	16
Tennessee:	
University of Tennessee	26
George Peabody College [1]	10
Texas: University of Texas	24
Utah: University of Utah	14
Wisconsin: University of Wisconsin	22
Total awards	942

[1] No awards, 1962–63.
[2] No awards, 1963–64.

Summary Tabulations

Program for training teachers of the deaf under Public Law 87–276

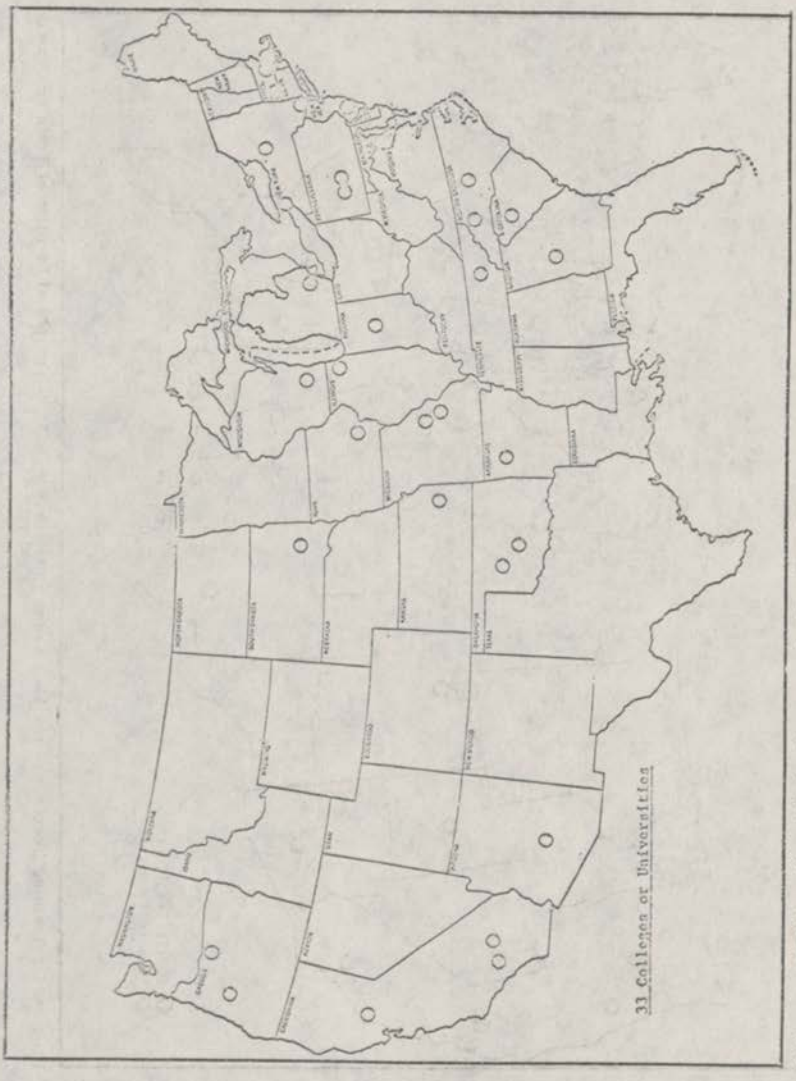
	1962	1963
Number of college or university applications for participation in the program	60	58
Number of approved programs	43	46
Number of awards to participating institutions	446	[1] 496
Number of awards utilized (this represents 85 percent utilization of grants available during 1st year of the program)	370	
Total amount awards to participating programs during each fiscal year	$1,495,238	$1,490,322

[1] Increase in the number of awards for 1963–64 was made possible by extension of funds not utilized during 1962–63.

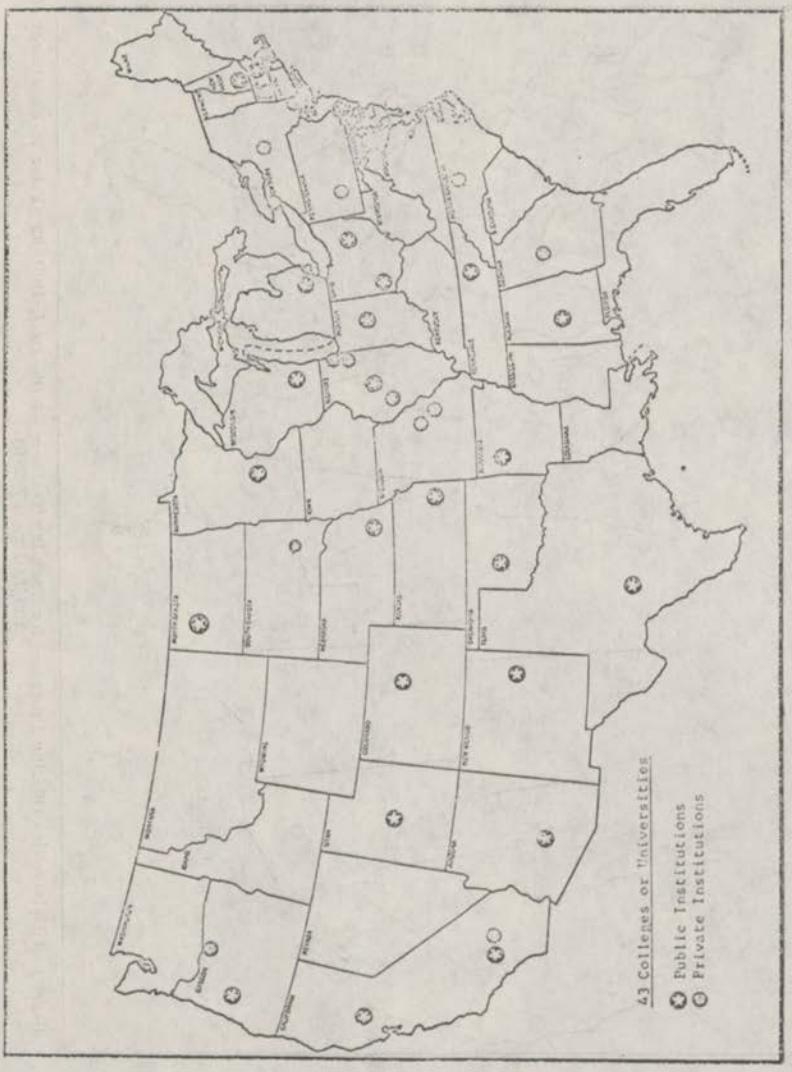
Additional information on training of teachers of the deaf (American Annuals of the Deaf, January 1963)

	Before Public Law 87–276, 1961–62 [1]	After Public Law 87–276, 1962–63
Total number of training centers	32	47
Number of training centers receiving support from Public Law 87–276		43
Total number of students in training	202	470
Number of students in training under Public Law 87–276		370
Number of students in training not supported by grants-in-aid program	202	100

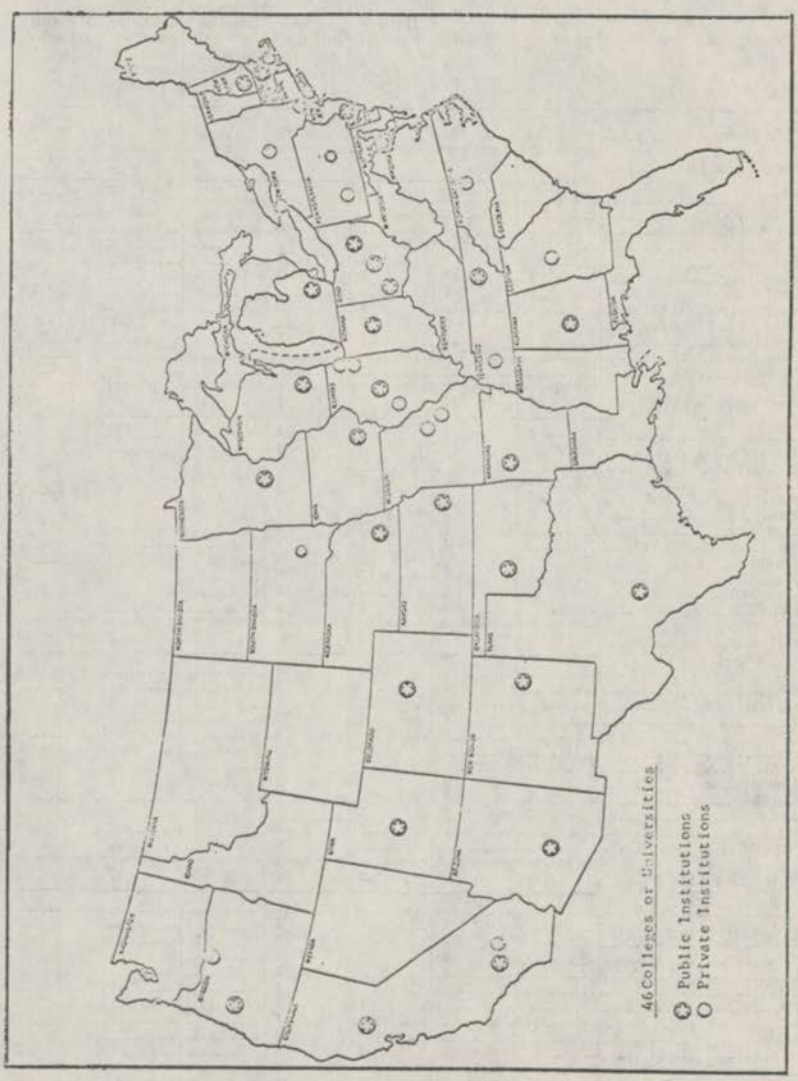
[1] Public Law 87–276 was enacted on Sept. 22, 1961. The 1st year of actual operation of grants-in-aid benefiting programs occurred during the 1962–63 school year.



Colleges and Universities Offering Programs for Training Teachers of the Deaf, 1961–62 (Prior to Enactment of Public Law 87-276).



Program for Training Teachers of the Deaf Under Public Law 87–276, Geographical Location of Training Centers, 1962–63.



Program for Training Teachers of the Deaf Under Public Law 87-276, Geographical Location of Training Centers, 1963-64.

ATTACHMENT 3

Number of colleges and universities reporting at least a minimum sequence of courses for the preparation of teachers of handicapped children during the regular academic year 1961–62, by region, tSate, and area of exceptionality

Region and State	Blind and/or partially seeing	Deaf	Hard of hearing	Speech impaired	Crippled and/or special health problems	Emotionally disturbed and/or socially maladjusted	Mentally retarded
United States	14	42	81	192	25	15	84
North Atlantic	2	8	18	34	8	2	22
Connecticut			2	2			2
Delaware							
District of Columbia		1		3			
Maine							1
Maryland			1	1			1
Massachusetts	1	2	3	3	1		3
New Hampshire		1					1
New Jersey			1	3			1
New York	1	4	6	14	6	2	9
Pennsylvania			5	8	1		4
Rhode Island							
Vermont							
Great Lakes and Plains	7	17	26	61	11	10	30
Illinois	1	5	5	14	1		5
Indiana			3	4	1		4
Iowa				2	1	1	2
Kansas		2	2	4	2	1	1
Michigan	4	4	3	8	5	6	5
Minnesota	1	1	2	4	1	1	4
Missouri		1	3	8			2
Nebraska		1	1	1			1
North Dakota			1	3			
Ohio		1	5	7		1	3
South Dakota	1	1		2			
Wisconsin		1	1	4			3
Southeast	1	7	15	33	3	2	10
Alabama			2	3			1
Arkansas		1		2			
Florida			2	4	1	1	2
Georgia		1	1	2			1
Kentucky				3			
Louisiana			4	5			1
Mississippi			1	3			1
North Carolina		2	1	2			1
South Carolina		1					
Tennessee	1	2	4	5	1	1	2
Virginia				3	1		1
West Virginia				1			
West and Southwest	4	10	22	64	3	1	22
Alaska							
Arizona		1		2			1
California	2	3	7	20	2		8
Colorado	1	1	2	4		1	2
Hawaii				1			
Idaho				1			
Montana			1	2			
Nevada				1			
New Mexico				2			1
Oklahoma		1	4	5			2
Oregon				5			1
Texas	1	3	5	14	1		5
Utah			2	3			2
Washington		1	1	4			
Wyoming							

Source: U.S. Office of Education, Branch on Exceptional Children and Youth. Preliminary data from 1961–62 survey of colleges and universities preparing teachers of exceptional children.

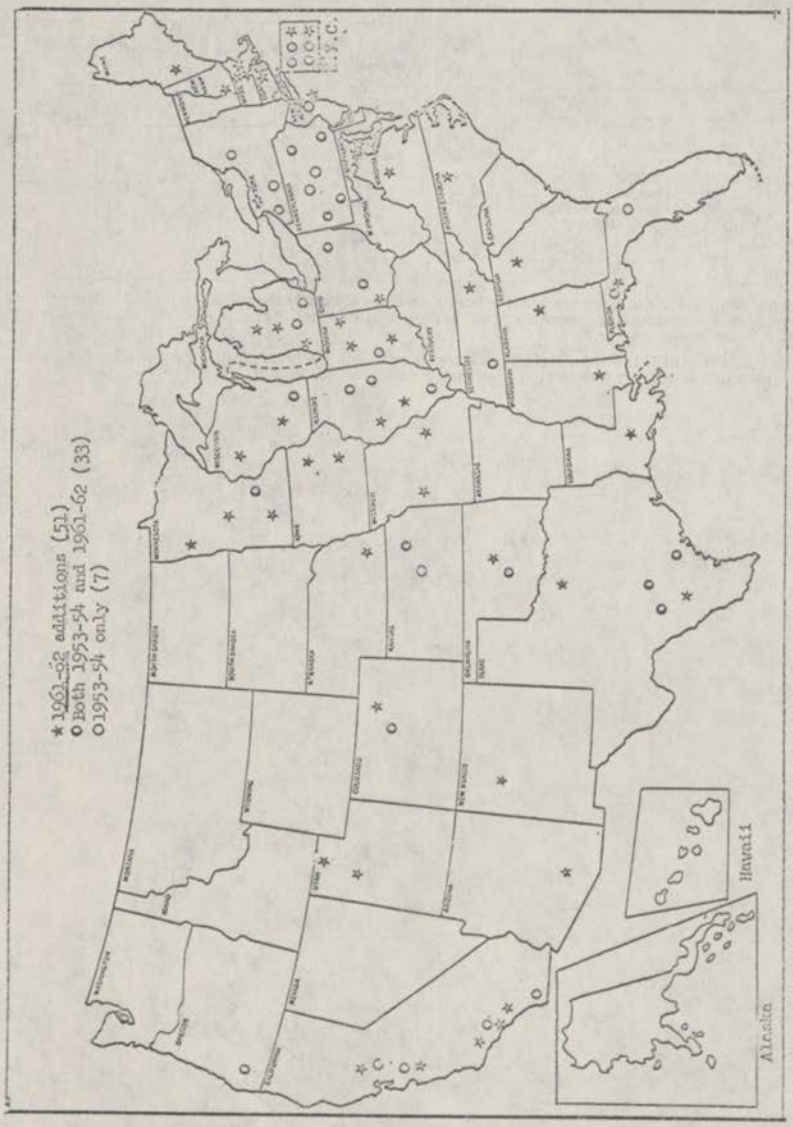
Number of students completing a program in special education during the calendar year 1961, by area of exceptionality [1]

Area of exceptionality	Total	Number of students completing program and receiving degree			Number of students completing program but not completing degree	
		Bachelor's	Master's	Doctor's	Undergraduate	Graduate
Total	4,950	2,175	1,193	71	309	1,202
Blind and/or partially seeing	101	16	36		6	43
Deaf and/or hard of hearing	343	109	128	5	29	72
Speech impaired (including combined speech and hearing program)	2,323	1,471	471	38	158	185
Crippled and/or special health problems	174	44	58	1	30	41
Emotionally disturbed and socially maladjusted	111	36	27	1	4	43
Mentally retarded	1,898	499	473	26	82	818

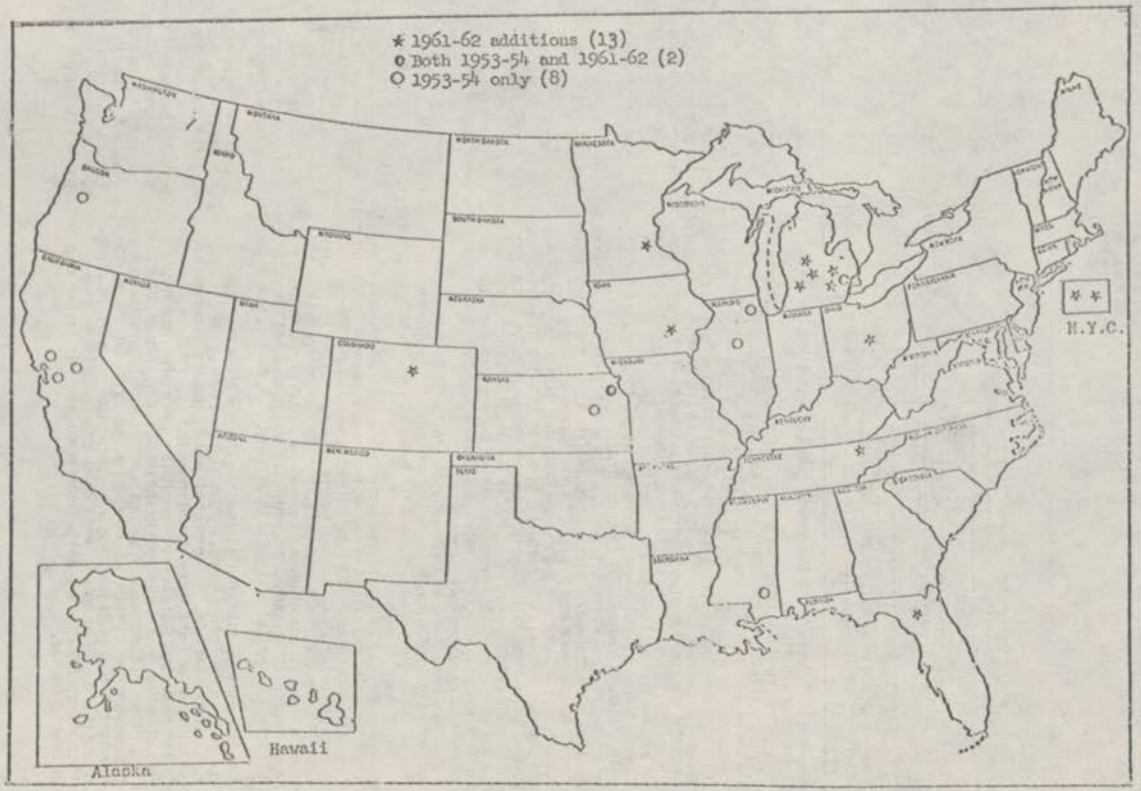
[1] Students completing degrees were included only for those areas of exceptionality in which the college or university gave a minimum sequence of courses in the specialized area during the 1961–62 regular academic year or the 1961 summer session.

Source: U.S. Office of Education, Branch on Exceptional Children and Youth. Preliminary data from 1961–62 survey of colleges and universities preparing teachers of exceptional children.

ATTACHMENT 4



MAP 1.—Location of colleges and universities which reported at least a minimum sequence of courses for the preparation of teachers of the mentally retarded during the regular academic year 1953–54 and 1961–62.
Source: U.S. Office of Education, Branch on Exceptional Children and Youth.



MAP 2.—Location of colleges and universities which reported at least a minimum sequence of courses for the preparation of teachers in the areas of the emotionally disturbed and/or socially maladjusted during the regular academic year 1953–54 and 1961–62.
Source: U.S. Office of Education, Branch on Exceptional Children and Youth.

ATTACHMENT 5

Table of preliminary estimates of the number of special education teachers needed in 1963 to instruct each type of handicapped child included in S. 1576

Area of exceptionality	Estimates of prevalence (percent)[1]	Estimated number of pupils (1963)[2]	Average teacher-pupil ratio [3]	Estimated total number of teachers required (1963)
Visual impairment:				
Blind	0.033	16,192	1–8	2,024
Partially seeing	.06	29,441	1–15	1,963
Deaf	.075	36,801	1–10	3,680
Speech and hearing impairment:				
Hard of hearing	.5	245,340	1–35	7,010
Speech impaired	3.5	1,717,380	1–100	17,174
Other physically handicapped:				
Crippled	1.0	490,680	1–15	32,712
Special health problems	1.0	490,680	1–20	24,534
Emotionally disturbed or socially maladjusted	2.0	981,360	1–20	49,068
Mentally retarded	2.3	1,128,564	1–15	75,238

[1] Estimates of prevalence of children needing special education, by area of exceptionality, are based on such sources as the following:

Blind.—Registration of the American Printing House for the Blind, January 1960, plus conservative estimates of numbers of legally blind children enrolled in private and parochial schools.

Partially seeing.—Estimates of the National Society for the Prevention of Blindness and Winifred Hathaway's, "Education and Health of the Partially Seeing Child," p. 16, 4th edition, 1959, published by the society, that 0.2 percent of the school and preschool population have serious visual losses but that according to interviews and replies to letters of inquiry about such children, about ⅓ of these are visually handicapped to the extent that they used frequent instruction (at least 1 hour per week) from a specially qualified teacher of partially seeing children. The estimated number of "legally blind" being educated as readers of print have been removed from this estimate.

Deaf.—Frampton and Gall, "Special Education for the Exceptional," vol. II, 1955, p. 149, and information supplied by Gallaudet College, Washington, D.C.

Hard of hearing and speech impaired.—"The Report of the Commissioner of Education in Response to the Request of the Committee on Appropriations of the House of Representatives for an Office of Education Plan in the Field of Speech and Hearing," Feb. 11, 1958, table 1, p. 8.

Crippled.—"Crippled Children's Program Statistical Highlights, 1958," Statistical Series No. 56, U.S. Children's Bureau, 1960, p. IV. Feristein, Mayer A., "What Teachers Should Know About the Child With Cerebral Palsy," "Special Education for the Exceptional," vol. III, 1956, p. 101. Martens, Elise N., "Needs of Exceptional Children," p. 4, leaflet No. 74, U.S. Office of Education, 1944.

Special health problems.—This category includes a variety of physical limitations, such as epilepsy, cardiac conditions, or chronic illnesses. The estimate of 1 percent is based on a compilation of estimates from such sources as the National Epilepsy League.

Seriously socially maladjusted or emotionally disturbed.—This estimate may be a very conservative one. The recent report of the California State Department of Education to the California State Legislature, "The Emotionally Handicapped Child and the School," Dec. 24, 1959, includes prevalance estimates ranging from 4 to 12 percent.

Mentally retarded.—The 2.3 prevalence figure for the mentally retarded includes children with an IQ of approximately 68 or below. (It is, of course, recognized that some other important factors besides the IQ are considered in defining mentally retarded children who need special education. The IQ, however, is the most generally used single measure.) Source: Edwards, Allen L., "Experimental Design in Psychological Research," 1950, p. 396. This figure of 2.3 percent needing special education is a very conservative one. A discussion of this estimate of prevalence may be found in the testimony of the U.S. Commissioner of Education on Senate bill 395 and S. 1092, published on pp. 47–49 of "Mentally Retarded Children—Hearing Before the Committee on Labor and Public Welfare, U.S. Senate, 85th Cong., 1st Sess., on S. 395 and S. 1092," Apr. 4, 1957.

[2] Based on an estimated 49,068,000 children 5 to 17 years of age in 1963. Source: "Illustrative Projections of the Population of the United States, by Age and Sex, 1960 to 1980." U.S. Bureau of the Census, Series P–35, No. 187, November 1958. (A number of special education programs enroll some types of exceptional children as young as age 3 and many extend to age 21.)

[3] Based on an analysis of State laws and regulations, as well as consultation with specialists in the various areas of exceptionality. As can be seen in the table, the teacher-pupil ratio varies from one area of exceptionality to another. In some cases itinerant teachers, such as speech correctionists, can work with a comparatively large number of pupils. In other cases such as the blind or the deaf the need for full-time individualized attention is so great that only a few pupils can be served by the special teacher. The teacher-pupil ratio for the hard-of-hearing is based on an average of both classroom and itinerant teaching since some children require full-time special classroom instruction while others require only a part-time itinerant speech and hearing teacher.

ATTACHMENT 6

SOME RESEARCH AND DEMONSTRATION NEEDS ON THE EDUCATION OF HANDICAPPED CHILDREN

The lack of systematic, comprehensive research programs and a continued increase in the number of children handicapped in school by one or more seriously disabling conditions have created an urgent need for new knowledge in this field of education.

Special educational programs for handicapped children in the United States date back well over 100 years but relatively little is known about the full educational implications of the varying degrees and types of disabling conditions found among these children. Many of the special instructional methods and procedures utilized in their education have not been subjected to research study and experimentation.

A Federal grant program such as that authorized under section 302 of title III of S. 1576 ($2 million annually for the next 3 years) would make possible the systematic identification and exploration of some of the most pressing problems and evaluation and testing of findings in the education of children handicapped in school by: Mental retardation, emotional disturbance or social maladjustment, impaired hearing, deafness, impaired speech, blindness or impaired vision, and crippling conditions or other health impairments. Demonstration projects also are authorized under this title. Such projects based on experimental research could be planned to meet the most immediate urgencies in various sections of the country. Field tests and demonstrations particularly those on effective methods of teaching and use of special aids and materials would hasten the application of new knowledge and bring about improvement of quality of school programs for handicapped children throughout the Nation.

SOME EXAMPLES OF RESEARCH AND DEMONSTRATIONS

Mentally retarded

The President's Panel on Mental Retardation, among its recommendations, pointed to the need for "projects to enrich the learning opportunities of preschool (nursery and kindergarten) mentally retarded children who live in homes where opportunities are inadequate." Under the proposed program research, evaluation, and demonstration of educational programs for young mentally retarded children could be conducted.

Emotionally disturbed and socially maladjusted

There is a very great need for research and practical testing of educational procedures for children with different types of emotional illness and social maladjustment. Much information is needed with respect to the place of education and interagency cooperation in the total program of readjustment of these children. This is one of the areas which has been most neglected of these mentioned in the proposed legislation.

Children with multiple handicaps

Unfortunately a given child may not only be blind or deaf but also emotionally disturbed or mentally retarded. A child with cerebral palsy may have defective speech and hearing as well as complex learning problems resulting from diffuse brain damage. Some children with multiple handicaps are so disabled that it is difficult to identify the exact nature of their handicaps and to provide suitable educational programs for them. Special educators are encountering increasing numbers of children with multiple handicaps whose special instructional needs cannot be met by existing facilities. New knowledge and demonstrations are urgently needed if adequate facilities are to be developed for these children.

ATTACHMENT 7

RESEARCH PROJECTS ON THE EDUCATION OF HANDICAPPED CHILDREN COMPLETED OR INITIATED UNDER EXISTING OFFICE OF EDUCATION RESEARCH PROGRAMS

COOPERATIVE RESEARCH PROJECTS IN SPECIAL EDUCATION

MENTAL RETARDATION

Initiated in fiscal year 1957

014 "Language Achievements of Mentally Retarded Children," Donald D. Darrell, Boston University, Boston, Mass.

015 "Refinement of a Nonverbal Group Measure of Delinquency Proneness That Can Be Used With Nonreaders, Slow Learners, and Mentally Retarded Children," W. C. Kvaracous, Boston University, Boston, Mass.

018 "A Study of the Structure of Attitudes of Parents of Mentally Retarded Children and a Study of Change in Attitude Structure," W. M. Cruickehank, Syracuse University, Syracuse, N.Y.

019 "Quantitative and Qualitative Analyses of Endogenous and Exogenous Children in Some Reading Processes," R. J. Capobianco, Syracuse University, Syracuse, N.Y.

026 "A Comparative Investigation of the Learning and Adjustment of Trainable Children in Public School Facilities, Local Segregated Facilities, and State Residential Centers," John R. Peck, University of Texas, Austin, Tex.

043 "An Investigation of Factors Involved in the Educational Placement of Mentally Retarded Children," Jeannette C. Stanton and Viola Cassidy, Ohio State University, Columbus, Ohio.

055 "The Education of Educable Mentally Retarded Children in Sparsely Populated Rural Areas," Marguerite Thorsell, Kansas State Department of Public Instruction, Topeka, Kans.

076 "An Investigation of Discrimination Learning Ability in Mongoloid and Normal Children of Comparable Mental Age," G. N. Cantor, George Peabody College for Teachers, Nashville, Tenn.

078 "Relationships Between Articulatory Development and Development of Phonetic Discrimination and Word Synthesis Abilities in Young Mentally Retarded and Normal Children," C. V. Mange, Syracuse University, Syracuse, N.Y.

081 "The Reasoning Methods and Reasoning Ability in Mentally Retarded Children," R. J. Capobianco, Syracuse University, Syracuse, N.Y.

082 "A Comparative Study of Some Characteristics in Better and Poorer Learners Among Children With Retarded Mental Development," L. M. DiCarlo, Syracuse University, Syracuse, N.Y.

090 "Specialized Educational Methodology With Hyperactive Mentally Retarded Children," W. M. Cruickshank, Syracuse University, Syracuse, N.Y.

091 "A Comparative Study on Some Learning Characteristics in Mentally Retarded and Normal Children of the Same Mental Age—I. Learning, Recognition, Recall, and Savings; IX. Proactive and Retroactive Inhibition; XXI. Generalization; IV Reasoning." G. O. Johnson, Syracuse University, Syracuse, N.Y.

092 "Social Behavior of Mentally Retarded Children in Public School and Institution Environments," R. J. Capobianco, Syracuse University, Syracuse, N.Y.

103 "The Effectiveness of Special Day-Class Training Programs for Severely (Trainable) Mentally Retarded Children," L. M. Dunn, George Peabody College for Teachers, Nashville, Tenn.

109 "Study of the Effect of Special Day Training Classes for the Severely Retarded," L. F. Cain, San Francisco State College (California State Department of Education), Sacramento, Calif.

127 "A Comparative Study of the Performance of Intellectually Retarded and Normal Boys on Selected Tasks Involving Learning and Transfer of Learning," W. M. Cruickshank, Syracuse University, Syracuse, N.Y.

129 "Study of Screening Procedures for Special Education Services to Mentally Retarded Children," W. R. Burria, Mississippi State Department of Education, Jackson, Miss.

144 "A Comparison of the Educational Outcomes Under Single and Two-Track Plans for Educable Mentally Retarded Children," J. W. Wrightstone, New York State Department and Board of Education of the City of New York.

145 "Effects of a Comprehensive Opportunity Program on the Development of Educable Mentally Retarded Children," J. B. Stroud, L. L. Smith, and Drexel Lange, Iowa State Department of Public Instruction, Des Moines, Iowa.

146 "A Comparison of Post-School Adjustment of Regular and Special Class Retarded Individuals Served in Lincoln and Omaha, Nebr., Public Schools," William R. Carriker, Nebraska State Department of Education, Lincoln, Nebr.

149 "Critique of Research on Psychological and Educational Factors in Mental Retardation," J. C. Stanley, University of Wisconsin, Madison, Wis.

150 "Conditions Influencing Insight and Problem Solving Behavior in the Mentally Retarded," Kai Jensen, University of Wisconsin, Madison, Wis.

151 "Perception of Symbols in Skill Learning by Mentally Retarded Children," V. E. Herrick, University of Wisconsin, Madison, Wis.

152 "Motor Characteristics of the Mentally Retarded," R. J. Francis and G. L. Rarick, University of Wisconsin, Madison, Wis.

153 "An Analysis of Learning Efficiency in Arithmetic of Mentally Retarded Children in Comparison With Children of Average and High Intelligence," H. J. Klausmaier, University of Wisconsin, Madison, Wis.

154 "A Study of Emotional Reactions to Learning Situation as Related to the Learning Efficiency of Mentally Retarded Children," T. A. Ringness, University of Wisconsin, Madison, Wis.

157 "How Mentally Handicapped Children Learn Under Classroom Conditions," Frances A. Mullen, Illinois State Department of Public Instruction, Springfield, Ill.

159 "Application of Mowrer's Autistic Theory to the Speech Habilitation of Mentally Retarded Pupils," M. D. Steer, Purdue University, Lafayette, Ind.

162 "How Can Reading Be Taught to Educable Adolescents Who Have Not Learned To Read?" Ruth Boyle, New Jersey State Department of Education, Newark (Teachers College at Newark).

165 "A Study of the Relative Effectiveness of Different Approaches of Speech Training for Mentally Retarded Children," Leon Lassers and Gordon Low, San Francisco State College (California State Department of Education), Sacramento, Calif.

167 "The Effect of Group Training of Four- and Five-Year-Old Children Who Are Mentally Retarded," M. H. Feuraeyo, Columbia University, Teachers College, New York, N.Y.

168 "An Evaluation of Education Mentally Handicapped Children in Special Classes and in Regular Classes," Thelma C. Thurstone, University of North Carolina, Chapel Hill, N.C.

170 "Terminology and Concepts in Appraising the Mentally Retarded," Irving Lorge, Columbia University, Teachers College, New York, N.Y.

172 "A Comparative Investigation of Methods of Testing Auditory and Visual Acuity of Trainable Mentally Retarded Children," W. G. Wolfe, University of Texas, Austin, Tex.

176 "Perceptual and Response Abilities of Mentally Retarded Children," J. O. Anderson, Southern Illinois University, Carbondale, Ill.

178 "A Study of Social Adequacy and of Social Failure of Mentally Retarded Youth in Wayne County, Mich.," J. J. Lee, T. G. Hegge, and P. H. Voelker, Wayne State University, Detroit, Mich.

184 "A Study of the Communication Problems and Their Effect on the Learning Potential of the Mentally Retarded Child," Nancy E. Wood, Western Reserve University, Cleveland, Ohio.

185 "Investigation of Mental Retardation and 'Pseudo-Mental Retardation' in Relation to Bilingual and Subcultural Factors," W. Abraham, Arizona State University, Tempe, Ariz.

192 "A Comparative Study of 'Day Class' versus Institutionalized Educable Retardates," M. C. Reynolds, University of Minnesota, Minneapolis, Minn.

Initiated in fiscal year 1958

171 "An Exploratory Study of Educational, Social, and Emotional Factors in the Education of Retarded Children in Georgia Public Schools," Stanley Ainsworth, University of Georgia, Athens, Ga.

175 "A Study of the Concerns and Rewards of Rearing Mentally Retarded Children," E. P. Willenberg, California State Department of Education, Sacramento, Calif.

263 "Perception of Symbols in Skill Learning by Mentally Retarded, Gifted, and Normal Children," V. E. Herrick and T. L. Harris, University of Wisconsin, Madison, Wis.

266 "Psychological Characteristics Underlying the Educability of the Mentally Retarded Child. I. Concepts Formation and Transposition in Young Mentally Retarded and Normal Children," W. E. Martin and A. H. Blum, Purdue University, Lafayette, Ind.

358 "Identification of Mentally Retarded Children in Wyoming Through Objective Statewide Screening," Velma Linford, Wyoming State Board of Education, Cheyenne, Wyo.

332 "Measurement of Educability of Severely Mentally Retarded Children," H. Newburger and H. Schueman, New York University, New York, N.Y.

365 "A Study of the Modification of Parental Attitudes Toward and Understanding of Mentally Retarded Children," D. B. Harris, University of Minnesota, Minneapolis, Minn.

382 "Development of a Program for Educable Mentally Retarded Children in Rural Schools," P. A. Annas, Maine State Department of Education, Augusta, Maine.

390 "Achievement Motivation in Normal and Mentally Retarded High School Children," R. deCharms and T. E. Jordan, Washington University, St. Louis, Mo.

408 "A Preliminary Exploration of Factors Association With School Holding Power for Educable Mentally Retarded Adolescents," C. J. Baer, Division of Public Schools of the State of Missouri, Kansas City, Kans.

418 "The Measurement of Sensory Thresholds in Exceptional Children," Lee Meyerson and J. L. Michael, University of Houston, Houston, Tex.

470 "Studies of the Effects of Systematic Variations of Certain Conditions Related to Learning. I. Conditions of Reinforcement," K. A. Blake, Syracuse University, Syracuse, N.Y.

Initiated in fiscal year 1959

416 "Study of the Effect of Special Day Training Classes for the Severely Mentally Retarded," L. F. Cain, San Francisco State College (California State Department of Education), Sacramento, Calif.

513 "A Comparative Study of the Speech Responses and Social Ages of Two Selected Groups of Educable Mental Retardates," M. L. T. Wilson, Grambling College, Grambling, La.

578 "Responses of Bright, Normal, and Retarded Children to Learning Tasks," L. F. Malpass and Neil A. Carrier, Southern Illinois University, Carbondale, Ill.

Initiated in fiscal year 1960

186 "The Adaptation for Group Classroom Use of Clinical Techniques for Teaching Brain-Injured Children," E. Gil Boyer, Rhode Island State Department of Education, Providence, R.I.

589 "Study of the Effect of Special Day Training Classes for the Severely Mentally Retarded," L. F. Cain, San Francisco State College (California State Department of Education), Sacramento, Calif.

619 "The Efficacy of Special Class Training on the Development of Mentally Retarded Children," H. Goldstein, University of Illinois, Urbana, Ill.

661 "Principles for Programing Learning Materials in Self-Instructional Devices for Mentally Retarded Children," L. M. Stolurow, University of Illinois, Urbana, Ill.

695 "Studies of the Effects of Systematic Variations of Certain Conditions Related to Learning. II. Conditions of Practice," K. A. Blake, University of Georgia, Athens, Ga.

833 "Inductive Concept Formation in Normal and Retarded Subjects," C. B. Elam, Texas Christian University, Fort Worth, Tex.

862 "Systematic Variation of Certain Conditions Related to Learning in the Mentally Retarded: Reinforcement," L. A. Fliegler, Syracuse University, Syracuse, N.Y.

922 "A Comparison of Especially Designed Art Activities with Traditional Art Activities as Used with Mentally Retarded Children and Youth," J. Hebeler, University of Maryland, College Park, Md.

973 "The Effects of Listening Training on the Auditory Thresholds of Mentally Retarded Children," B. B. Schlanger, West Virginia University, Morgantown, W. Va.

Initiated in fiscal year 1961

859 "Relationship Between Perception and Learning in the Mentally Retarded," G. O. Johnson, Syracuse University, Syracuse, N.Y.

1182 "The Social Relations of Mentally Handicapped Children in Regular and Special Public School Classes," John deJung, N. G. Haring, University of Kansas, Lawrence, Kans.

Initiated in fiscal year 1962

1267 "Comparison of Two Automated Teaching Procedures for Retarded Children," L. F. Malpass, A. S. Gilmore, M. W. Hardy, and C. F. Williams, University of South Florida, Tampa, Fla.

1356 "Studies of the Effects of Systematic Variations of Certain Conditions to Learning. III. Task Conditions," K. A. Blake, University of Georgia, Athens, Ga.

1394 "The Validation of Selected Measures of Hyperactivity in Children with School Problems," Matthew J. Trippe, Syracuse University, Syracuse, N.Y.

1440 "Factors Influencing Learning and Problem Solving Behavior in the Mentally Retarded," Kai Jensen, University of Wisconsin, Madison, Wis.

1533 "Success of Young Adult Male Retardates," John R. Peck, University of Texas, Austin, Tex.

1575 "Stimulus Synthesis in Normal and Retarded Subjects," C. B. Elam, Texas Christian University, Fort Worth, Tex.

1607[1] "Efficacy of Speech Therapy with Educable Mentally Retarded Children," M. A. Wirtz and F. B. Wilson, Missouri State Department of Education, Jefferson City, Mo.

d–014 "A Field Demonstration of the Effects of Automated and Nonautomated Responsive Environments on the Intellectual and Social Competence of Educable Mentally Retarded Children," Burton Blatt, University of Boston, Boston, Mass.

d–041[1] "Demonstration: An Educational Program for Slow Learners in grades 7 through 12. Part I," C. V. Matthews, P. H. Bowman, and G. T. Wilkins, Illinois State Department of Public Instruction, Springfield, Ill.

[1] Pending negotiation of contract.

SPEECH AND HEARING HANDICAPPED

Initiated in fiscal year 1958

289 "Verbal Learning Among Children with Reduced Auditory Acuity," John H. Gaeth, Wayne State University, Detroit, Mich.

387 "A Study of Cognitive Development and Performance in Children with Normal and Defective Hearing," Mildred C. Templin, University of Minnesota, Minneapolis, Minn.

Initiated in fiscal year 1959

492 "An Assessment of Behavioral and Academic Implications of Hearing Loss Among School Children," M. D. Staer, Theodore D. Hanley, George Shaffer, and Frances Patton, Purdue University, Lafayette, Ind.

495 "Motivation of Speech and Hearing Handicapped Children," Bruce M. Siegenthaler, Pennsylvania State University, University Park, Pa.

499 "Effects and Interactions of Auditory and Visual Cues Utilized in Oral Communication," John W. Keys, University of Oklahoma, Norman, Okla.

502 "Education of the Aurally Handicapped: A Psycholinguistic Analysis of Visual Communication," Edgar L. Lowell, University of Southern California, Los Angeles, Calif.

649 "Speech Pathology and Audiology Programs in Elementary and Secondary Schools: A National Survey of Current Status and Problems," M. D. Steer, Purdue University, Lafayette, Ind.

Initiated in fiscal year 1960

620 "Development and Evaluation of a Speech Improvement Program for Kindergarten and First Grade Children," Margaret C. Byrne, University of Kansas, Lawrence, Kans.

685 "An Experimental Investigation of the Effects of Institutionalization on the Psycho-Educational Development of Children with Impaired Hearing," Stephen P. Quigley, Gallaudet College, Washington, D.C.

818 "The Identification of Kindergarten Children Least Likely to Show Spontaneous Improvement in Speech Sound Articulation," University of Minnesota, Minneapolis, Minn.

Initiated in fiscal year 1961

907 "A Linguistic Approach to the Education of Aurally Handicapped Children," Edgar L. Lowell and Mary F. Woodward, University of Southern California, Los Angeles, Calif.

969 "Effectiveness of Educational Audiology on the Language Development of Hearing Handicapped Children," Joseph D. Stewart, University of Denver, Denver, Colo.

1001 "Verbal and Nonverbal Learning in Children, Including Those with Hearing Losses," John H. Gaeth, Wayne State University, Detroit, Mich.

Initiated in fiscal year 1962

1198 "Speech Inaccuracy in Children as Related to Etiology," Joseph M. Wepman, University of Chicago, Chicago, Ill.

1538 "A Predictive Screening Test for Children with Articulatory Speech Defects," Charles Van Ripar, Western Michigan University, Kalamazoo, Mich.

DEAF

Initiated in fiscal year 1960

690 "The Role of Non-Verbal Symbols in the Education of the Deaf," Maria Meier, Queens College, Flushing, N.Y.

Initiated in fiscal year 1962

1383 "New Methods of Language Development in Deaf Children," Howard L. Roy and Jerome D. Scheing, Gallaudet College, Washington, D.C.

1633 "Evaluation of High School Mathematics Programmed Texts When Used with Deaf Students," Harry Bernstein, Gallaudet College, Washington, D.C.

VISUALLY HANDICAPPED

Initiated in fiscal year 1958

424 "An Experiment in Teaching Topographical Orientation and Spatial Organization to Congenitally Blind Children," Ralph Garry, Boston University, Boston, Mass.

Initated in fiscal year 1960

916 "The Nature and Formation of Spatial Concepts in Congenitally Blind Children Between the Ages of 2 and 5," Ralph J. Garry, Boston University, Boston, Mass.

Initiated in fiscal year 1961

1005 "Comparative Comprehension by Blind Children of Braille and Recordings at Different Compressions," Ray H. Bixler and Carson Y. Nolan, the University of Louisville, Louisville, Ky.

Initiated in fiscal year 1962

1370 "Comprehension of Rapid Speech by the Blind: Part II," Ray H. Bixler and Emerson Foulke, University of Louisville, Louisville, Ky.

SOCIALLY MALADJUSTED AND EMOTIONALLY DISTURBED (INCLUDING DELINQUENTS)

Initiated in fiscal year 1957

012 "A Sociopsychological Study of Conformity and Deviation Among Adolescents," Dr. A. J. Reiss, Jr., Vanderbilt University.

120 "A Study of Social Climates in High Schools," Dr. James S. Coleman, Johns Hopkins University. (Study was done while Dr. Coleman was at the University of Chicago.)

179 "Sociological and Educational Factors in the Etiology of Juvenile Delinquency," Dr. George G. Stern, Syracuse University.

181 "A Sociopsychological Study of Acts of Vandalism in Schools," Dr. Nathan Goldman, Syracuse University.

Initiated in fiscal year 1958

201 "Relationship of School Experiences to Delinquency," Dr. William W. Wattenberg, Wayne State University.

Initiated in fiscal year 1959

526 "The Status of Schoolboys and School Leavers as Factors in their Friendship Changes," Dr. Jackson Toby, Rutgers University.

566 "The Identification, Development, and Utilization of Human Talents," Dr. John C. Flanagan, University of Pittsburgh. (A Special Study of 15 Year Olds in and Out of School.)

Initiated in fiscal year 1961

1124 "Evaluation of the Higher Horizons Program for Underprivileged Children," Dr. J. Wayne Wrightstone, Board of Education of New York City, State Department of Education, New York.

Initiated in fiscal year 1962

1527 "An Assessment of the All-Day Neighborhood School Program for Culturally Deprived Children," Dr. Adele Franklin, New York State Department of Education.

INTELLECTUALLY GIFTED

Initiated in fiscal year 1957

052 "The Effectiveness of a Modified Counseling Procedure in Promoting Learning Among Bright, Underachieving Adolescents," Sister M. Vitarbo McCarthy, Regis College, Weston, Mass.

098 "The Gifted Adolescent in the Classroom," J. W. Gatzels and P. W. Jackson, University of Chicago, Chicago, Ill.

099 "Social Adaptation of the Highly Intelligent Pupil," Alvin Zander, University of Michigan, Ann Arbor, Mich.

Initiated in fiscal year 1958

208 "Educational Motivation Patterns of Superior Students Who Do and Who Do Not Achieve in High School," Paul H. Bowman, University of Chicago, Chicago, Ill.

297 "The Identification and Classroom Behavior of Elementary-School Children Each of Whom is Gifted in at Least One of Five Different Characteristics," Frederick B. Davis, Hunter College, New York, N.Y.

320 "Identification and Development of Talent in Heterogenously Grouped Students in a General Education Program at the Secondary-School Level," Paul R. Klohr, Ohio State University, Columbus, Ohio.

423 "Effects of Special Training on the Achievement and Adjustment of Gifted Children," Tom A. Lamke and Nellie D. Hempton, Iowa State Department of Public Instruction, Des Moines, Iowa.

Initiated in fiscal year 1959

392 "The Identification of Gifted Elementary School Children with Exceptional Scientific Talent," Frederick B. Davis and Gerald S. Lasser, Hunter College, New York, N.Y.

458 "A Study of Factors Involved in the Identification and Encouragement of Unusual Academic Talent Among Underprivileged Population," Horace Mann Bond, Atlanta University, Atlanta, Ga.

577 "An Evaluation of Ability Grouping," Walter R. Borg, Utah State University, Logan, Utah.

608 "The Effectiveness of Homogeneous and Heterogeneous Ability Grouping in Ninth Grade English Classes with Slow, Average, and Superior Students," Elizabeth M. Drews, Michigan State University, East Lansing, Mich.

614 "Effects of Special Training on the Achievement and Adjustment of Gifted Children," Nellie D. Hampton, Iowa State Teachers College, Cedar Falls, Iowa.

623 "The Extent to Which Group Counseling Improves the Academic and Personal Adjustment of Underachieving Gifted Adolescents," Merle M. Ohlsen and Fred C. Proff, University of Illinois, Urbana, Ill.

Initiated in fiscal year 1960

657A "Factors Influencing the Recruitment and Training of Intellectually Talented Students in Higher Education Programs," Donald L. Thistlethwaite, Vanderbilt University, Nashville, Tenn.

790 "Effects of Motivational Factors on Perceptual-Cognitive Proficiency of Children Who Vary in Intellectual Level," Charles D. Smock, Purdue University, Lafayette, Ind.

923 "Effects of Special Training on the Achievement and Adjustment of the Gifted Children," Nellie D. Hampton, Iowa State Teachers College, Cedar Falls, Iowa.

Initiated in fiscal year 1961

932 "The Discovery and Guidance of Superior Students," John W. M. Rothney, University of Wisconsin, Madison, Wis.

933 "Improved School Adjustment of Underachieving Gifted Fifth Graders," Merle M. Ohlsen, University of Illonis, Urbana, Ill.

965 "Productive Thinking of Gifted Children," James J. Gallagher, University of Illinois, Urbana, Ill.

1097 "Sex Differences in Achievement Motivation of Able High School Students," Paul H. Bowman and James V. Pierce, University of Chicago, Chicago, Ill.

1203 "Factors of Specific Set (Attensity) in Learning of Gifted Secondary Students," Doris R. Entwisle, Johns Hopkins University, Baltimore, Md.

Initiated in fiscal year 1962

1283 "Achievement-Related Motivation and Ability Grouping," John W. Atkinson, University of Michigan, Ann Arbor, Mich.

1636 "Talent Development Through Students' Self-Concept Enhancement," Wilbur Brookover, Michigan State University, East Lansing, Mich.

D–009 "Accelerated and Enriched Curriculum Programs for Academically Talented Students (Mathematics)," A. H. Passow and Miriam L. Goldberg, Teachers College, Columbia University, New York, N.Y.

D–010 "A Field Demonstration of the Effectiveness and Feasibility of Early Admission to School for Mentally Advanced Children," Jack W. Birch, University of Pittsburgh, Pittsburgh, Pa.

MENTAL RETARDATION

Initiated in fiscal year 1962

1607 Efficacy of Speech Therapy With Educable Mentally Retarded Children

G–001 Research Seminar in Mental Retardation

Initiated in fiscal year 1963

1731 Procedures for Evaluating the Hearing of the Mentally Retarded

SPEECH AND HEARING

Initiated in fiscal year 1963

1983 Audiovisual Test for Evaluating the Ability To Recognize Phonetic Errors

F–010 Research Planning Conference in Speech/Hearing for Mentally Retarded Children

DEAF

Initiated in fiscal year 1963

1769 Relationship Between Early Manual Communication and Later Achievement of the Deaf

2207 Verbal and Nonverbal Learning in Children Including Those With Hearing Losses

VISUALLY HANDICAPPED

Initiated in fiscal year 1963

1650 Construction and Standardization of a Battery of Braille Skill Tests

SOCIALLY MALADJUSTED AND EMOTIONALLY DISTURBED, INCLUDING DELINQUENTS

Initiated in fiscal year 1962

1635 Mental Abilities of Children in Different Social and Cultural Groups

Initiated in fiscal year 1963

1621 Interpersonal Attitudes of Adolescents

1980 Prediction of School Adjustment

INTELLECTUALLY GIFTED

Initiated in fiscal year 1962

E–006 Construction of a Theory of Self-Actualization: Development and Utilization of Talent

F–006 A Conference on Research in the Education of Gifted Children

Initiated in fiscal year 1963

1967 Conformity and Nonconformity as Indicative of Creativity in Preschool Children

1976 Measurement of Social Intelligence

HS–041 A High School Social Studies Curriculum for Able Students

Cooperative research projects in special education—Federal funds by fiscal year

MENTAL RETARDATION

Project No.	Fiscal year 1957	Fiscal year 1958	Fiscal year 1959	Fiscal year 1960	Fiscal year 1961	Fiscal year 1962	Fiscal year 1963	Fiscal year 1964	Total
014	$6,340								$6,340
015	7,000	$6,000	$6,000	$1,500					20,500
018	21,750	23,750	11,500	5,555					62,555
019	13,242								13,242
026	5,175	16,680	16,680	4,176					42,711
043	8,797	18,802	4,830						32,429
055	4,611	6,867	6,867	3,105					21,450
076	8,625								8,625
078	8,800	14,159	5,754						28,713
081	9,821								9,821
082	16,618	15,545							32,163
090	39,537	46,874	28,976						115,387
091	15,865	21,903							37,768
092	18,458								18,458
103	40,906								40,906
109	49,414								49,414
127	8,407								8,407
139	1,837	28,300	14,992						45,129
144	22,645	63,260	67,523	11,572					165,000
145	11,730	60,605	60,605						132,940
146	4,650								4,650
149	6,765								6,765
150	5,606	8,508	8,508						22,626
151	6,555								6,555
152	7,877								7,877
153	13,685	18,308	18,313						50,306
154	2,702	7,848	7,850						18,400
157	53,084	183,494	183,494	171,114					591,186
159	11,975								11,975
162	6,011	32,251	18,876						57,138
165	3,288	24,126	40,195	8,494					76,103
167	58,182	109,863	119,043	64,846	$102,531	$30,348			482,811
168	34,096	52,624	52,624						129,344
170	40,000								20,000
172	5,000	14,000	14,000	4,565					37,565
176	10,484	41,938	31,454						83,876
178	15,239	52,943	18,736						86,918
184	4,270	37,996	30,860	19,561					92,637
185	2,685	21,338	31,338	31,338					96,635
192	2,185	20,585	19,607	12,995					55,372
171		16,646	16,316						33,068
175		33,696	23,780	24,241					81,747
253		17,146	17,376	17,606	19,561				71,680

266		11,569							11,560
313		23,400							23,408
332		29,843							29,843
365		21,735							21,735
382		29,659							291658
390[2]		3,394							3,386
408		5,722	15,361	10,605	5,786				22,654
418		27,370							27,378
470		31,508							31,588
416			69,903						69,968
513			3,245						3,245
578			2,807	17,651	12,790				33,243
186				33,166					33,166
589				72,474	66,651				139,125
619				50,196	48,471	40,812	$40,812	$40,812	[1] 255,521
661				16,715	16,215	8,860			41,796
695				11,194	12,823				24,097
833				12,351	22,954	9,775			45,080
862				19,895					19,895
922				22,400					22,400
973				15,495					15,495
859					26,549	25,413	12,956		64,918
1182					3,267	24,243	10,026		31,536
1267						24,526	22,548		47,074
1356						13,260	15,525	10,070	38,855
1394						19,438	23,326	3,887	46,651
1440						15,380	18,084	18,429	[1] 92,748
1533						11,827	32,971	15,738	60,536
1575						8,046	30,285	19,410	57,741
1607 [3]						6,000	17,000	12,000	41,000
D-014						58,930	58,680	41,700	163,105
D-041 [3]							20,000	40,000	60,000
Subtotal	664,008	1,210,255	967,522	654,230	337,598	266,510	302,213	202,046	4,606,719

Footnotes appear at end of table, p. 165

Cooperative research projects in special education—Federal funds by fiscal year—Continued

SPEECH AND HEARING HANDICAPPED

Project No.	Fiscal year 1957	Fiscal year 1958	Fiscal year 1959	Fiscal year 1960	Fiscal year 1961	Fiscal year 1962	Fiscal year 1963	Fiscal year 1964	Total
289		$15,104	$19,376	$20,251	$3,347				$58,078
387		2,754	14,553	13,230	12,460	$12,460	$9,345		64,792
492			18,708						18,708
495			4,185						4,185
499			5,833						5,833
502			29,700						29,700
649			6,670	25,376	17,332				49,378
620				14,778	12,194	11,964	2,530		41,466
685				8,407	2,702				11,109
818				8,139	16,652	11,774	12,100		48,665
907					22,978	24,782	24,617		72,327
969					6,189	12,379	12,379	$12,379	[1] 62,441
1001					22,233	26,447	27,124	4,341	80,145
1198						16,239	16,145		32,384
1538						3,398	6,871	6,871	[1] 29,360
Subtotal		17,858	99,015	110,207	116,087	119,393	111,111	23,591	608,560

DEAF

690				$20,026	$26,316	$1,512			$47,854
1383						11,976	$10,235	$2,065	24,276
1633						2,975	12,793	8,351	24,119
Subtotal				20,026	26,316	16,463	23,028	10,416	96,249

VISUALLY HANDICAPPED

424	$7,130								$7,130
916				$4,000	$16,000	$16,000	$2,658		38,658
1006					14,815				14,815
1370						5,349	10,577	$5,228	21,154
Subtotal	7,130			4,000	30,815	21,349	13,235	5,228	81,757

SOCIALLY MALADJUSTED AND EMOTIONALLY DISTURBED, INCLUDING DELINQUENTS

012	$15,100	$14,600	$2,229						$31,929
120	7,500	15,812	25,449						48,561
179	8,060	19,025	10,968						38,053
181	8,917	21,402	8,155						38,474
201		5,840	4,683						10,523
526			6,000	$6,071	$6,071	$4,000			22,142
566			49,105	73,645	27,555				150,305
1124					2,280	27,193	$27,005	$24,902	81,380
1527						5,529	31,068	31,973	[1] 81,162
Subtotal	39,577	76,679	106,589	79,716	35,906	36,722	58,075	56,875	502,529

INTELLECTUALLY GIFTED

052	$5,000								$5,000
098	7,763	$20,930	$21,965						50,658
099	10,350								10,350
208		13,771	13,771						27,542
297		11,110	11,072	$1,769					23,951
320		22,500							22,500
423		44,150							44,150
392			19,521	3,910					23,431
458	0		13,074	15,692	$2,868				31,634
577			3,737	17,589	14,375	$14,375	$5,894		55,790
608			3,056	17,404	5,706				26,166
614			46,754						46,754
623			24,593						24,593
657				40,161	27,796	23,000			90,957
790				5,020	18,628	19,598	3,227		46,473
923				8,646	35,216	18,359			62,221
932					29,319	23,793	9,598		62,710
933					40,000	20,000	3,364		63,364
965					21,000	28,000	5,368		82,368
1107					4,899	9,258	532		14,689
1097					14,680				14,680
1203					870				870
1283					17,710				17,710
1636						5,000	27,000	$28,000	68,000
D–009						9,722	15,102	12,895	64,037
D–010						12,000	19,515	18,200	49,715
Subtotal	23,113	112,461	157,561	110,191	215,357	200,015	110,917	59,095	1,030,313
Subtotals:									
Mentally retarded	664,008	1,910,255	967,522	654,230	337,598	266,510	302,213	202,046	[1] 4,606,713
Speech and hearing handicapped		17,858	99,015	110,207	116,087	119,393	111,111	23,951	608,571
Deaf				20,026	26,316	16,463	23,028	10,416	96,249
Visually handicapped	7,130			4,000	30,815	21,349	13,235	5,228	81,757
Socially maladjusted and emotionally, etc	39,577	76,679	106,589	79,716	35,906	36,722	58,075	56,875	[1] 502,529
Intellectually gifted	23,113	112,461	157,561	110,191	215,357	200,815	110,917	59,095	1,030,313
Total	733,825	1,417,253	1,330,777	978,370	762,079	662,252	618,579	357,611	6,926,138

[1] Includes funds for fiscal years beyond 1964.

[2] Contracts to be negotiated; also funds are estimated.

Additional cooperative research projects in special education—Federal funds by fiscal year

No.	Fiscal year 1962	Fiscal year 1963	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966	Total
MENTAL RETARDATION						
1607	$5,255	$16,365	$16,649	$1,647		$39,916
G-001	19,510					19,510
1731		65,830				65,830
SPEECH AND HEARING						
1983		$10,330				$10,330
F-010		9,798				9,798
DEAF						
1769	$11,103					$11,103
2207			$26,975	$30,655	[1] $34,297	91,927
VISUALLY HANDICAPPED						
1650	$31,728					$31,728
SOCIALLY MALADJUSTED AND EMOTIONALLY DISTURBED, INCLUDING DELINQUENTS						
1621		$13,305				$13,305
1635		55,163				55,163
1980			$19,528			19,528
INTELLECTUALLY GIFTED						
E-006	$12,300					$12,300
F-006	9,942					9,942
1967		$14,090				14,090
1976		22,987	$30,025	$32,281	$14,296	99,589
HS-041		23,790	49,120	51,110	[1] 125,980	250,000

[1] Includes fiscal year 1966, 1967, and 1968.

Projects initiated under title VII, parts A and B, National Defense Education Act, July 1, 1958–June 30, 1961

Area	Title, duration, and funds	Grantee and investigator
Deaf	The Development and Evaluation of Programed Instruction in Language for Children With Auditory Impairments. June 1961–May 1962. $11,845.	University of Pittsburgh. E. Ross Stuckless. Jack W. Birch.
	A Survey of Visual Aid Programs in Residential and Day Schools and Classes for the Deaf in the United States. June 12, 1961, to Sept. 30, 1962. $7,590.	Gallaudet College, Washington, D.C. Jerome Schein. John Kubis.
Gifted	The Identification and Evaluation of an Economical and Practical Method of Providing Intellectual Stimulation to Gifted Pupils in Small Secondary Schools Through a Televised Instructional Program. May 1959–February 1962. $227,236.	State Department of Education, Augusta, Maine. Joseph J. Devitt.
	Challenging the Superior Student by Making the Study of Russian Available in the Elementary School Curriculum Via Television. July 1959–December 1962. $105,630.	University of Utah, Salt Lake City, Utah. Keith M. Ergor. Oakley J. Gordon.
	Programed Teaching Materials in Mathematics for Superior Students in Rural High Schools. June 1960–June 1962. $57,778.	Bucknell University, Lewisburgh, Pa. Wendell I. Smith. J. William Moore.
	The Effectiveness of Special Training with Audio-visuals in Changing Aspirations of Intellectually Superior Students. March 1961–August 1963. $116,395.	Michigan State University, East Lansing, Mich. Elizabeth N. Drews.
	The Construction and Evaluation of a Self-Instructional Program in Russian. February 1961–January 1963. $78,117.	Indiana University, Bloomington, Ind. Irving J. Saltzman. John F. Beebe. Henry A. Bern.
Mentally retarded	A Comparative Study of the Effectiveness of Three Techniques of Film Utilization in Teaching A Selected Group of Educable Mentally Retarded Children Enrolled in Public Schools in Louisiana. June 1959–August 1960. $20,551.	Grambling College, Grambling, La. Lamore J. Carter. Mamie L. T. Wilson. Roy B. Moss.
	The Effects of Mental Retardation on Film Learning: A Study to Determine What Types of Instructional Film Experiences are Meaningful to Children With Mental Retardation, Regularly Enrolled in Public Schools. April 1960–September 1961. $12,458.	University of California, Los Angeles, Calif. John P. Driscoll.
	The Development and Evaluation of a Curriculum for Educable Mental Retardates Utilizing Self-Instructional Devices or "Teaching Machines." June 1960–May 1963. $165,924.	Edward R. Johnstone Training and Research Center, Bordentown, N.J. Leonard S. Blackman. Marshall P. Smith.
	Automated Programs for the Instruction of Arithmetic Concepts to Mentally Retarded Children. February 1961–August 1962. $2,875. Grand total, $806,399.	Partlow State School, Tuscaloosa, Ala. James E. Price.

Projects initiated under title VII, parts A and B, National Defense Education Act, Sept. 2, 1958–June 30, 1963

Area	Title, duration, and funds	Contractee/or grantee and investigator
Blind	Programed Learning Materials for the Blind. January–December 1963. $4,025.	Western Michigan University, Kalamazoo, Mich. George G. Mallinson.
Deaf	Development and Evaluation of Programed Language Instruction for Deaf Children. June 1961–August 1962. $11,845.	University of Pittsburgh, Pittsburgh, Pa. Jack W. Birch. E. Ross Stuckless.
	Development of a Filmed Program for Teaching the Manual Alphabet. June 1962–June 1965. $47,236.	Gallaudet College, Washington, D.C. Harry Bornstein.
	Investigation of Audiovisual Techniques to Improve Parents' Attitudes Toward and Information About the Education of Deaf Children. April 1959–March 1963. $162,993.	John Tracy Clinic, Los Angeles, Calif. Edgar L. Lowell.
	Programed Instruction for the Correction of Written Language in Adolescent Deaf Students. June 1962–October 1963. $18,009.	University of Pittsburgh, Pittsburgh, Pa. E. Ross Stuckless.
	Steering Committee Conference to Plan a 5-Year Elementary and Secondary Curriculum Using Visual Aids in the Education of the Deaf. February–May 1963. $1,518.	Ball State Teachers College, Muncie, Ind. Alan W. Huckleberry.
	Survey of Visual Aid Programs in Residential and Day Schools and Classes for the Deaf in the United States. June 1961–September 1962. $7,590.	Gallaudet College, Washington, D.C. Jerome Schein.
Gifted	Challenging the Superior Student by Making the Study of Russian Available in the Elementary School Curriculum Via Television. July 1959–March 1963. $105,630.	University of Utah, Salt Lake City, Utah. Keith M. Engar. Oakley J. Gordon.
	Construction and Evaluation of a Self-Instructional Program in Russian. February 1961–July 1963. $86,872.	Indiana University, Bloomington, Ind. Irving J. Saltzmann. John F. Beebe. Henry A. Bern.
	Effectiveness of Audiovisuals in Changing the Aspirations of Intellectually Superior Students. March 1961–August 1963. $116,395.	Michigan State University, East Lansing, Mich. Elizabeth M. Drews.
	Evaluation of Method of Providing Intellectual Stimulation to Gifted Pupils in Small Secondary Schools Through Televised Instruction. May 1959–February 1962. $227,236.	Department of Education, State of Maine, Augusta, Maine. Joseph J. Devitt.
	Programed Teaching Materials in Mathematics for Superior Students in Rural High Schools. June 1960–June 1962. $57,778.	Bucknell University, Lewisburg, Pa. Wendell I. Smith. William Moore.
Mentally retarded	Automated Programs for Teaching Arithmetic Concepts to Mentally Retarded Children. February 1961–August 1962. $2,875.	Partlow State School, Tuscaloosa, Ala. James E. Price.
	Comparative Study of the Effectiveness of Three Techniques of Film Utilization in Teaching a Selected Group of Educable Mentally Retarded Children Enrolled in Public Schools in Louisiana. June 1959–August 1960. $20,551.	Grambling College, Grambling, La. Lamore J. Carter. Mamie L. T. Wilson. Roy B. Moss.
	Demonstration Film on the Use of Self-Instructional Devices in a Curriculum for Educable Mental Retardates. February 1963–July 1963. $30,217.	Edward R. Johnstone Training and Research Center, Bordentown, N.J. Leonard S. Blackman. Marshall Smith.
	Development and Evaluation of a Curriculum for Educable Mental Retardates Utilizing Self-Instructional Devices or "Teaching Machines." June 1960–May 1963. $165,924.	Edward R. Johnstone Training and Research Center, Bordentown, N.J. Leonard S. Blackman. Marshall P. Smith.
	Effects of Mental Retardation on Film Learning: A Study to Determine What Types of Instructional Film Experiences Are Meaningful to Children With Mental Retardation Regularly Enrolled in Public Schools. April 1960–September 1961. $12,458.	University of California, Los Angeles, Calif. John P. Driscoll.
	Improvement of Reading for Retarded Readers Through Auditory Training. June 1963–December 1965. $80,460.	New York Medical College, New York, N.Y. Shirley Feldmann.

Mr. JONES. Thank you, sir.

Mr. ROBERTS. I appreciate your usual fine contribution in your statement.

I would like to direct one question to Dr. Felix. With respect to the provisions of title III, having to do with the training teachers of mental retarded and other handicapped children, I wonder, Doctor, if you would give us your opinion as to whether or not this is as much of a health measure as the provisions under titles I and II, in your opinion?

Dr. FELIX. The short answer is "Yes," it is, in my opinion.

Then to enlarge on this a bit, Mr. Chairman, any of us who treat emotionally disturbed children or treat, deal with, and try to assist mentally retarded children know that there are two or three different avenues of approach.

One is through the use of drugs, that is, chemical substances which will help to calm them, make them more accessible for other kinds of treatment.

Then there is the usual so-called psychotherapy in which you deal with the psychological problems of the children. In addition to this, since one of the five fundamental, basic needs of a child is to acquire knowledge—this is not only the human child; but animal children generally—they explore, they acquire knowledge about those things essential to living, it is therapeutically important that a child have the experience of acquiring knowledge within his capacity to learn. They must learn. This is how they are able to take care of themselves as adults.

This need in the child, whether he be a retarded, mentally ill, or a healthy child must be met. Therefore, this becomes an important therapeutic aspect of the treatment of a child.

It may well be, and in many cases it is so, that the kind of educational endeavor is not the same as in the public school classroom because of the severe illness of the child.

Let me deal for a moment with the mentally ill child, which is an area in which I have had some experience and have done work in past years. This was part of the work I did when I was in Colorado before I came with the Federal Government.

Very frequently these children are so ill that, while they need to be placed in the environment of a classroom, but, since they are not able to tolerate this kind of environment without a great deal of difficulty and disruption, it requires individual one-to-one kind of care and treatment.

The teacher may very well, because of the child's emotional difficulty, spend weeks with the child just building up enough confidence so that he will relate a picture of a cat and the letters "c-a-t" with the sound "cat." The fact that the child finally can see three letters "c-a-t" and identify it as a "cat" is really from the standpoint of me as a psychiatrist, incidental.

The main thing is the psychological, the medical, gain we have made by doing this. I have seen many cases where, for instance, the teacher will take the child up on her lap and talk to the child for hours sometimes before the child can even begin to endeavor to learn.

These teachers, the kind that we use with our emotionally disturbed children, require a very special kind of training. They have to have

a great deal of psychiatric know-how, psychological insight. They have to have pretty specific personality characteristics which will allow them to tolerate some of the things that happen.

It is not unusual at all for these children to bite, to strike, to kick, to throw things at these teachers. I will never forget we had eight of these children for several years under special study at the clinical center, the National Institute of Mental Health, in my Institute. The teacher one day was working with one child on her lap and another one of the children who was quite upset with the fact that this second child was not getting enough attention, picked up a coffee pot and turned it upside down over the teacher. This is not considered good procedure in a public school classroom and can even disrupt the class for a few minutes.

This teacher in our situation out there, specially trained for this, dealt with this in a quite calm manner. It was a little hot and she did jump, but she immediately got hold of herself. She called the psychiatrist, reported the incident to see if there was anything special that the psychiatrist need to do, and then went on with her teaching.

This is a long way around, Mr. Chairman, to tell you that from my point of view as a physician, the actual 3 hours that these children get at this stage is secondary to the most important objective of this kind of education or training, which is a therapeutic one.

As a matter of fact, we call it therapeutic training. Some few months ago on a TV station in New York—I have forgotten which one it was—they had an hour show, a documentary, of these schools in the city of New York and what they do for these children.

The objective of this particular show was to demonstrate that in all of the city of New York there were not—I have forgotten the number—facilities for more than 500 children because there aren't enough teachers to do it. These teachers then are colleagues and partners in the effort to restore mental health to these children.

Have I answered you?

Mr. ROBERTS. I think so, Dr. Felix. I would like to ask you also about what training is required in the case of teachers for the deaf and the blind?

Dr. FELIX. Mr. Chairman, I am not as knowledgeable in this area as I am with the mentally ill. I do know that there are special skills needed in order to communicate some of the fundamental educational knowledge to the visually handicapped and the deaf.

One common thread runs through this and also runs through other kinds of rehabilitation in which you reeducate or educate for the first time people to live as nearly completely normal independent lives as possible, and that is the repeated discouragement and the depression which accompanies disappointment which occur in the lives of such people and which can be countered and nullified to a great extent, if not completely, by a properly psychologically oriented teacher who has had special training in dealing with such problems.

This is equally true of the child, for instance, who has never had sight and the child or adolescent who once had sight and has lost it or has it just to the point that he can, oh, see light from dark, but cannot really find his way around unaided.

The psychological aspects of this then, the medical aspects of it, psychiatric aspects, are of extreme importance.

Mr. NELSEN. Mr. Chairman, might I ask a question at this point?

Mr. ROBERTS. Mr. Nelsen.

Mr. NELSEN. Your discussion goes more to the mentally disturbed or mentally ill child than it does to the mentally retarded, does it not, relative to the therapy talked about, the attitude and the attention of the teacher?

Dr. FELIX. I did address myself more to that, Mr. Nelsen, because I have had more experience in this area. To be frank, I think I can defend myself better if you want to question me in this area.

Mr. NELSEN. The mentally retarded would be in some degree different, would it not, than the child you referred to?

Dr. FELIX. Yes, there would be some degree of difference, although one must remember that the child, no matter what his intellectual level, who is falling behind his companions reacts to this psychologically. We have all seen this and there can be with rather profound emotional manifestations and these have to be dealt with.

Mr. NELSEN. I would like to direct a question to Mr. Jones. I notice on page 9 you refer to making educational provisions for about one-third of the Nation's handicapped children.

In the mental retardation bill, as I understand it, provisions are made in title II for research centers and then in title III provisions are made for educating or training of teachers.

There is nothing in the bill, as I understand it, that will provide any community facilities for training, for education.

Is that not true?

Mr. JONES. That is not true, Mr. Nelsen. We only discussed yesterday, I think, the provisions for the research centers.

Mr. NELSEN. Yes.

Mr. JONES. But the bill also provides for community mental retardation facilities.

Mr. NELSEN. For eductaion?

Mr. JONES. For education, for training, for the actual services required by the mentally retarded. There is special emphasis, Mr. Chairman, given to the construction of facilities that are affiliated with universities, particularly those that have medical centers, so that the needs of mentally retarded can receive the attention of a wide variety of medical disciplines as well as disciplines that are found only in a major university. The objective is that a mental retardation service unit affiliated with a medical center and its parent university gives the best opportunity for bringing to bear the best of scientific minds on problems of the mentally retarded. They can develop new techniques, new patterns, and can train oncoming physicians and other health personnel in the problems of the mentally retarded. Many of them are not exposed to these problems through their normal educational program, so that community-based mental retardation facilities will include training programs.

Mr. ROBERTS. Would the gentleman yield at that point?

Mr. NELSEN. Yes, I yield.

Mr. ROBERTS. Has any consideration been given to the utilization of schools for the deaf and blind where they have a hospital in connection with the school?

Mr. JONES. For utilization of them in respect to training of personnel?

Mr. ROBERTS. Yes, or possibly to expand their own facilities in this field.

Mr. JONES. Yes. I am quite sure that the local communities and local interested groups will develop patterns of expansion of existing services such as a school for the deaf.

Mr. ROBERTS. Would they be excluded under the language of the bill, in your opinion, as written now?

Mr. JONES. Not, as I understand it, if it is a part of a mental retardation program, related to the problems of the deaf who are mentally retarded, but the direction of the program is toward the mentally retarded.

Mr. NELSEN. One of the apparent gaps, as I see it, in the provisions dealing with the mentally retarded is a facility for education, for training of the youngsters who are mentally retarded.

In many of our rural areas the public school is not equipped to put these youngsters among other students who can progress. It is a very psychologically difficult barrier for the youngsters.

In the hearings I know of no suggestion made as to just regular classroom facilities or how do we proceed to provide the classroom the facility in some of these areas.

The bill, I wouldn't suppose, goes that far, that a classroom facility would have any matching funds. Does it do that?

Mr. JONES. The bill, Mr. Nelsen, would make provisions for Federal matching for individual projects as submitted under State plans.

Mr. NELSEN. I see.

Mr. JONES. For developing a comprehensive program.

Mr. NELSEN. Leading up to the next question, I had this idea: That under our school reorganization all over the country, country schools have been vacated, very good schools. I can think of a number of four-room school houses with a heating plant, playground equipment, toilet facilities—very good buildings.

I have a letter here from the Minnesota Association of Retarded Children, which I ask be inserted in the record.

Mr. ROBERTS. Without objection, the letter will be inserted in the record.

(The letter referred to follows:)

MINNESOTA ASSOCIATION FOR RETARDED CHILDREN, INC.,
Minneapolis, Minn., July 9, 1963.

Hon. ANCHER NELSEN,
House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN NELSEN: Reading the report of the hearings before the Subcommittee of the Committee on Interstate and Foreign Commerce on H.R. 3688, H.R. 3689, and H.R. 2567, I was impressed with your comments on page 83, where you referred to possible use of vacated good country schoolhouses for programs for the mentally retarded.

In Minnesota, the 1963 legislative session appropriated $155,000 to be used by the State to match local funds for day activity centers for the retarded not able to attend public schools and not needing institutional care. There are several instances of the use of country schoolhouses. At Rochester, an excellent country school is being used for an activity center for school-age mentally retarded. Another example is at Austin, where the Association for Retarded Children purchased an almost new country school when the schools in that district were consolidated. At the present time, the Minneapolis ARC is contemplating expansion of their day activity center for the severely retarded and are now raising funds to purchase the Emmanual Coen Jewish Community Center on the

north side of Minneapolis. These are several examples of the use of existing facilities for the mentally retarded.

I do not know if the proposed legislation calling for construction of facilities for the mentally retarded would make any funds available for purchase of existing facilities. In many instances, the existing facilities may be better than new ones which would be constructed. It certainly would be less costly.

One of the needs which I see at the present time is for additional funds for day activity centers. The $155,000 appropriated by the State will not be nearly enough. Secondly, the State matching funds cannot be used for rental of facilities. This money must be obtained from other sources.

Many counties are matching the State funds, thereby providing a tax-supported program for these severely retarded not able to attend public schools, for which their parents are paying taxes. It is my feeling that the school-age mentally retarded, especially, should be provided for through tax funds.

I think the Federal Government could very well help stimulate the development of services to the mentally retarded through use of Federal funds—not necessarily on a continuing basis but just to get the program started and to demonstrate to the States and to the counties the benefits which these children can receive from participation in such programs.

We appreciate your interest in programs for the mentally retarded.

Cordially yours,

GERALD F. WALSH,
Executive Director.

Mr. NELSEN. I was hoping that there could be some arrangement made so we are sure that the acquisition of properties like this would be encouraged. It would seem to me we would make great progress by the use of existing facilities rather than groping for money to build new ones.

Mr. JONES. That would be quite appropriate, Mr. Nelsen, for participation in this program.

Mr. NELSEN. I see.

Mr. JONES. Part C of title I of the bill is specifically directed toward grants for construction of facilities for the mentally retarded.

Mr. NELSEN. In this case perhaps the value of the facility is quite great. Would its value be regarded as matching, or would it depend entirely on what the cost would be on the acquisition of it?

Mr. JONES. This program does not provide for the purchase of property. It is a construction program for new facilities which are directed and designed for the purposes of the program.

Dr. TERRY. Mr. Nelsen, may I call your attention to paragraph (b) of title IV under section 401, which defines the term "facility for the mentally retarded"?

It means "A facility especially designed for the diagnosis, treatment, education, training, or custodial care of the mentally retarded, including facilities for training specialists, sheltered workshops" and so forth and so on, so that it is the intention of this legislation, as we understand it, to cover all types of facilities which are needed for the care and education, management, training of the mentally retarded.

Mr. NELSEN. Let us suppose that a facility that does exist at the present time does meet the requirement. There would be nothing in here that would bar the use or, shall we say, the remodeling of such a facility? I am thinking of the dollars involved to get something going.

We could acquire the property perhaps for a dollar and the remodeling might be something, but is there any language in the bill which would bar the use of these facilities?

Mr. JONES. No, sir.

Dr. TERRY. Certainly there is nothing that would bar the use of these facilities. I am certain that the legislation would not provide for the purchase cost of acquiring existing facilities.

I am frankly not quite certain on whether it would allow grants to aid in the renovation or adaptation of existing facilities, but I do not believe that is covered in this legislation.

Mr. JONES. Mr. Nelsen, with regard to an existing facility that is to be remodeled under the terms that have just been read and designed for programs directed toward the problems of mental retardation, the cost of remodeling or of additional construction would be eligible for a matching grant.

Mr. NELSEN. We should examine this very closely.

Mr. JONES. But not the purchase of an existing facility as such.

Mr. NELSEN. I understand.

Mr. JONES. I could check this, I think, right now.

Dr. TERRY. I have that here, Mr. Nelsen. Paragraph (e) of title IV refers further—

> The term "construction" includes construction of new buildings, expansion, remodeling, and alteration of existing buildings, and initial equipment for such buildings (including medical transportation facilities); including architects' fees, but excluding the cost of offsite improvements and the cost of the acquisition of land.

Mr. NELSEN. I want the record to show that it is clear. About a year ago, a neighbor lady came to visit me. They have a mentally retarded boy and the public school does not have the facility for the training of this child, and he does not quite fit in. We have a little four-room schoolhouse, with a playground fenced in, water, heating facilities, and, in general, a very, very good building. It stands with the windows boarded up, and it would seem to me that if McLeod County could acquire this through the regular State channels we would get started with something. If we couldn't acquire it, and we had to put up the money, we probably wouldn't get started, so I would like the record to show that this does have some possibility. It has already been demonstrated by this letter from the Minnesota Association for Retarded Children that a start has been made in this direction.

I noticed in the comparison that our good chairman provided yesterday that in the field of research in mental retardation money is already being spent in research activities now, and again getting back to the original questions about overlapping, is it possible that the research could be done under the present arrangements for research for your 10 medical centers, is it the feeling that it works out better under this whole package?

I am just wondering why you need to have a new research approach here when you already are doing research under existing law.

Mr. JONES. This gets back to the special research centers for mental retardation that we discussed yesterday.

Mr. NELSEN. Yes.

Mr. JONES. Mr. Nelsen, the provisions of this bill are only for construction of research facilities that will be specially designed for interdisciplinary approach to the problems of mental retardation and of human development that has a relationship to the problems of mental retardation.

This is a special provision because of the fact that no university, or very few at least, has, at the present time, the resources or even the direct interest, as a part of an ongoing educational program, this interdisciplinary approach to problems of mental retardation.

The stimulation of perhaps as many as 10 major mental retardation research centers located strategically about the country at universities with medical centers, through the provision of special facilities through matching grants, would provide locations for concentrated attention especially on problems of mental retardation.

The research activities that will be carried on in such facility would be supported under our normal research grants program, so there will be no duplication in that sense.

Mr. NELSEN. I see. Thank you very much. No more questions.

Mr. ROBERTS. The gentleman from Colorado.

Mr. BROTZMAN. Referring to title III of S. 1576 for a moment, obviously the thrust of this title is to train teachers for the mentally retarded and then I think this has been expanded, as I read the bill, to include teachers for the hard of hearing, deaf, speech impaired, visually handicapped, emotionally disturbed or socially maladjusted, crippled, or other health impaired children. There is some very broad language here.

Take socially maladjusted, for example. Is that term defined in this bill?

Mr. JONES. The term "socially maladjusted"?

Mr. BROTZMAN. Yes.

Mr. JONES. I don't think it is defined as such in the bill. It is a term that is understood generally in professional fields. It is a rather broad definition of a series of problems that have to do with emotional disturbances related to the social environment. It is a handicapping condition in terms of this definition.

Mr. BROTZMAN. You are telling me that the term "socially maladjusted" is a term of art; is that correct? It has specific meaning?

Dr. FELIX. I didn't hear you.

Mr. BROTZMAN. I asked, Are the two words "socially maladjusted" terms of art?

Dr. FELIX. I believe the "socially maladjusted" here means children who are sufficiently ill mentally that they cannot adjust in society without some special provisions, as opposed to mentally retarded children who may adjust very well, although at a level not quite equal intellectually with their better endowed brothers and sisters.

Mr. BROTZMAN. Just to test this, is there a difference between a socially maladjusted child and an emotionally disturbed child?

Dr. FELIX. All socially maladjusted children may not be emotionally disturbed, but emotionally disturbed children are usually socially maladjusted so far as I know. By this I mean there are other kinds of social maladjustments besides that which is usually described as "emotionally disturbed", although I am sure that if some of my distinguished colleagues were here today they would say that the terms could be used interchangeably.

Personally, I have thought of certain conditions as being maladjustment, while not being quite in the same category with the emotionally disturbed child. Very frequently we speak about a person socially decompensating when they become sufficiently ill that special

provisions have to be made for them, and I think this is probably where this term came from.

Mr. BROTZMAN. It strikes me that the term "socially maladjusted" is a broader term than "emotionally disturbed" or any of the other designations in this bill as I read it.

Mr. JONES. It is a handicapping condition, Mr. Brotzman, which is the reason it is included. I don't know how to be more specific in defining it. Perhaps some of the expert witnesses you will hear a little bit later can define it more specifically for you.

Mr. BROTZMAN. The point I was going to make, is I think, as I said the outset, the expenditure for this section is supposed to be to train people.

Mr. JONES. That is correct.

Mr. BROTZMAN. Teachers that can teach others, I would assume, how to train mentally handicapped children, mentally retarded, and the other specifically set forth provisions here.

Mr. JONES. That is correct.

Mr. BROTZMAN. I would assume, however, that it is not your position that this bill is to train teachers to take care of every socially maladjusted child in the country. In other words, don't you intend that it should be related to the specific crippling defect?

Mr. JONES. You are quite correct, Mr. Brotzman. I think if you will look at page 34 of S. 1576 you will notice that the context is—"and inserting in lieu thereof, mentally retarded, hard of hearing * * *."

Mr. BROTZMAN. Are you on page 34?

Dr. FELIX. On 36 if you have the subcommittee print. He is reading from page 36.

Mr. JONES. My point is made beginning on line 17, if you have it there——

Mr. BROTZMAN. Yes.

Dr. FELIX. Line 22 on yours.

Mr. JONES. It says: "mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, emotionally disturbed or socially maladjusted * * *"

The two are grouped together in that context. The implication is very strong that it is a handicapping condition due to emotional disturbance and/or socially maladjustment. The two terms are so closely interchangeable that they are put together rather than separated by commas. It is one group and it does relate to a major handicapping condition primarily emotional disturbances.

Mr. HARRIS. Will the gentleman yield there?

Mr. BROTZMAN. Yes, sir.

Mr. HARRIS. Just what do you mean, Mr. Jones, when you talk about emotionally disturbed?

Mr. JONES. I can give you a lay answer, Mr. Chairman. I would suggest that Dr. Felix might like to give you an answer.

Mr. HARRIS. Dr. Felix, I would be glad to have you comment on that. I assume that what would be recognized as a definition of "emotionally disturbed" generally and the application of this proposed legislation would be the same.

Dr. FELIX. Mr. Chairman, as I read this now, I believe that they are using "emotionally disturbed" and "socially maladjusted" as synonymous words as I see it here.

To answer your question about the emotionally disturbed: Emotionally disturbed children are considered by psychiatrists as children so mentally ill as to be unable to get along in the community without some assistance, treatment, or special facilities; children who become so emotionally ill that they divorce themselves from the realities of life. They are what we call in a dreamworld most of the time.

"Disturbed" to the psychiatrist does not mean just violent, and kicking, and screaming, but it is an emotional disturbance. The children who would, and this is not too uncommon among emotionally disturbed children, take out their difficulties by, oh, torturing animals, things of this nature, are emotionally disturbed children also, so these are children who are sufficiently sick psychologically that they cannot live without some kind of special provisions or assistance in the home and in the community.

Mr. HARRIS. I do not want to take the time away from the gentleman.

Mr. BROTZMAN. Please go ahead.

Mr. HARRIS. Is it easy, Doctor, to detect the difference between an emotionally disturbed child who needs treatment and an emotionally disturbed child who just has a natural tendency to act that way and with the proper discipline something can be done about it?

Dr. FELIX. To put it in plain old-fashioned words, is it easy to tell the difference between an emotionally sick child and a brat? Yes, sir; it usually is. A youngster who needs a little bit more of the hickory stick and a little more firm discipline at home can be differentiated from the child who is quite ill—that is, differentiated by one who is trained to do it—from the child who is sufficiently emotionally disturbed that his behavior is abnormal. Of course, one thing you see here not infrequently is a person who is not properly trained, and this can happen in schoolrooms as well as in society in general.

They can say, "What this kid needs is to be taken out in the woodshed and have a couple of shingles worn out on him and he will be all right." It could very well be, and in many cases it is so, that this is the worst possible thing you could do for this sick child.

If there were time I could give you illustrations of this in which the child's whole difficulty has developed as a result of various kinds of abandonment in the home, not necessarily the parents having gone off and left them, but the emotional situation much the same as I was trying to tell Mr. Bennett about the monkeys yesterday. This is the same thing.

To take a child like this and to lay a strap across his backside does no good at all. In fact, it makes matters worse, but this can be differentiated without too great difficulty, Mr. Harris, by people trained to do it.

Mr. ROBERTS. Would the gentleman yield?

Mr. HARRIS. Mr. Brotzman has the floor.

Mr. BROTZMAN. I would like to pursue this more, but I will be glad to yield. I would like to get back to this point when you have finished.

Mr. ROBERTS. I just have one brief question. Is this child you are

speaking about, not a brat, but emotionally disturbed child, frequently the product of a broken home, or parents are not getting along, or too much alcohol, or other problems?

Dr. FELIX. Yes, sir; it should be remembered that broken homes can be broken with both persons living in the house. There are more ways of breaking the home than just one person being absent.

Mr. BROTZMAN. I would like to get back to this one clause just for a moment, "emotionally disturbed or socially maladjusted." Of course, I do understand that there are commas setting forth the exterior limits of that clause. I also note, though, that the disjunctive term "or" is used.

Is it your statement that you are talking about socially maladjusted children who are such resultant from emotional disturbance?

Mr. JONES. Mr. Brotzman, I will undertake to reply without as complete assurance as one who is a professional in this field might have, but I can envision a situation in which a child grows up in a home so socially deprived, which is a term I picked up from sociologists and others, that the home lacks what one expects as a normal environment for the upbringing of a child that the youngster, when he becomes of school age, does not know how to act appropriately with other people, especially other children.

It may be an isolated child who has had no contact with the outside world, with other children, or even with other adults. This is a form of social maladjustment which requires special attention because the child is handicapped.

It is a handicapping condition which is not necessarily the result of emotional illness, but of a deprivation of normal experience and opportunity to the point that he is so maladjusted and handicapped as to require special attention.

That is my understanding of this term.

Mr. BROTZMAN. Are there teachers that are particularly skilled in handling this situation, or is this a social worker type of person we are trying to train?

Mr. JONES. No; this relates to the educational process of how this child can be educated normally. But in the process the child has to be adjusted to the educational environment because his own experiences are not the equivalent of the children with whom he is associated.

This requires special education of the teacher just as is required for the management of the emotionally ill, of the crippled child, of the hard-of-hearing, of the blind. There may be some special aspect of the training that relates to this particular problem, but it is part of the educational process, not the adjustment of social conditions in the home, which would be more in the field of social work.

Mr. BROTZMAN. Let's move over to one other clause here, I am trying to see the limits of the authorization that Congress is being called upon to delegate.

The other words here are "or other health-impaired children."

This is in the same sentence. I am now referring to the top of page 37 and beginning at line 1 it says: "* * * socially maladjusted, crippled, or other health-impaired children."

Then there is a parenthetical phrase that refers to all of these as "handicapped children."

My question is when you say "other health-impaired children," it would seem to me that without some definition this could mean any kind of a health impairment a child might be possessed of.

Mr. JONES. If it is a handicapping condition that requires in and of itself special attention in the educational process.

Mr. BROTZMAN. This language, I would assume, was inserted over in the Senate. Is that correct?

Mr. JONES. That is correct; yes, sir.

Mr. BROTZMAN. Just a couple more short questions. Since this is designed to train teachers and since it is evident that it would require specialized training, are there institutions of higher learning now in the United States where they are specifically qualified to give training in these areas?

Mr. JONES. Yes, sir; and included in the material which I had suggested to the chairman would be available for insertion in the record if the committee chose to do so is a complete listing of this kind of activity, the institutions where they are located, the nature of program, and other similar information.

It is fully available.

To answer your question; yes, there are places that are qualified to give this training. They are inadequately supported, which forms the basis for the rationale for moving in with additional health programs. This program can be made much stronger, it can produce more teachers, and it can more adequately handle this major health problem.

Mr. BROTZMAN. If there are more teachers available in these specific areas to give the training, how will they then fit into the pattern of actually educating these children? More specifically, will they go to a local school district; for example, in our school districts in Colorado? Will they then institute a program to hire that teacher to train the handicapped children in that area, or what is the overall plan after we have developed this resource of new teachers?

Mr. JONES. The program as envisioned here would be directed toward increasing the supply of these specially trained people for use wherever the need exists in our normal community activity in regard to handicapped children. Some would go into regular school systems that had special programs for handicapped children. This would require special training for these teachers.

Some would go into the mental retardation centers. Some would go to schools for the deaf or the blind. They would be incorporated into the total structure of service to the handicapped children through all of these mechanisms.

Mr. BROTZMAN. One more question.

What is meant by the appropriation for "research or demonstration" projects?

Mr. JONES. There is a special problem, Mr. Brotzman, of learning to deal with a handicapped child with a special condition. There is not now fully available techniques of teaching handicapped children.

The research aspect of the program would provide grants for especially skilled people in proper research environments to develop new methods of educating handicapped children, whether they be partially blind, hard-of-hearing, speech handicapped, crippled children, or mentally retarded.

It will be the development of methodology for the better education and training of these handicapped individuals. That is the research aspect of it.

The demonstration aspect would be the support of particular utilization of the new methods, the new techniques developed from research activity. This new technique would be demonstrated in one situation so that it could be copied in other places. This then spreads the utilization of new knowledge.

It is comparable to your analogy yesterday. It is to make sure that those that could benefit from new knowledge have the use of it.

Mr. BROTZMAN. Thank you.

Mr. ROBERTS. Thank you, Mr. Brotzman.

Any further questions?

Mr. ROGERS of Florida. Just one or two quick ones.

There are centers now that are doing this type of work that have methodology developed?

Mr. JONES. Yes.

Mr. ROGERS of Florida. And it would be from these experiences that you would now put into this program?

Mr. JONES. That is quite correct.

Mr. ROGERS of Florida. How much money is now going into this training program; the same type that you would continue to carry on?

Mr. JONES. Let me see. I think I can give that to you specifically.

Mr. ROGERS of Florida. Several million dollars?

Mr. JONES. About a million dollars. A million dollars for this program as of the present time.

Mr. ROGERS of Florida. $1 million?

Mr. JONES. Yes.

Mr. ROGERS of Florida. And that trains how many people per year?

Mr. JONES. I don't have those figures. I can supply them for you. I will supply the actual money and the number of people involved.

Mr. ROGERS of Florida. That will be helpful at the college level, as well.

Mr. JONES. Yes.

Mr. ROGERS of Florida. How many are trained at the college levels.

Mr. JONES. Yes.

Mr. ROGERS of Florida. Now, are there any other moneys from NIH that might be going to this training program?

Mr. JONES. They are available, likewise.

Mr. ROGERS of Florida. There are some funds?

Mr. JONES. Yes.

Mr. ROGERS of Florida. Could you give us just a general estimate right now of how much money is going into this program?

Mr. JONES. I don't know. It could not be a great deal but it would be some. We will provide that figure for you.

Mr. ROGERS of Florida. Will you let us know?

Mr. JONES. Yes.

Mr. ROGERS of Florida. And is there any limitation on the amount of money that can be directed out of your general funds of NIH for research into this field or not?

Mr. JONES. Yes, but I think we should make the distinction, Mr. Rogers. The NIH general program effort is related to the causes and cures of disease conditions whereas this program contemplates the

methodology of instruction and utilization of techniques and knowledge rather than the causes and cures

Mr. ROGERS of Florida. I thought they had some money for training grants.

Mr. JONES. They do.

Mr. ROGERS of Florida. That is what I wanted to know.

Mr. JONES. Yes.

Mr. ROGERS of Florida. Thank you.

Mr. ROBERTS. Thank you.

Mr. HARRIS. I would like to ask, Mr. Chairman, with regard to mental retardation under the proposal here, are there any funds in the fiscal 1964 budget?

Mr. JONES. For which of the programs? For the research and demonstration?

Mr. HARRIS. Well, you have mental retardation, research centers. Are there any funds in the 1964 budget for research centers?

Mr. JONES. We contemplate $6 million for the fiscal year ending June 30, 1964.

Mr. HARRIS. That is already in the budget, submitted to Congress?

Mr. JONES. No. That would come as a supplemental after this was authorized.

Mr. HARRIS. It has not yet been submitted to the Congress?

Mr. JONES. No, sir; not for this.

Mr. HARRIS. All right.

Is there anything in the budget that has been submitted to Congress for university grants for construction of facilities under the mental retardation program?

Mr. JONES. No, sir.

Mr. HARRIS. Is there anything in the budget for any of the programs in the three titles recommended here?

Mr. JONES. No, sir; except for the program of teachers for the deaf which is in the budget as of now. I will have to check that for you, Mr. Chairman. I will check that for you.

Mr. HARRIS. Will you check that and supply it for the record?

Mr. JONES. Yes, sir.

Mr. HARRIS. Thank you.

Mr. ROGERS of Florida. May I ask for some information to be furnished?

Mr. ROBERTS. Surely.

Mr. ROGERS of Florida. I think it would be wise for us to know if the proposed training grants under the bill if it is passed and your present program as previously improved are in line with the other training provisions that you carry on in different phases or if there is any difference.

Mr. JONES. We will provide that for you, Mr. Rogers.

Mr. HARRIS. That leads to one other question.

With regard to training grants in connection with title III, these grants would have to be made for this coming school year?

Mr. JONES. Yes, sir.

Mr. HARRIS. In other words, if the grants are not made by September, then they could not be effective for this next school year.

Mr. JONES. Not fully effective, Mr. Chairman. There would be school programs where the money for training would be effectively

used at the beginning of a new semester or a new quarter which may be in the middle of a school year.

Mr. FELIX. It should be pointed out open hunting season for faculty is during the summer and most of the faculty is committed by fall as far as what they are going to do the next year. So, as far as obtaining faculty for this is concerned, if the funds are not available by the opening of the school year, it would certainly open on a very reduced scale because you could not get the people to teach.

Isn't that correct, Mr. Jones?

Mr. JONES. Yes.

Mr. HARRIS. This is July. We have a month and a half, and the bill has not been reported out of the committee, and then comes August. I am not going to give a lecture about the season of the year.

The bill has got to make its way through and, as everybody knows, the legislative wheels are sort of like the mills of the gods; they grind exceedingly slow.

Mr. JONES. That is quite correct.

Mr. HARRIS. I see no possible chance for any way to hurry this thing up. Even with all the expeditious efforts that we made up to August; a supplemental budget would have to be set up. That requires time. Come October, we probably would still be here; I don't know. I hope not, but it looks like it.

To my knowledge, we never have any supplemental budgets in the fall. The only one we have ever had, it tied us up and kept us here for a longer period of time, and then got nothing done.

So, I am just wondering and trying to find practical ways of approach.

Mr. JONES. Mr. Chairman, we have limited appropriation now for a million dollars in the program for training of teachers of the mentally retarded, and a million and a half dollars in the program for training of the teachers for the deaf. These programs we hope would be continued.

Mr. HARRIS. Do these expire this year?

Mr. JONES. Yes, sir.

Mr. HARRIS. When?

Mr. JONES. The only one that really expires is the deaf program on June 30 of this year which is a program for a million and a half dollars.

Mr. HARRIS. Which has already expired.

Mr. JONES. Yes, sir.

Mr. HARRIS. Yes. Well, that would be continued regardless of whether there are continuing resolutions.

Mr. JONES. No, sir.

Dr. TERRY. I believe the authorization has expired; it is not a question of separate appropriation.

Mr. HARRIS. In other words, if this bill is not passed, then you don't have that?

Dr. TERRY. That is correct.

Mr. JONES. That is correct.

The point is, Mr. Chairman——

Mr. HARRIS. You do have in the budget that million and a half?

Mr. JONES. Yes, sir. The President's budget for 1964 made provision for the 1964 costs of this proposed program.

Mr. HARRIS. In this year's budget?

Mr. JONES. Yes, sir.

Mr. Chairman, I think there is now so much interest in this program and so much need for it——

Mr. HARRIS. I am not arguing about that; I am not asking you for a speech on that.

Mr. JONES. Let me finish this point.

There is so much faith by people in this field that the Congress will provide a program that they are planning for it. It will not be a total loss if the program is delayed until fall, although we cannot fully utilize the authorization for the year if the program is not approved until late, as you well know. You are quite correct in this.

Mr. HARRIS. Well, there is no need worrying about closing the gate after the horse gets out.

If you are going to have a 3-year program, it is necessary to meet these needs, but you cannot start it because it cannot be gotten through in time. You ought to consider recognizing the facts and plan a program that can be effective and do the work that has to be accomplished.

That is all, Mr. Chairman.

Mr. ROBERTS. Thank you, gentlemen.

(The following information was later received from Mr. Jones:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, July 12, 1963.

HON. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D. C.

DEAR MR. CHAIRMAN: Attached is a statement concerning budget provisions relating to title III of S. 1576, which was a matter under discussion at the committee hearing July 11. I hope that this memorandum will give you full information that you may need, which I was unable to provide with clarity during the hearing.

You will note that provision has been made in the budget for full funding of the program in fiscal year 1964.

Sincerely yours,

BOISFEUILLET JONES,
Special Assistant to the Secretary (Health and Medical Affairs).

Enclosure.

TABLE III—TRAINING OF TEACHERS OF MENTALLY RETARDED AND OTHER HANDICAPPED CHILDREN

Title III of S. 1576 would amend Public Law 85–926, approved September 6, 1958, which authorizes grants to institutions of higher learning for training personnel who can, in turn, train teachers of mentally retarded children, and grants to State educational agencies to assist them in providing training of teachers of mentally retarded children and supervisors of such teachers.

The program would be extended to all handicapped children and grants would be expanded to include grants for training teachers of all handicapped children and supervisors of such teachers, and for training speech correctionists, and other specialists and research personnel for work in this area. The present limitation of $1 million per year would be increased to $11,500,000 for fiscal year 1964.

Public Law 87–276, approved September 22, 1961, which authorized a 2-year program of grants-in-aid to accredited public and nonprofit institutions of higher education for the purpose of encouraging and facilitating the training of teachers of the deaf, expired on June 30, 1963.

Title III of S. 1576 would extend this program for 1 year at the authorized level of $1,500,000 for the training of teachers of the deaf. After June 30, 1964, the amended Public Law 85–926 would include provision for persons preparing

for employment as teachers of the deaf in the general authority to train teachers and supervisors for all handicapped children.

In addition to the training provisions, there is included an authorization of $2 million for grants to States, State or local educational agencies, institutions of higher learning, and other public or nonprofit private educational or research organizations for research and demonstration projects relating to education of handicapped children.

The President's budget for 1964 made provision for the 1964 costs of this proposed program. An amount of $1 million was budgeted for the program of expansion of teaching in the education of the mentally retarded under existing legislation, and an amount of $14 million was included in the 1964 budget under proposed legislation, consisting of $1,500,000 for the deaf program, $2 million for research and demonstration, and $10,500,000 for expansion of the mentally retarded program and for other handicapped children.

Following is a table showing the 5-year costs of the proposed legislation:

MENTAL RETARDATION FACILITIES AND COMMUNITY MENTAL HEALTH CENTERS CONSTRUCTION ACT OF 1963

Title III.—Training of teachers of mentally retarded and other handicapped children

	1964	1965	1966	1967
Appropriation requirements:				
Personnel training	[1] $12,000,000	$14,500,000	$19,500,000	
Research and demonstration grants	2,000,000	2,000,000	2,000,000	
Administrative expenses:				
Personnel compensation	195,000	280,000	280,000	
Other	95,000	70,000	70,000	
Subtotal	290,000	350,000	350,000	
Total appropriation requirements	14,290,000	16,850,000	21,850,000	
Expenditures:				
Personnel training		12,000,000	14,500,000	$19,500,000
Research and demonstration grants	2,000,000	2,000,000	2,000,000	
Administration expenses	267,000	345,000	350,000	28,000
Total expenditures	2,267,000	14,345,000	16,850,000	19,528,000
Number of positions	31	31	31	31
Man-years of employment	22	31	31	31

[1] Does not include an amount of $1,000,000 for the mentally retarded program. This amount is included in the Appropriation Act for 1964. It does include $1,500,000 for the 1-year extension of the program for training teachers of the deaf which expired June 30, 1963

Mr. ROBERTS. The next witness is our colleague from Massachusetts, the Honorable Edward P. Boland. Mr. Boland, we will be glad to hear you at this time.

STATEMENT OF HON. EDWARD P. BOLAND, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MASSACHUSETTS

Mr. BOLAND. Mr. Chairman, it is a pleasure to submit this testimony to your committee on H.R. 4622 and H.R. 4623—my two bills, identical to the administration's H.R. 3688 and H.R. 3689, which you introduced—to launch a major national effort in behalf of the mentally ill and retarded. I say "launch" to describe the purpose of these two bills, because I feel the President, himself, christened this national effort when he delivered his moving and comprehensive message to Congress on February 5 of this year outlining the breadth of the program he ultimately hopes to have enacted.

Moreover, he did not mince his words in telling the Congress and the Nation that the twin problems of the mentally ill and retarded are the responsibility of everyone:

> The time has come for a bold new approach. New medical, scientific, and social tools and insights are now available. A series of comprehensive studies initiated by the Congress, the executive branch and interested private groups have been completed and all point in the same direction.
>
> Governments at every level—Federal, State, and local—private foundations and individual citizens must all face up to their responsibilities in this area.

It certainly must be gratifying for those dedicated few who have worked years on these problems to at least have a President of this country who leads them in their efforts, and a President who is clearly sincere and emphatic in his sponsoring of this legislation and in his urging of the forwarding of their entire cause.

It is only to be deplored that these problems did not receive the attention they should have years ago.

Ten years ago, the National Association for Retarded Children issued a booklet entitled, "The Child Nobody Knows." A few years ago, the booklet was revised under the title, "Now There Is Hope." Today, this booklet bears a cover with these words on it: "The Retarded Can Be Helped." The differences among these captions are indications of the advances that have been made in the understanding and awareness of mental retardation, and of the hope that is now held out to those parents and friends of the retarded who for so many years have experienced the feelings of neglect and helplessness.

The impact of President Kennedy's proposed program was heightened by the fact that it was sent to Congress in the form of an historic, "first-time" special message on mental illness and mental retardation. Never before have these two problem areas been placed before the Congress and the American people by way of a special Presidential message.

I am sure that it was done, in this way, to dramatize the magnitude and seriousness of the problem. Mental illness and mental retardation are among our most critical health problems. They occur more frequently, affect more people, require more prolonged treatment, cause more suffering by the families afflicted, waste more of our human resources, and constitute more financial drain upon the public treasury and personal finances of the individual families than any other single condition.

The backbone of the President's program is embodied in the two bills I want to support today—H.R. 4622 and H.R. 4623. I call these bills the backbone because they are the bills that really embody the "bold new approach"—the idea of having programs that are essentially community oriented and administered. Moreover, these are the bills that if passed will provide for the construction of facilities where much of the future work in mental health and mental retardation will take place for years to come.

In short, these bills are the foundation—and a good solid foundation—upon which future programs can grow.

H.R. 4622 or H.R. 3688 would authorize funds for the construction and initial staffing of community mental health centers. Hopefully, this type of community based treatment will grow to replace completely the old custodial institution of the State, and also draw

together into one place various facilities for various phases of the treatment of a mentally ill person.

Recently, Dr. Robert H. Felix, Director of the National Institute of Mental Health, at the National Congress on Mental Illness and Health, had this to say about treatment in a community center and the tremendous difference it can make in the patient's progress and readjustment. He said:

> All of us who have had experience with programs of care and treatment for the mentally ill have had it forceably brought home to us that our problems of treatment and prevention will not be solved until the responsibility and programs are placed where they belong—at the community level.
>
> Our patients become ill in communities and it is to communities that they must return when they have recovered. It is in communities that they must adjust and it is community life and problems they meet and deal with * * * the patient remains close to his family and friends. He is easily seen and remains in contact, hopefully in a therapeutic relationship, with his family physician. The orientation of the patient, his family and those treating him is toward return to the community at the earliest possible moment consistent with good medical principles and practice, as is true with any other illness. * * * Because the facilities are at home, they will not appear so mysterious and fearful. Those who need them are more likely to avail themselves of them earlier, thereby, hopefully, coming under treatment at an earlier stage of illness when the disease can be shortened and the loss in time and money can be minimized. Because the facilities are at home, all branches of medicine will become more understanding of mental illness. * * * And, finally because of all these things, the stigma will be erased from these illnesses which will facilitate even earlier treatment and programs of prevention.

It would be hard to ignore these words of one of the chief experts on mental health in the Nation.

The community mental health centers bill does not. It would authorize for fiscal 1965 and the 4 succeeding years "such sums as Congress may determine." These funds would be allotted to the States on the basis of population, the extent of the need for facilities, and the financial need of the State. The Federal share would never exceed 75 percent nor would it ever be allowed to drop below 45 percent.

Title II would help with the initial staffing of the centers constructed under title I. It authorizes for fiscal year 1965 and following "such sums as may be necessary for grants by the Secretary to assist" in meeting such staffing costs. These grants may be awarded to a center for only 4 years and 3 months. The Federal share is scaled at a decreasing rate: it cannot exceed 75 percent for the first 15 months, 60 percent for the next year, 45 percent for the next, and 30 percent for the final year that Federal funds are available for this purpose.

The bill also includes specific regulations to see that its purposes are safeguarded. The Secretary will prescribe, after consultation with the Federal Hospital Council, the kinds of community mental health services needed to "provide adequate mental health services for persons residing in a State." Before a State approves an individual plan for a center, it will ascertain that there are provisions in it for persons unable to pay for services but who need them unless this requirement is absolutely not financially feasible.

H.R. 4623 is an attempt to legislate intelligently in terms of certain findings of the President's Panel on Mental Retardation. The two biggest findings were: that of the 5.4 million retarded only 0.4 million will need continual supervision all their life; and that mental re-

tardation definitely has a higher incidence in low income and deprived areas. The implications of these two statements are that, rather than despairing over retardation, we must begin to think in terms of developing limited but potentially productive capabilities and that research must be conducted more intensely than ever into both the medical and sociological causes of retardation.

Specifically, H.R. 4623 authorizes $6 million for fiscal year 1964, $8 million for fiscal year 1965, $6 million for each of the next 2 years, and $4 million for fiscal year 1968 for the construction of research centers. The money will go to public and nonprofit institutions anywhere in the country with an acceptable plan. The Federal share may never exceed 75 percent of the costs.

Title II authorizes "such sums as Congress may determine" during 5 fiscal years, beginning with fiscal year 1965, for the construction of treatment facilities. Once again, the money will be allocated to the States on the basis of population, the extent of need for facilities, and the financial need of the State. The Federal share cannot exceed 75 percent of the costs.

The important feature of this title is that $5 million in the first fiscal year and $10 million in the next 4 fiscal years must go to facilities associated with college or university hospitals or other appropriate parts of the college or university. This provision will keep the treatment and research aspects of the problem in close contact and also will facilitate training of more personnel in this specialty.

It is hard for me to believe that there can be really justifiable reasons for opposing these bills. They are good bills; and they will, at least, start us on the way to seting up a national program of which we can be proud, rather than ashamed as we have been in the past.

I unqualifiedly urge their passage this year.

Mr. ROBERTS. Are there any questions? If not, we thank you for your appearance and testimony, Mr. Boland.

Mr. BOLAND. Thank you, Mr. Chairman.

Mr. ROBERTS. Mr. Arlie Adams, chief, State Department of Public Welfare, Pennsylvania Department of Health, Harrisburg, Pa.

The Chair does not want to foreclose anyone from testifying or from asking questions, but I would like you to bear in mind that I have eight witnesses, many of whom are from outside of Washington, who have schedules to make to get back home. I would appreciate any brevity on the part of the witnesses or questions.

STATEMENT OF ARLIE ADAMS, CHIEF, STATE DEPARTMENT OF PUBLIC WELFARE, PENNSYLVANIA DEPARTMENT OF HEALTH, HARRISBURG, PA.

Mr. ADAMS. Thank you, Mr. Chairman.

My name is Arlie Adams. I am secretary of welfare of the Commonwealth of Pennsylvania.

I consider it a privilege to be here.

I think I should say at the outset the Department of Public Welfare in Pennsylvania includes the activities devoted to the mentally ill and the mentally retarded.

In line with the chairman's suggestion, I think I would say that I subscribe to the statement which was presented by the previous speaker.

I don't think there is any doubt, as Chairman Harris has already remarked himself, about the need of the program, and I am not going to burden the record.

We are wholeheartedly in favor of the legislation which is now being considered. We think there is a great need in all the areas covered by the legislation.

Mr. ROBERTS. Mr. Adams, when were you appointed to your present position?

Mr. ADAMS. Appointed in December of 1962 and confirmed in January.

Mr. ROBERTS. You took office with Governor Scranton?

Mr. ADAMS. Yes, sir.

Mr. ROBERTS. Do you believe that there is support for this new approach that would be made under S. 1576 and the other House bills which have been before the committee?

Mr. ADAMS. I do, indeed.

Mr. ROBERTS. Do you believe that such a program entered into jointly by the States and Federal Government can do a much better job than is being done under the present approach of mental health and the mentally retarded?

Mr. ADAMS. I do. We have considered this matter very carefully in Pennsylvania. We have agreed that great progress could be made under this program.

Mr. ROBERTS. How much is the State of Pennsylvania spending per annum in its programs for the mentally retarded and for the mentally ill?

Mr. ADAMS. The combined programs would come to about $120 million a year.

Mr. ROBERTS. How many State institutions do you have at the present time?

Mr. ADAMS. Covering both the mentally ill and the mentally retarded, there are about 31 at the present time. I say about because we are right in the process of opening two and I am not positive whether that second one has been opened. The other one was opened about a month ago.

Mr. ROBERTS. Now, are these scattered over the State or are they concentrated in areas of greatest population?

Mr. ADAMS. They are still scattered over the State.

Mr. ROBERTS. Now, are you speaking in your capacity as Chief, or do you speak for the Governor, also?

Mr. ADAMS. The Governor has asked me to appear here. He knows that I am here and he knows my views and he subscribes to them, sir.

Mr. ROBERTS. Thank you very much.

We certainly appreciate your comments, Mr. Adams.

Mr. NELSEN. No questions.

Mr. ROBERT. Mr. Rogers?

Mr. ROGERS of Florida. Just two or three quick ones, Mr. Chairman.

Are most of your facilities custodial in nature or are they more of an outpatient clinic type?

Mr. ADAMS. The overwhelming portion of the State facilities are custodial in nature. We have very limited outpatient facilities in this field.

Mr. ROGERS of Florida. How about the new facilities that you are building?

Mr. ADAMS. The new facilities go more in the direction of outpatient facilities.

Mr. ROGERS of Florida. How many psychiatrists are employed in the State, approximately?

Mr. ADAMS. They go into the hundreds and, unfortunately, you cannot just take the number because many of these people are on a part-time basis.

Mr. ROGERS of Florida. Do you use private physicians and psychiatrists in your State program?

Mr. ADAMS. Yes. We find that is necessary; otherwise, we could not staff the institution.

Mr. ROGERS of Florida. Do they have the right of bringing in their own private patients into the State facilities?

Mr. ADAMS. No. We do not permit them to bring their private patients into the facilities, but if they are on a part-time basis, they can bring their private patients into their own offices.

Mr. ROGERS of Florida. You pay them directly from State funds?

Mr. ADAMS. Pay them just for what they do for the State from State funds; yes, sir.

Mr. ROGERS of Florida. What is the hospital population?

Mr. ADAMS. Are you talking about the mentally retarded or mentally ill?

Mr. ROGERS of Florida. Both.

Mr. ADAMS. About 40,000.

Mr. ROGERS of Florida. How many psychiatrists do you have in training in your State?

Mr. ADAMS. Are you talking about in the State institutions or throughout the State?

Mr. ROGERS of Florida. Throughout your State.

Mr. ADAMS. It would go into the hundreds because we have a large number of medical schools in the State of Pennsylvania.

Mr. ROGERS of Florida. Would you let us have those figures, please?

Mr. ADAMS. I would be glad to, sir.

Mr. ROGERS of Florida. How many do you anticipate recruiting for your State program in Pennsylvania?

Mr. ADAMS. Well, we are trying very hard to induce more and more of the medical students to go into the field of psychiatry.

Mr. ROGERS of Florida. I just wanted the number that you try to get each year.

Mr. ADAMS. Well, as many as we can, because we have such a limited success.

Mr. ROGERS of Florida. What do you pay your psychiatrists as they graduate from school? What would be your starting salary?

Mr. ADAMS. The starting salary for a psychiatrist right out of a medical school, so to speak, with some of his internship and residency completed is about $12,000 a year.

Mr. ROGERS of Florida. What is the top salary?

Mr. ADAMS. Well, the commissioner of mental health gets $25,000 a year in Pennsylvania and his bureau chiefs are now receiving a little more than $21,000 a year.

Mr. ROGERS of Florida. I was thinking of your practicing psychiatrists.

Mr. ADAMS. The superintendents at the institutions range between about $16,000 and $20,000, depending upon their responsibilities, and I would say that the active psychiatrists at the institutions below the superintendent level are averaging $14,000 and $17,000 per year.

Mr. ROGERS of Florida. Do you feel that your State could participate in this program as outlined in the provisions of this bill?

Mr. ADAMS. Yes; very actively, sir.

Mr. ROGERS of Florida. You have sufficient funds to match those grants?

Mr. ADAMS. Yes, sir.

Mr. ROGERS of Florida. Thank you, Mr. Chairman.

Mr. ROBERTS. Mr. Brotzman.

Mr. BROTZMAN. Mr. Adams, title III is listed in the training of teachers of mentally retarded and other handicapped children.

My question: Have you institutions of higher learning in your State that are specifically adapted and qualified to give instructions in these particular areas?

Mr. ADAMS. I believe that both the University of Pennsylvania Medical School and the University of Pittsburgh Medical School, which is closely related to our Western Psychiatric Institute, are prepared to do this type of teaching.

Mr. BROTZMAN. You say you believe?

Mr. ADAMS. Yes, sir.

Mr. BROTZMAN. Your testimony is "Yes"; right?

Mr. ADAMS. Right; yes.

Mr. BROTZMAN. Just to get to the point quickly: An individual, for example, giving instruction to the deaf, that would not be a psychiatrist; you would not have a psychiatrist. What kind of a degree would a person have that is particularly qualified in this area to instruct the deaf?

Mr. ADAMS. No. I agree with you it would not necessarily have to be a psychiatrist. It could be someone with an M.D. degree, a Ph. degree in psychology. There are a number of disciplines that could be utilized in giving that type of instruction.

Mr. BROTZMAN. I think that there are two problems, the detection and the knowledge of the fact that a child is hard of hearing and then probably speech therapy or training; is that correct?

Mr. ADAMS. That is correct.

Mr. BROTZMAN. I have no further questions.

Mr. ROBERTS. Thank you very much, Mr. Adams.

Mr. ADAMS. Thank you, Mr. Chairman.

Mr. ROBERTS. The next witness will be Dr. John H. Venable, director of the Georgia Department of Public Health, Atlanta, Ga., accompanied by the director of the Division of Mental Health.

STATEMENT OF DR. JOHN H. VENABLE, DIRECTOR, STATE OF GEORGIA DEPARTMENT OF PUBLIC HEALTH; ACCOMPANIED BY DR. ADDISON M. DUVAL, DIRECTOR, DIVISION OF MENTAL HEALTH

Dr. VENABLE. Mr. Chairman, I am Dr. Venable, and this is Dr. Duval.

We have prepared statements that are very brief, if you would like to have us present them.

Mr. ROBERTS. You may proceed as you wish.

Dr. DUVAL. Mr. Chairman, my name is Addison M. Duval. I am a physician, a psychiatrist, and a mental health administrator. My entire professional career has been in public service—first for 30 years at St. Elizabeths Hospital in the Department of Health, Education, and Welfare, and then in Missouri, in Virginia, and in Georgia since March 1, 1963.

As director of the Division of Mental Health of the Georgia Department of Public Health, I am pleased to appear before you in support of S. 1576 and to speak specifically to title III relating to training of teachers of mentally retarded and other handicapped children.

During the past several years in Georgia, much improvement has been made in our program both for the mentally ill and the mentally retarded. Our large State hospital at Milledgeville has been transformed from a custodial to a treatment hospital and our Gracewood School and Hospital for the mentally retarded in Augusta ranks among the best in the Nation.

Our program for the treatment of indigent mentally disabled citizens in psychiatric units of community hospitals has attracted national interest. This experience of treating patients early in their illness and in community hospitals near their homes has been so successful that we are even more encouraged in our efforts to develop added mental health services, such as day hospitals, night hospitals, outpatient clinics, and consultation to local agencies which would then comprise our concept of a community mental health center.

We hope eventually to bring all local health services together, including mental, physical and environmental, into one health program, thus reaching our concept of a unified community health center. We believe we have a better chance of reaching this goal because Georgia is one of the few States in the Nation having all State health functions located in one department of health with close cooperation with all local health services at the county level through the utilization of district health directors.

Even though Georgia has made good progress in improving mental health programs in the past few years, much remains to be accomplished. To furnish a sound basis for future improvement, we will in the next 2 years plan a long-range mental health program utilizing all the knowledge and resources at our command. We will include the fields of treatment, rehabilitation, education and training, and research for mental illness, mental retardation, alcoholism, and drug addiction.

This blueprint for the future will include a built-in flexibility for adaptation, change, or altered direction as dictated by advancing knowledge, available manpower or financial capability.

By the time our comprehensive program plan is completed we will also have completed our new State-owned Georgia Mental Health Institute now under construction in Atlanta. This facility—provided at a cost of $12 million—will add an important dimension in research and education to Georgia's efforts to combat mental disability and to promote better mental health for all citizens of the State.

In our expanding efforts to reach our goals in mental health, we look forward hopefully to the enactment by the Congress of S. 1576. This proposal, if brought to fruition, would give Georgia some much

needed financial support and without doubt would enable us to move forward more quickly and expeditiously than would be possible otherwise.

In this general context, Mr. Chairman, I would like to speak specifically to title III relating to the training of teachers of mentally retarded and other handicapped children.

In Georgia we have improved our one hospital and school for the mentally retarded and plans are now proceeding for building a second institution which will help us expand our services and thus reduce our present waiting list of children to be admitted. This waiting list now is over 1,300 children.

We believe there will always be some mentally retarded children who will have to be cared for in institutions. We also believe many children now in institutions need not have been admitted if we could have developed helping services to these children and their families in their own community. Such help should include special education and training provided by specially trained teachers.

In Georgia, there is a unity of concept and a fine spirit of cooperation between the department of eduation (including vocational rehabilitation) and the department of health as to the needs of these handicapped children. We agree that each handicapped child is entitled to the State's best efforts to assist him in the development of his limited mental and physical capacities to their highest potential.

At present we are rapidly expanding our educational efforts for these children both at the institutional and at the community level as our capabilities permit. However, we are seriously handicapped by the lack of teachers who have the special knowledge, skills, and experience to do this special job. In this very necessary endeavor to provide assistance to these mentally retarded or otherwise health impaired children so that they may become wholly or partially self-supporting and better integrated individuals, it would seem logical that the Federal Government should also assist the States financially in its solution. This is, of course, but one facet in a broader program (1) to treat what can be treated while preventing extended disability therefrom, (2) to prevent the development of mental disability in the first place, and (3) to promote good mental health through maximum development of personal capabilities and resources.

However, it is an important and necessary facet which might be overlooked in our enthusiasm about the newer and possibly more exciting developments in the areas of therapy and prevention of disease and disability. For this reason, I hope you will not overlook the importance of title III as it does very seriously affect our total mental health efforts.

Thank you, Mr. Chairman, for your patience and for your courtesy. We believe that Georgia will develop a very fine mental health program in the years ahead. Your help and assistance to us in these efforts are deeply appreciated.

Mr. ROBERTS. Thank you very much, Doctor.

I believe you said you had been in this field for a period of about 31 years, first at St. Elizabeths and then in Missouri and Virginia.

Dr. DUVAL. Now Georgia.

Mr. ROBERTS. So you have a very fine understanding of this problem.

Is it your feeling that teaching of handicapped children and exceptional children and disturbed and mentally retarded is as much a matter of using therapy as it is and the training should be guided along those lines as much as in the educational field?

Dr. DUVAL. Yes, sir.

Mr. ROBERTS. In other words, would you say that it is as much of the health problem or more so than it is the educational problem?

Dr. DUVAL. I think it is both, sir. I don't know whether you could really say that one is more important than the other. I think both are necessary and that this should be expressed through a combination of work, both at the therapy level and at the educational level with these children.

Mr. ROBERTS. How many children do we have in this country of ours, about how many, do you know, do you have any figures that come to your mind—about how many mentally retarded children do we have?

Dr. VENABLE. Mr. Chairman, I relate to this in my statement. Perhaps you would like for me to make mine and then question both of us.

Mr. ROBERTS. That will be fine. Go ahead.

Dr. VENABLE. My name is John H. Venable, and I am director of the Georgia Department of Public Health.

I hold degrees in medicine and public health and am a diplomate of the American Board of Preventive Medicine.

After early experience in medical education, I have served as local health officer in Georgia, in various capacities in the State health department, and since January 1, 1960, have been director of the department.

As Dr. Duval has told you, the general content, philosophy, and objectives of S. 1576 are in complete accord with the thinking and planning that has been and is being done in Georgia. While the major part of our responsibility relates to other titles of S. 1576 than title III, we are also seriously concerned about needs which will be met by enactment of this title.

There has developed in Georgia an ideal relationship between the Georgia Department of Public Health, the special education and rehabilitation divisions of the State department of education, and there is developing the same sort of relationship with the new (July 1, 1963) division of children and youth of our department of family and children services (formerly the welfare department) inasmuch as I serve ex officio as a board member of this division.

The total emphasis in Georgia is swinging, as it should, from case-finding, domiciliary, and medical care to training, education, and rehabilitation of handicapped children and adults whether that handicap be physical, mental, or mental retardation.

As we project our programs as described by Dr. Duval, over the next 5 years, we see the acute need of not only employing more trained teachers for the mentally retarded and the children who are mentally ill and under our care but almost a greater need for improving through short courses and specialized work the competencies of the teachers already employed. Unless this is done, we will tend more toward the warehousing of such individuals than toward their rehabilitation.

The division of special education in our State department of education is now supporting through local school systems 500 teachers in

special education classrooms attended by 12,343 children. I understand in the fiscal year just begun they have funds for the addition of 75 additional teachers but the 12,000 children now receiving such attention form only slightly more than 10 percent of the estimated number in Georgia who need such attention.

The unmet needs of the remaining 91,000 are of tremendous concern. The recruitment situation is such that of the totals already employed many are only minimumly qualified and require opportunity for upgrading their competencies.

It might be well to point out to you here that the cooperation between health and education extends to the local level where some member of the local health department serves in an advisory capacity to the school system operating one of these specialized classrooms. With the development of more comprehensive community health centers as described by Dr. Duval, this relationship between health and education at the local level will be even more effective.

I have already pointed out that Georgia's increment has already financed for this fiscal year an additional 75 teachers. If funds are appropriated as title III proposes, I estimate that Georgia's share of these training funds would provide approximately this number each year for the next 3 years so that from our State alone I would consider the proposed amounts only barely adequate inasmuch as we hope and expect to accelerate our rate of increase.

Furthermore, there are three universities in Georgia which provide teacher-training programs for the area of exceptional children. Without going into details, I will simply say the capacities of these 3 universities within the State are more than adequate to graduate annually numbers in excess of 75. Vacancies in these programs now exist and as the programs expand as already planned there will be, of course, additional vacancies.

In summarizing, Mr. Congressman, let me say there is a crying need in our State for training teachers adequately in adequate numbers which can be obtained only with additional Federal assistance, that every indication is that Georgia will have the funds and the administrative requirements for employing more teachers than can be trained with presently proposed Federal authorization and, finally, that until the States of this Nation can move strongly toward training and education of mentally handicapped children, we will not be meeting our responsibility.

Thank you very much.

If I may, I have a brief statement from our Governor who could not be here today because of other commitments, that he has signed and authorized me to read, if you would like to hear it, Mr. Chairman.

Mr. ROBERTS. We would be glad to have it.

Dr. VENABLE (reading):

STATE OF GEORGIA,
EXECUTIVE DEPARTMENT,
Atlanta, July 10, 1963.

HON. KENNETH A. ROBERTS,
Chairman, Subcommittee on Health and Safety, Committee on Interstate and and Foreign Commerce, House of Representatives, Washington, D.C.

DEAR CONGRESSMAN ROBERTS: I am sorry that pressure of other business prevents my appearance before your subcommittee today but I am happy to make this statement which I hope you will permit Dr. Venable to present for me to the committee.

As Dr. Duval and Dr. Venable have indicated to you there is a great need in Georgia for the improvement of care for the mentally handicapped child although Georgia has made great progress in this direction in the last few years.

It is essential that any further development of our program emphasize more and more the training, education and rehabilitation aspects of our program in order to bring these handicapped children to the optimum level of health and productivity.

Data have been presented to you indicating the gap which exists between what we are doing and what we want to do. You have ben told how effectively we might make use of additional trained personnel in the education of our handicapped.

I wish to say to you as Governor that this administration is enthusiastically behind the developments that are occurring in Georgia and that it will support to the greatest extent possible the abilities of its several departments to utilize trained people in larger and larger numbers. I support the provisions included in S. 1576 including those of title III.

Thank you and the committee very much for having this statement read.

Sincerely,

CARL E. SANDERS, *Governor.*

Mr. ROBERTS. I have some questions, but in the interest of time I am going to pass any questions I might have.

Mr. NELSEN. Just one question. We enlarged on the question that the chairman of the subcommittee asked relative to the title II in dealing with the mentally retarded and mentally disturbed patients and the training and teaching there; to teach the multiplication tables and how to write and how to spell is almost infinitesimal as compared to the therapeutic approach, is it not?

It is quite a different field when you deal with the mentally retarded and the mentally disturbed patient; it is more psychological than it is educational, is it not?

Dr. DUVAL. Yes; I think you could say that, sir.

What we try to do is figure out what is the potential for development of each individual child, going back and studying his basic potential for such development. This has to be planned on the basis of each individual child's basic capabilities so we have different goals in education for each one of these children. We have in Gracewood over 600 children who cannot feed themselves for instance. A matter of training of these children, if we could just train the 600 to actually feed themselves, look how much further ahead we would be.

Now, other children have additional capabilities from this. These capabilities range all the way up from the very severely retarded child to the very mildly retarded child.

What we try to do is prepare a program that fits each child and to help them reach their capability.

Mr. NELSEN. My purpose in asking the question: There are those who argue here that education is education but in this field it is a quite different situation. That is the point I wish to develop and I think your statement very clearly indicates that there is a great difference and I thank you.

Dr. DUVAL. Maybe we could call this therapeutic education.

Mr. NELSEN. I see. Thank you very much. No more questions.

Mr. ROBERTS. Mr. Brotzman.

Mr. BROTZMAN. I want to congratulate you on what seems to be a fine program. I have one question.

I would assume that your program for mentally handicapped is applied without regard for the race, creed, color or national origin of the child; is that correct?

Dr. DUVAL. Yes, sir; this is what we are attempting.

Mr. BROTZMAN. So that everyone gets the same treatment without regard to these other factors?

Dr. DUVAL. Yes, sir.

We have, for instance, in Gracewood facilities for Negro children there and we actually in our infirmary are moving both Negro and white children right into the same facility. This, we hope, will be a gradual but successful move.

Dr. VENABLE. I might also point out they share in the deficiencies we have.

Mr. BROTZMAN. Thank you very much.

Mr. ROBERTS. Thank you, gentlemen.

Our next witness will be Dr. Gunnar Dybwad, executive director of the National Association for Retarded Children, Inc., New York, N.Y.

STATEMENT OF DR. GUNNAR DYBWAD, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION FOR RETARDED CHILDREN, INC., NEW YORK, N.Y.

Dr. DYBWAD. Mr. Chairman, it is a distinct privilege to appear before this distinguished committee on behalf of the National Association for Retarded Children and its more than 1,000 member associations throughout the country.

Since in March we already had an opportunity to present to your committee our views with regard to H.R. 3689, now incorporated in S. 1576 under title I, we may be merely reiterating our general endorsement of the provisions of this title.

Research in mental retardation has been neglected for decades. The creation of this part A of title I will give us physical facilities so urgently needed in this field where biological, medical, social and behavioral efforts must merge in order to deal effectively with the complex problems of prevention and amelioration.

The long neglect of mental retardation has resulted in a dearth of good clinical training facilities for staff and hence we want to reiterate to you the great importance of the project grants for construction of university affiliate facilities for the mentally retarded.

We need to train specialists in mental retardation. This cannot be done adequately in facilities geared to the treatment of the mentally ill.

Part B of title I will give us a beginning program.

Finally, the grants for construction of facilities for the mentally retarded covered in part C of title I will allow us to provide facilities to demonstrate and further develop the outstanding progress being made now in the training, treatment and amelioration of even the most severely retarded.

May I now make two specific points?

First, staffing should not just be provided under title II for mental health facilities. There is from every point of view just as urgent a need for assistance with the staffing of the mental retardation facilities envisioned under title I.

Secondly, in view of the very limited amount of funds that actually will be available to the States under title I, we wish to reiterate from our previous testimony rendered before this committee, the recom-

mendations in section 401 in line 9 of page 38, and this is the original bill, the words "custodial care" be stricken and the term "residential day care" be substituted. Custodial care has been recognized as a wasteful and inefficient type of care, and, unfortunately, still prevails in some of our outdated, overcrowded institutions.

Surely, none of the precious money available under this bill should be used for such an outmoded purpose.

We are deeply grateful for the leadership Congress has so often given in the field of mental retardation and in this spirit we urge this committee to eliminate the phrase "custodial care" which is offensive to all the membership as a relic from an unfortunate past.

Let me now turn to section 3. This title demands in a very significant way the provision of the Public Law 8696, under which provision we have already trained more than 200 specialists in the education of the mentally retarded with the existing appropriation of a million dollars.

These new amendments first extend to the law an inclusion of speech correctionists, therapists, and research workers, along with teachers, supervisors, and teacher educators. In view of the desperate shortage of these highly specialized therapists and correctionists in the special field of education, this broad edge of the law is welcome, indeed.

Secondly, the amendment of bill 8696 provided in section A of title III is welcome in another respect. It provides financial assistance for training of personnel in all areas of handicap. As early as 1959, I testified before a subcommittee of the House Education and Labor Committee that the National Association for Retarded Children recognized the urgent need for strengthening special education services for 12½ percent of our school population who, by reasons of blindness, deafness, speech defects, mental retardation, and emotional problems and social problems and other childhood disabilities, require special attention.

If I may interpolate here, Mr. Brotzman, as one who has worked for quite a few years in institutions for the delinquent child, I know personally of the need for specially trained teachers who deal with what is referred to as the social maladjustment problems of the delinquent child. We do have in this country in these facilities need for specially trained teachers.

In addition, there are fewer of our large cities such as New York who have special schools specifically for these children, not the emotionally disturbed child, but the child with social maladjustment problems who is not in need of psychiatric treatment so much as this particular educational approach.

As we pointed out then, what helps all exceptional children helps all mentally retarded. A lag in even this will affect the others.

Therefore, the National Association for Retarded Children allows the appropriation in section 7 of $45 million over a 3-year period, 1964 to 1966, for this purpose as a realistic start toward meeting the critical personnel shortages in this field.

In addition, we strongly endorse section 302 of title III which provides specific earmarked funds for demonstration projects related to the education of handicapped children.

Under the Cooperative Rehabilitation Act, limited funds made available for research in the educational field are not to be swallowed

up by the demands of general education. The National Association for Retarded Children recognizes the question of earmarking funds; still, in this instance, we deem it vital to the execution of congressional intent unless we get research funds which go specifically to the problems of, as somebody said quite correctly, therapeutic or, as we usually say, special education. This field, we know from experience, will be neglected.

The $6 million earmarked for research and demonstration in fiscal years 1964–66 is most useful when looked upon as a start in this important area.

Since the funds provided for this purpose in title III are limited, we hope that the centers for research and mental retardation provided for in title I will include educational research within the purview. In turn, we can expect that some of the personnel trained under the provisions of title II will be available for the staffing of mental retardation research centers.

In other words, we see a very definite cross connection between title I and title III of this bill.

Thank you, Mr. Chairman, for extending to me the opportunity of presenting very briefly the views of the National Association of Retarded Children on this vitally needed legislation.

Mr. ROBERTS. Thank you, Doctor.

It is a pleasure to have you.

How many State associations do you have?

Dr. DYBWAD. There are 1,000 associations. The only State where we do not have a State association is Alaska, but, otherwise, we have 1,000 associations throughout the country.

Mr. ROBERTS. Do you take the position that title II is just as necessary for the training of the mentally retarded children, the teachers of those children and the training, and certain therapeutic techniques is just as important as it would be in the education?

Dr. DYBWAD. Very definitely.

You see, so many of the severely retarded children have problems of deafness; they have visual defects; they are severely crippled; they have other severe health problems. This is the reason why the classes for these youngsters are small, because the teachers, besides their teaching assignment, have to, of necessity, consider the physical problems of these children.

So, while it is an educational process, it is an educational process which moves along, you might almost say, clinical lines with a far more individualized attention to each child's specific needs because besides being retarded he has some other needs which often make the mere seating of the child in the classroom a problem. He may need special equipment merely to be able to sit upright at a table and from this viewpoint this is, of course, as much a clinical as an educational process.

Mr. ROBERTS. I suppose, too, you have many special problems with the deaf and the blind. You find, I suppose, in most instances that most of the children are quite sensitive when they come to the school; there is a period of adaptation and adjustment that must take place in getting acquainted with the teacher, with the grounds and with the accommodations; it is a problem.

Dr. DYBWAD. Definitely, because, along with the physical facility of a class for the severely retarded children, it has to be considered in terms almost of hospital construction. You have to avoid steps; you have to have special seating facilities; you have to have special facilities in terms of toilets and so on because these children are so often physically handicapped.

So, it is a special problem.

Mr. ROBERTS. Thank you very much.

Any questions?

Mr. NELSEN. No questions.

Mr. ROBERTS. Mr. Brotzman.

Mr. BROTZMAN. Just one.

Since you have kindly volunteered a little information on this term "socially maladjusted," define for me what a socially maladjusted child is.

Dr. DYBWAD. I would define this, Mr. Brotzman, within the provisions of this bill which deals with title III with special education. The special educator would speak of special education for the socially maladjusted child or one whose behavior is so complicated that he does not fit into a normal classroom procedure.

Certainly, we have in every classroom in this country where there are 40 children one or more you might call as having emotional problems or having some social maladjustment. We are talking here about special education, about children where this behavior is so severe that it actually interferes with their ability to sit from 8:30 to 11:45 in a classroom, fitting into a group of 30, 40 children.

Therefore, in many of our school systems, we have special classes for these youngsters so it really has to be understood here in the context of special education. It is a child so severely maladjusted socially that he does not fit into the normal classroom procedure and has to be educated, trained in special facilities with smaller classes, with a somewhat different curriculum, often with a greater emphasis on physical activity and the like.

Mr. BROTZMAN. Now let me ask you this question: Is this child that you are alluding to emotionally disturbed?

Dr. DYBWAD. Not necessarily, because if this child comes from a thoroughly deteriorated neighborhood he is well adjusted to his neighborhood; he has no inner personal conflicts; he behaves like his father, mother, brothers do, and he is not conflicted as another socially maladjusted child might be who comes from a family where his conduct is in conflict with that of the other members of the family and an outgrowth of emotional disturbance.

As a matter of fact, we spoke in our training school, where I spent 6 years in Warwick, N.Y., of the social type. These were not necessarily antisocial youngsters; they just lived outside of what you and I call our society, following rules of behavior with some of their own and so they were not emotionally disturbed. They were merely living at best with themselves from their family but not at best with the rest of society.

This is a quite different picture from the youngster who gets into delinquency because he has been subjected to emotional strain at home.

It is the kind of youngster who one day told me—he was a youngster from a deteriorated neighborhood in Brooklyn, and he was working

in our institution in the disposal plant, which was a good place isolated from the rest—to put some of these aggressive youngsters who behave perfectly well; they didn't get in trouble in training school; they didn't have temper outbursts or anything; they knew they had to serve time so they worked there.

A little bit outside the institution they caught rabbits from time to time and would roast them on the coal shovel, you know, and have a little special feast. One day I asked him, "Do you ever catch pheasants?"

This boy looked me straight in the face and says, "Pheasants? No; you can't catch pheasants. Pheasants are smart. They know right from wrong."

I puzzled over this until I finally found out that for this boy right was getting away with things and wrong was being caught, and all he was trying to tell me was pheasants were too smart to get caught. This was his philosophy.

In an institution a perfectly well adjusted boy; in a community a problem to police and society but not emotionally adjusted. The psychiatrist could have him on the couch until Doom's Day and nothing would happen.

Mr. BROTZMAN. One more question. Just a quick answer to this because I know everybody is pressing to get to various places at this time.

Is there a special course of training for a teacher to teach this boy?

Dr. DYBWAD. We have developed in this country over the past 20 years, I think Dr. Fritz Wraddle was one of the first pioneers in this, a definite content of feeling with these youngsters and we have at various institutions of higher learning courses—I know, for instance, from my Michigan experience teaching teachers how to deal with this type of youngster; yes, sir. We definitely do.

Mr. BROTZMAN. Thank you

Mr. ROBERTS. Thank you very much, Doctor.

Our next witness will be George T. Pratt, chairman, Committee on Legislation.

I am advised that Dr. Lowell would also like to appear with Mr. Pratt; is that correct?

If you gentlemen would like to come around, we will make seats available for you.

Just for the record, this is Mr. George T. Pratt; Dr. Edward L. Lowell, administrator of the John Tracy Clinic, Los Angeles; Dr. S. Richard Silverman, director, Central Institute for the Deaf, St. Louis.

Glad to have you gentlemen.

STATEMENT OF HON. SILVIO O. CONTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MASSACHUSETTS

Mr. CONTE. It is a great pleasure for me to make a brief apperance before this distinguished subcommittee headed by the gentleman from Alabama, Mr. Roberts.

By way of preface, I would like to make a few brief remarks relative to the legislation that has brought a number of distinguished gentlemen here to testify.

While I have always been an active supporter of programs in the area of mental and public health, I had a unique experience recently which solidified my position to an even greater extent.

I refer to a commencement address that I delivered last month at the Clarke School for the Deaf in Northampton, Mass., an important city within my congressional district. Few experiences have moved me more, Mr. Chairman, than the short speeches made by the members of that graduating class.

I sat on the platform and was overwhelmed with the courage these students demonstrated. Their desire to succeed in life through normal communication procedures was without parallel. Here were young, otherwise healthy boys and girls who were—with supreme confidence—addressing a large gathering of friends and parents on graduation day.

One of the reasons, Mr. Chairman, for their confidence was undoubtedly due, in good measure, to the high quality of teachers present at that famous institution at Northampton which received great impetus in its early days from Alexander Graham Bell.

It is imperative, Mr. Chairman, that we continue to receive the necessary number and increase the quality of teachers of mentally retarded and other handicapped children.

I have given a close reading to the report by the distinguished gentleman from Alabama of the other body, Mr. Hill, and feel that there is a definite need for the favorable reporting of S. 1576.

I am particularly anxious for the eventual enactment of title III of this legislation, which will provide grants to institutions of higher learning for the training of (*a*) personnel who can, in turn, train teachers of mentally retarded and other handicapped children; (*b*) teachers of such children; and (*c*) other specialists and research personnel work in this area. It would also provide necessary grants for research and demonstration projects related to the education of handicapped children.

This said, Mr. Chairman, I would now like to introduce one of the Nation's outstanding specialists in the field of handicapped, and, specifically, deaf children. He is the principal of the Clarke School for the Deaf in Northampton and a man for whom there is widespread respect and admiration.

It is a great privilege for me to present Mr. George T. Pratt.

Mr. HARRIS. Before Dr. Pratt proceeds, let me say to our distinguished colleague that we are glad to have you appear before us on this legislation. We welcome your interest in this program and the fine, precise statements that you have made in justification for it.

We have already had extensive hearings on the program but in view of the other issues which the gentleman referred to regarding title III and some other things that came up, we decided to hold these supplemental hearings.

I think the suggestion has been well justified thus far, Mr. Chairman, during these 2 days. I believe it has strengthened the record. I think it has given some of us further insight as to the need, even though I think the record was ample beforehand.

I will join the chairman and the other members of the committee in welcoming our colleague here in support of this legislation.

Mr. CONTE. Thank you, Mr. Chairman.

Again, I repeat, it was a distinct pleasure and privilege for me to appear before this distinguished body with the opportunity to present my case before the distinguished chairman.

Mr. ROBERTS. I would like to add to what our distinguished chairman has said, the distinguished chairman from Massachusetts.

It is my pleasure to be associated with him on a rather mean job. We serve on the committee of objectors, we object to Congressmen's bills, of all things, and I have also felt him to be very dedicated and very sincere in his work. He is a good, objectionable Congressman. [Laughter.]

Mr. HARRIS. While on the one hand you might disappoint a few members with your objection, from my observation and experience here, you do a tremendous job, Mr. Chairman, in your role as an objector when you let our bills go through. [Laughter.]

Mr. ROBERTS. All right. Mr. Pratt.

Mr. BROTZMAN. I, too, would like to welcome our distinguished colleague. I had an opportunity to do this informally a moment ago. I think his remarks are certainly most beneficial to the members of the subcommittee. I also would like to thank him for a very able introduction of the distinguished gentlemen who now appear before the subcommittee.

STATEMENTS OF GEORGE T. PRATT, CHAIRMAN, COMMITTEE ON LEGISLATION, COUNCIL ON EDUCATION OF THE DEAF, THE CLARKE SCHOOL FOR THE DEAF, NORTHAMPTON, MASS.; DR. EDGAR L. LOWELL, ADMINISTRATOR, JOHN TRACY CLINIC, LOS ANGELES, CALIF.; AND DR. S. RICHARD SILVERMAN, DIRECTOR, CENTRAL INSTITUTE FOR THE DEAF, ST. LOUIS, MO.

Mr. PRATT. Mr. Chairman, first of all, I would like to express my appreciation to Congressman Conte for a very gracious and generous introduction.

We think very highly of Congressman Conte and appreciate his taking the time from his busy day to come here for this purpose.

With your permission, we would like to give testimony as a panel so that we may divide the question into several parts. I shall follow the prepared statement which you have. My part of it is to give some statistics with regard to training teachers of the deaf.

Dr. Silverman will talk to the point of the specialized nature of teaching the deaf and the specialized training which teachers require, and Dr. Lowell will speak to the point of research activity.

Mr. ROBERTS. You may proceed as you desire, gentlemen.

Mr. PRATT. Congressman Roberts and members of the subcommittee, thank you for inviting me to appear as a witness in these hearings.

Those of us who are charged with the responsibility of staffing our programs for deaf children are beset with many problems. We stand in support of S. 1576 because we believe that the provisions include in title III will assist us in meeting the manifold concerns facing us daily, largely in the area of specially trained personnel and the search for new information and knowledge.

Adequate provision for the deaf children of our country lies within the fields of both health and education. Basically, the problem is one

of medicine or health since its essence is organic or neurologic. However, until our doctors or research teams are able to come up with a cure or a significant alleviation, we must continue to attempt to make it possible for deaf children to take their places in our society through special education.

We have made great strides over the past 150 years, but much remains to be done. The key to the present situation involves attracting and preparing capable young people to devote their abilities and energy to this special profession.

We have felt that the first and most necessary step was to fill the reservoir of fully qualified classroom teachers of the deaf. From this group is likely to emerge the more able and energetic who will become the leaders, the supervisory personnel, and the best administrative people to advance our profession in the future. The understanding derived from direct, daily contact with deaf children should also provide a substantial background for those who may wish to qualify as clinicians, diagnosticians, psychologists, researchers, guidance counselors, and social workers with the deaf. In short, we believe that we are on stronger ground for the long haul if we attempt to strengthen the profession from the bottom up than from the top down.

Public Law 87–276, passed by the Congress and signed by the President in September 1961, has helped us immeasurably. In its first year of operation, it has increased the number of students in our training centers from 202 to 470, more than doubling the number in addition to raising the caliber of the applicants. At the same time, it has encouraged an increase in the number of training centers from 32 to 47. The following table presents the significant statistics, with the figures for 1962–63 showing the impact of Public Law 87–276:

Teachers in training, January 1963—American Annals of the Deaf

	1952–53	1958–59	1959–60	1960–61	1961–62	1962–63
Number of training centers	20	22	25	31	32	47
Total number of teachers finishing training	93	129	177	231	202	470

Students in training under Public Law 87–276	370
Number of training centers under Public Law 87–276	43

In view of the performance of Public Law 87–276, its impetus for our profession should be extended. S. 1576 provides for that.

Now, the next is a tabulation of the programs offered for hearing- and speech-impaired children in the United States. We have public residential schools, public day schools, public day classes, denominational and private residential schools, denominational and private day classes, and schools and classes for the multiple handicapped who are not only deaf but may also be mentally retarded or emotionally disturbed or have some other problem. Altogether, there are 427 schools and classes for deaf children in the United States.

This year, there is an enrollment of 29,398 in those schools and classes and 4,733 teachers. That is the educational program.

Personnel are also needed in speech and hearing clinics and I have extracted this information from the "American Annals of the Deaf." I believe we have submitted two copies of the "American Annals of the

Deaf" for your information, Mr. Chairman, in case you may wish to refer to them.

There are 206 speech and hearing centers located in colleges and universities across the country. There are 107 speech and hearing centers located in hospitals. There are 39 speech and hearing centers which are private in nature. There are 35 speech and hearing centers located in schools for the deaf. There are 66 speech and hearing centers located in medical schools. All told, there are 453 speech and hearing clinics.

The services which they offer are as follows: Hearing tests, hearing aid selection, otological examination, auditory training, speech training, speech reading, social service, vocational counseling, job placement, social program, services for parents of preschool children, services for deaf and hard-of-hearing adults and services for deaf and hard-of-hearing children.

The types of personnel employed are audiologists, psychiatrists, psychologists, speech pathologists, research assistants, speech therapists, speech clinicians, teachers of the deaf, preschool teachers, diagnosticians, social workers, speech correctionists, research fellows, technicians, and practice students.

Mr. ROBERTS. Page 2 of your written statement will appear in full in the record.

(The document referred to follows:)

PROGRAMS OFFERED FOR HEARING AND SPEECH IMPAIRED CHILDREN IN THE UNITED STATES

1. Educational programs (January 1963 "American Annals of the Deaf," p. 160):

Schools and classes	Number	Enrollment	Teachers
Public residential	70	16,575	2,890
Public day schools	15	2,309	311
Public day classes	267	7,896	1,025
Denominational and private residential schools	16	1,359	142
Denominational and private day classes	46	1,024	179
Schools and classes for the multiple handicapped	13	235	146
Total	427	29,398	4,733

2. Speech and hearing clinics (January 1963 "American Annals of the Deaf," p. 197):

A. Number and location:

Location	*Number*
Colleges and universities	206
Hospitals	107
Private	39
Schools for the deaf	35
Medical schools	66
Total	453

B. Services offered (January 1963 "American Annals of the Deaf," p. 189):

Hearing tests
Hearing aid selection
Otological examination
Auditory training
Speech training
Speech reading
Social service
Vocational counseling
Job placement
Social program
For parents of preschool children
For deaf and hard-of-hearing adults
For deaf and hard-of-hearing children

C. Personnel employed (January 1963 "American Annals of the Deaf," pp. 192-197) : Audiologists, psychiatrists, psychologists, speech pathologists, research assistants, speech therapists, peech clinicians, teachers of the deaf, preschool teachers, diagnosticians, social workers, speech correctionists, research fellows, technicians, practice students.

Mr. PRATT. Next, we move to need, and the national shortage of qualified personnel persists.

In April 1963, the Council on Education of the Deaf conducted a survey to determine the need for qualified teachers of the deaf in schools, classes, and clinics in the United States for the school year beginning September 1963. There were 234 respondents out of a possible 427 schools, classes, and speech and hearing clinics with classes for the deaf. However, because of the nature and size of the schools responding, the figures furnished represent approximately 70 percent of the actual need, as follows:

	70 percent	30 percent	Estimated total
Teachers needed to complete staff for September 1963	675	202	877
Number of replacements employed as of May 1	366	110	476
Number of positions unfilled as of May 1	309	93	402
If trained teachers of the deaf were available, how many positions would be needed to complete staff to meet school or community needs (additional persons only)?	367	110	477
Number of present staff not fully qualified teachers of the deaf	559	168	727

In summary: 1. Even though advances have been made, particularly under the impetus of Public Law 87-276, our profession still suffers from a national shortage of qualified personnel including teachers, teachers of teachers, supervisory personnel, administrative personnel, and special service personnel.

2. Problems related to deafness, and the provision of necessary services for deaf children, need to be approached from the fields of medicine, health, and education.

3. There should be a continuous search for new knowledge and understanding if we are to improve our programs and our methods.

4. All areas of endeavor are seeking to attract and hold the most capable young people in the land. However, we are special in the highest sense of the word. Deaf children are at the mercy of the caliber of personnel we provide them. It is essential that we get our share of the best since the inherent nature of our work demands superb ability, unusual devotion, and dedication over and beyond the call of duty.

5. We urge you to report favorably S. 1576, since title III provides the assistance which could make the difference between noon and twilight for thousands of deaf youngsters. In addition, it is simply the right thing to do.

Thank you, sir.

Mr. ROBERTS. Thank you very much, Mr. Pratt.

Dr. Silverman.

Dr. SILVERMAN. I am S. Richard Silverman. I am director of Central Institute for the Deaf in St. Louis and professor of audiology in the School of Medicine, Washington University, St. Louis.

I am also the president of the Council of the Education of the Deaf and have at one time been the president of the American Speech and

Hearing Association and the Alexander Graham Bell Association for the Deaf.

I am grateful for the opportunity to appear before you in support of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, bill S. 1576.

My colleagues will have informed you of the desperate shortage of properly qualified teachers of deaf children and of children with other handicaps. They also will have made known to you the need for research in the education of handicapped children that seeks new knowledge and new applications of existing knowledge.

The point I want to emphasize is that the need for more teachers is matched in urgency by the need for better teachers. Teaching deaf children is a taxing, difficult task. After all, education consists of communicating ideas, information, and attitudes.

From infancy to early school age, the chief mode of communication for the normal hearing child is auditory. The child hears and learns to talk from what he hears. Furthermore, he not only learns how to communicate; he also learns what to communicate. He acquires language, which is a symbol system for communication.

For a child who does not have the daily experience of listening to language, its acquisition is indeed difficult, if not impossible for some, even with instruction. English, with its multiple meanings, its abstractions and its syntactical complexities, is a tough language to learn. For example, a teacher may teach the verb " to run," by performing the act. But what does the child do with such items of language as "the street runs north and south," "the water is running," "your nose is running," "the man runs his business," "who is running for President?" "the Battle of Bull Run," and so on.

As I said before, the teacher may teach "to run" by performing the act, but how does she teach the verb "to hope"? In other words, the teacher is confronted with the task of communicating language to a child in the absence of the sensory system considered to be essential for its acquisition.

We can prepare better teachers if we take advantage of recently acquired knowledge and experience. A major body of pertinent knowledge consists of techniques for early detection and assessment of hearing loss. It has been said that our rate of learning is greatest from infancy to the age of 6. Public health measures and otologic and audiologic techniques make it possible for us to find children, to diagnose them, and to classify them for education so that the early years when the child is tractable may be properly exploited for educational purposes.

The creation of knowledge, skills and attitudes in future teachers to accomplish this constitutes one of our most significant tasks in the preparation of teachers and, I believe, one of our most promising prospects for a substantial advance in teacher preparation.

Here I digress from my prepared statement to comment on a question that was running through all the discussion this morning, particularly from the committee.

Here we find a coalescence between the medical and the teaching. The teacher must be prepared to exploit the information that flows out of the medical and audiologic assessment.

In our own field, for example, the early medical and audiologic assessment may indicate to a teacher just how much and what kind of hearing a child has that she can exploit. So, divisions between medicine and education at the early age level are quite artificial.

We have to create in our teachers and understanding of this information as I have said before to exploit it for educational objectives.

I return now to my prepared statement.

I turn now to a consideration of the task of the teacher at the other end of the educational experience.

Of growing concern to the Nation in general and to educators, economists, labor and business leaders, criminologists, social workers, and lawmakers, in particular, is the increasing number of young people between the ages of 17 and 22, who enter the labor market without any marketable skills or with skills that, at best, are marginal. The technological revolution that goes on unabated and at a rapidly increasing pace is drastically reducing the employment opportunities for those with marginal or obsolescing skills.

As teachers of children with severe disorders of communication, we cannot ignore this distressing situation, since realism compels us to recognize that in any economy our students may find their economic opportunities limited. The burgeoning technology compounds our problem and underlines our responsibility. The old panacea, "give them vocational training," will no longer do. Vocational training for what?

Educators are faced with the perplexing problem of preparing young people for jobs that at the time of their schooling do not yet exist. And specific vocations for which they are being prepared may cease to exist when the students graduate or after they have been employed for a discouragingly short time.

These are not fanciful and theoretical issues. I come in contact with them almost daily as I talked with young (and some not so young) deaf people, with professional colleagues, and with agencies of the Government, for all of whom the problem is vital and present. Fortunately, Government and private agencies are cognizant of the situation, and solutions are being sought by competent and interested people.

Final and complete solutions are not yet in sight, but one principle, I believe, is becoming increasingly clear. We must equip young people with those fundamental skills that enable them to acquire new skills when the situation demands that they do so. They must be prepared to accommodate to change.

For educators of speech and hearing handicapped children, it means among other things, that we must renew and reinvigorate our effort to minimize the obstacle of inferior communication that may block the path to vocational success. And we must extend the period of time over which we stress such skills as reading, language usage, and mathematics, and not replace them with premature and poorly conceived "vocational training." Our people must learn to learn.

Economic well-being is an essential ingredient of individual and social self-realization. I am convinced that the first steps to its attainment begin as soon as the child's education begins.

Here, again, the connection between the early diagnosis and the task of the teacher is very important to perform. So what happens

at the other end of the scale in terms of these economic problems it seems to me determines what happens by what happens in the beginning.

I consider that S. 1576, with its provisions for support of preparation of professional workers and research, is vital and essential if we are to reduce, and hopefully to eliminate, the economic, social, and psychological dependency of our handicapped citizens. Proper education by well-prepared teachers begun, as soon as hearing loss is discovered, should add to the numbers of those handicapped citizens who are already economically productive and socially useful citizens of our society.

Mr. ROBERTS. Thank you, Dr. Silverman.

Our next witness will be Dr. Edgar L. Lowell, administrator of research, John Tracy Clinic, Los Angeles.

Dr. LOWELL. Thank you, Mr. Chairman.

I am Edgar L. Lowell.

Mr. Chairman, it is a pleasure and a privilege for me to appear before this subcommittee.

As administrator of a clinic which offers its services to families of deaf children throughout the world, and as a research worker in the field of deafness, I want to urge your favorable consideration of title III of S. 1576.

Those of us blessed with good hearing, may not realize what it is like to live in a silent world. One of the saddest things about deafness is that we still, as yet, have very little notion of its causes, the things we can do to prevent it, or after it has occurred, the best way to help the deafened individual, whether through surgery, the use of hearing aids, or special instruction.

Because deafness is not dramatic—it doesn't kill people, and you cannot see it—it has attracted relatively little public attention, and consequently little support for research. Yet, the field is a promising one for research. It was only 10 years ago that Dr. Samuel Rosen's research led to the perfection of stapes surgery which has restored hearing to literally thousands of persons suffering from deafness caused by otosclerosis.

Today, there is heartening progress in research with computers which analyze the activity of the brain in response to sound, and in the development of new audiologic tests which give us a much clearer picture of deafness. There is even some exciting new experimental work in which a miniature hearing aid is buried in the mastoid bone, and electrodes carry the sound directly to the inner ear. But more research is needed.

In 1960, the Vocational Rehabilitation Administration sponsored a national conference to survey research needs in the area of deafness. The summary of that conference is perhaps most remarkable for the way in which it points out the very elementary nature of our reasearch needs in this field. Basic research data is not available to us.

There is much to be done, and it is our conviction that passage of the legislation under consideration will be an important step toward obtaining the information which is necessary to provide better care and treatment of the deaf.

Thank you.

Mr. ROBERTS. I thank you, Dr. Lowell, and all of you gentlemen.

I spent almost 5 years right across from the campus of the Alabama School for the Deaf and Blind. Some of my closest friends there knew the names of the deaf and blind people there and I have also had the greatest respect for them. Some of the things that they have accomplished really amazed me.

I appreciate very much the appearance of you gentlemen here.

The subcommittee has felt from the beginning that title III was a very important part of the Senate bill. We take Senator Hill's bill because it was very conveniently adaptable to the plan, itself.

We are very happy to have you people in the field and I just want to congratulate each one of you on your appearance here and on the fine testimony you have presented to the subcommittee. It will be very helpful.

Any questions?

Mr. NELSEN. No questions.

Mr. PRATT. Thank you, sir.

With your permission, there is a statement addressed to you from Dr. June Miller of the Hearing and Speech Department, University of Kansas Medical Center, Kansas City, Kans.

If you would permit this to go into the record without reading——

Mr. ROBERTS. Without objection, it will be included in the record.

Mr. PRATT. I will just pass it on.

Mr. ROBERTS. Without objection.

(The letter referred to follows:)

UNIVERSITY OF KANSAS MEDICAL CENTER,
DEPARTMENT OF HEARING AND SPEECH,
Kansas City, Kans., July 11, 1963.

Congressman KENNETH ROBERTS,
Chairman of the Subcommittee on Public Health and Safety of the Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

DEAR SIR: I am very pleased to hear of your holding hearings regarding S. 1576 and I am particularly interested in title III, which includes providing training for teachers of the deaf for the classroom and for leadership. I am sorry that I cannot attend the hearing in person because I must meet a summer school teaching schedule.

I am the educational director of the hearing and speech department at the University of Kansas Medical Center in Kansas City and also a member of the department of education on the University of Kansas campus at Lawrence. I speak, not only for myself, but for these two organizations. I am a member of the conference of executives of the American Schools for the Deaf, the Convention of American Instructors of the Deaf, am on the board of directors and secretary of the Alexander Graham Bell Association for the Deaf, a fellow of the American Speech and Hearing Association, member of the Council on Education of the Deaf, and consultant to the Kansas City, Mo., Day School. These organizations strongly recommend the principles of the above-named bill.

The primary responsibility of the University of Kansas Medical Center is teaching in its various disciplines. The dean of the medical school says if we can provide teachers and therapists Kansas communities will provide facilities. Some of these children could be helped by a teacher of the deaf, some by a person who has specialized in audiology, others by the speech pathologist, others by those trained to work with the mentally retarded and the emotionally disturbed, but these trained personnel are not available. We do have a preschool program with 40 children enrolled who are deaf and hard of hearing but we also have a waiting list of children living in the Greater Kansas City area. Those living out of this area have nothing.

The University of Kansas Medical Center has been a part of the teacher training program during the past year and has been granted awards for the coming year. The establishment of the grant-in-aid teacher training program is a

tribute to the vision of those involved in its first consideration and renewal. We are experiencing a change in the total educational pattern of deaf and hard-of-hearing children with earlier detection of the problem, parent education, the change of emphasis in the educational procedures, and more deaf children in high school. This aggravates the teacher shortages which had previously existed as we now have need to be met at both ends of the continum of education of the child, in addition to research, and counseling and guidance programs. Also, there is evidence that a higher caliber student is interested in the field and is realizing the need and potential. We have many applications from students who have been successful in their academic achievements at the undergraduate level to enter our graduate program.

Even with the present help that has been attained, we are not beginning to reach the goal that we have set out for ourselves in providing teachers for the classrooms as well as teachers for clinics and hospitals. There still remains a terrific need. At the present time, I know of some 15 vacancies in the local communities, at the Kansas School for the Deaf, public schools in Wichita and Topeka, as well as the Kansas City, Mo., Day School, the Missouri School for the Deaf, the Kansas City Society for the Hard of Hearing, Mercy Hospital, and Menorah Hospital.

In the medical center setting, because of the advance of medicine, we find that we are working more frequently with children who have multiple handicaps. In this setting, the teacher of the deaf has the opportunity to learn anatomy, physiology of the hearing and speech mechanism, the opportunity to work in clinics with the otologist, pediatrician, neurologist, psychologist, social worker, as well as having the opportunity to observe and do practice teaching in an organized school system. This experience is especially valuable to them as they work with the multiple-handicapped child. This gives the student a much broader background and the opportunity to look into all aspects of the child's problem and in the present age of science this is most important.

One of the major problems facing their field today in addition to the shortage of teachers, is the need for supervisors and college teachers in these areas. It has been estimated that there are approximately 60 persons in the United States who have doctoral degrees and a background in education of the deaf. The majority of these people are now working in hospitals and clinics as audiologists rather than in teaching at the university level. We need both types of people. We have been looking for an additional person with a doctor's degree to join our staff for the past 4 or 5 years. This has not been at all possible. I know of other universities that have been looking for such personnel for even longer periods of time. We are lucky in that we do have two doctoral people, as well as a number of other people with master's degrees in the field of deaf education, as well as a number in the areas of speech pathology and audiology.

The need for teachers and supervisors in these areas is very apparent but the thing that probably is not as apparent, is that if these children are not educated, we as taxpayers will be providing custodial care, not only for a brief period of time but for the long time to come. They also must be prepared for the new age of automation and all of its needs.

Sincerely,

JUNE MILLER, Ed. D.,
Educational Director.

Mr. ROBERTS. Thank you, gentlemen.

Dr. Frances P. Connor, head of the department of special education, will be our next witness.

I am sorry it has taken us so long to get to you but I am sure you understand our problem. I understand you have a speaking engagement this afternoon at 3 o'clock.

STATEMENT OF FRANCES P. CONNOR, HEAD, DEPARTMENT OF SPECIAL EDUCATION, TEACHERS COLLEGE, COLUMBIA UNIVERSITY, NEW YORK, N.Y.

Dr. CONNOR. I am going to Kentucky this afternoon at 3.

I would like to introduce to you Mr. William Greer, who is the executive secretary of the Council for Exceptional Children.

Mr. Greer has had long experience in the education of exceptional children in a State education department, a State department of health, a local school assistance, and also in the regional board of higher education in the South.

I am Frances P. Connor, head of the Department of Special Education, Teachers College, Columbia University, N.Y., and president of the Council for Exceptional Children for which I am speaking today.

Since it was organized in 1922, CEC has had as its principal purpose the development of the education of exceptional children, including the handicapped and the gifted.

Approximately 12 percent of the Nation's schoolchildren are exceptional to the extent that they require special education services. These children are distributed throughout both rural and urban sections of the United States.

One of the principal concerns of CEC's more than 17,000 members, who are located throughout all 50 States, is the passage of Federal legislation which will assist in the provisions of services for all children, and specifically for all children who, because they are different from what is considered the usual, need special education.

The purpose of our testimony today is to demonstrate our interest in, and concern for, the education and welfare of handicapped children.

With the chairman's permission, we would like to place in the record a written statement of CEC's legislative position, and a statement by Dr. Maynard Reynolds, vice president of CEC and chairman of the Department of Special Education at the University of Minnesota.

Mr. ROBERTS. Without objection, those documents will be included in the record.

(The documents referred to follow:)

THE COUNCIL FOR EXCEPTIONAL CHILDREN—A POLICY STATEMENT REGARDING FEDERAL LEGISLATION ON SPECIAL EDUCATION (ADOPTED BY THE DELEGATE ASSEMBLY, APRIL 1960)

I. INTRODUCTION

The Council for Exceptional Children is an association of educators with major concern for those children and youth whose instructional needs differ sufficiently from others to require special services and teachers with specialized qualifications. Included among these children are the gifted, blind, partially seeing, deaf, hard of hearing, crippled, speech impaired, mentally retarded, emotionally disturbed, delinquent, neurologically impaired, and others.

This council—a 17,000-member department of the National Education Association—consists principally of teachers, school administrators, and teacher educators, complemented by a smaller number of psychologists, physicians, audiologists, physical therapists, and members of other related professions. These professional workers are to be found wherever a community effort has resulted in a comprehensive program for exceptional children. They serve in State and local school systems, in day programs, residential centers, and in college and university settings.

This council is deeply interested in securing Federal legislation which can effectively augment programs which the States now have underway. To provide the scope of Federal services needed, the council sees broad implications for legislation and appropriations that will strengthen and enhance, on all levels, this Nation's school programs for exceptional children and youth. The remainder of this policy statement deals with these implications.

II. COORDINATION

So many factors are involved in contributing to good education for exceptional children and youth that coordination of effort on the Federal level is highly essential. Thus, Federal programs designed to provide special materials and equipment for use in behalf of the handicapped; research designed to find ways

of preventing, correcting, or compensating for a handicap; grants-in-aid to promote research in better instructional methods or to provide leadership training programs at the university and college level; and programs established to make pertinent statistical studies or engage in other related activities, need coordination for functional and effective operation.

III. LEVEL OF FEDERAL PROGRAM NEEDED

For many years, the section on Exceptional Children and Youth of the U.S. Office of Education operated, most of the time, with a professional staff of one person and with never more than two. In spite of that, it tried to provide informational and consultative services for the Nation and make factfinding and opinion studies. More recently, it developed, with outside cooperation, a study on the competencies needed by administrators, supervisors, and teachers in all areas of exceptionality. In 1958, Congress and the Office began laying plans for limited program expansion. More recently an announcement has been made of a reorganization of the Office of Education which, when completed, may improve the Office staff. It is the urgent recommendation of this council that the Federal program for the education of exceptional children and youth be given status commensurate with its national importance and the financial support required for its proper operation.

IV. PROFESSIONAL PREPARATION

The quality of educational services for exceptional children and youth resides in the abilities and qualifications of the personnel who provide those services. Therefore, the CEC believes that the Federal Government possesses an unusual challenge and opportunity to upgrade and expand school services for the handicapped and the gifted, through fostering professional preparation of special educators. We also believe that a single comprehensive piece of legislation would best accomplish a high-quality, coordinated approach. Such legislation should encompass preparation at each of the three recognized levels of higher education: namely, the undergraduate, graduate, and postgraduate. We ask that this legislation authorize training of personnel in all areas of exceptionally, including the preparation of classroom and itinerant teachers; consultants, coordinators, supervisors, and administrators; and college instructors and research workers. We further request legislation that will provide scholarships and fellowships to colleges, universities, and State departments of education, with supporting grants for the colleges and universities.

V. GRANTS-IN-AID TO STATES

Grants-in-aid should be furnished to States and public and private nonprofit organizations and agencies that hold promise of making a substantial contribution to the education of exceptional children. Such grants should assist in meeting costs of projects for research demonstration training traineeships and special projects, facilities, equipment, and other like expenses.

Additional grants-in-aid programs of matching funds to State departments of education, to encourage and hasten the establishment, improvement, and expansion of education programs for exceptional children, are of vital importance. Such grants would assist in the expansion and improvement of services and support on both the State and local levels.

VI. RESEARCH

Federal legislation should provide the organization and means for a comprehensive research program, in the Office of Education, for the improvement of educational programs for exceptional children. Objectives of such legislation should include (1) the dissemination and interpretation of pertinent research findings conducted by public and private agencies and individuals; (2) the provision of demonstration and research facilities, personnel, equipment, and research grants in all areas concerned; (3) the encouragement of research training; (4) the provision for continued reevaluation of national research needs; (5) the provision in the Office of Education for advisory and consultative research services; and (6) the provision for liaison with all relevant research units of the Government.

VII. MINIMUM STANDARDS

All grants under this proposed program should be made through the U.S. Office of Education on the basis of appropriate minimum standards, which the profession of special education, upon request of the Commissioner, will be pleased to outline.

VIII. SERVICES OFFERED

This council is pleased to offer its professional services freely to the Congress; the Director of the Study Committee on Special Education and Rehabilitation; the Secretary of Health, Education, and Welfare; the Commissioner of Education; and/or others concerned with the advancement of a Federal program for the education of exceptional children and youth.

UNIVERSITY OF MINNESOTA, COLLEGE OF EDUCATION,
DEPARTMENT OF SPECIAL EDUCATION,
Minneapolis, Minn., July 8, 1963.

Hon. KENNETH A. ROBERTS,
Chairman, Subcommittee on Public Health and Safety, Committee on Interstate and Foreign Commerce, U.S. House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: I wish that it might have been possible for me to attend hearings of the Subcommittee on the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (S. 1576). Teaching duties prevent my presence at the hearings, but I appreciate the opportunity to present this brief written statement. I write to you as professor and director of the Department of Special Education of the University of Minnesota. As such I have responsibility for programs which train teachers and some other specialists who serve needs of handicapped children in the schools of our region and for research in the same fields.

I am also writing on behalf of the Council for Exceptional Children which I serve as first vice president. The Council for Exceptional Children is the largest professional organization in our Nation concerned with education of handicapped and gifted children. CEC provides leadership in all fields of special education, including those which serve children who are mentally retarded, emotionally disturbed, and socially maladjusted, blind and partially seeing, deaf and hard of hearing, orthopedically handicapped and neurologically impaired, speech handicapped or gifted. Interests in these programs are, of course, shared with many other organizations.

The total bill (S. 1576) is of great interest to me and to all members of CEC. CEC members have contributed whenever possible in the many studies which have led to this highly perceptive bill. The programs which it proposes are greatly needed. In this brief statement I should like to concentrate upon title III of the bill which pertains to the training of teachers of handicapped children and to research and demonstration projects relating to education of the handicapped.

It is highly appropriate that title III be retained in this bill. It recognizes the prudence of concentrating efforts at prevention, treatment, and education at childhood levels. It further recognizes that many handicapping conditions have educational and social origins which must be dealth with, in major part, in the schools of the Nation. Finally, this title focuses on the major problems faced by schools as they attempt to upgrade programs for the handicapped. These problems are teacher recruitment and training and research. It would seriously weaken the total effort in this field should title III not be included in a final version of the bill.

One of the reasons for our unsatisfactory progress in education of handicapped children is that the necessary training programs for specialized teachers have been lacking. Such training programs are relatively expensive, college staff members have been in short supply and not all of the individual States can support the necessary programs. In some of the fields, such as education of the blind, perhaps only five or six major research and training centers are needed for the entire Nation. In other fields, such as mental retardation, teacher training centers are needed in all States, but it is not feasible to develop advanced programs for research specialists and college instructors in all States. The few outstanding centers which now exist in the various fields send students to all parts of the Nation. All of this is to say that effective and orderly develop-

ment of the necessary training programs for teachers and other professional schoolworkers in this field depends upon national leadership and support. Regional arrangements among some States have been greatly helpful, but inadequate to the truly national character of many of the problems.

With but a few exceptions and these mostly of recent origin, training to teach handicapped children and research in related fields have not been well established in colleges and universities of the nations. As a result we have depended too much upon mere on-the-job training methods for new teachers of the blind and in other special education fields. There has been too little investment in search for better methods of teaching and prevention. Under provisions of title III the grants to colleges and universities would make it feasible to establish education of the handicapped as legitimate and important areas of scholarship in institutions of higher education. I believe it is wise to move in this direction.

Title III of the bill would also provide fellowships and traineeships for students who undertake training in the fields involved. At the University of Minnesota we have participated in programs under Public Law 85-926 and Public Law 87-276 and we know the crucial importance of supporting students who undertake advanced training programs. Most of the students recruited to these special fields already hold bachelor's degrees and many of them leave regular teaching positions to do graduate study. They simply cannot afford to give up all earnings and incur costs of graduate work for a year or more in the period of young adulthood without special support. I'm sure the U.S. Office of Education can provide you with data which is most encouraging as regards results of fellowship programs now operating in two fields—mental retardation and deaf.

The research and demonstration project support proposed as part of title III is extremely modest, but highly important. In a fast-developing field it is wise to dedicate a substantial part of total expenditures to support of research and demonstration work. Because of the earlier effectiveness of programs under Public Law 85-926 I believe there is a good degree of readiness to utilize at least the $2 million per year proposed for this work.

In closing my remarks I should like to stress two things. First, S. 1576 would bring a needed equity among the various aspects of educaton of the handicapped. Although we have been pleased to participate in federally supported programs relating to education of the mentally retarded and the deaf, it has seemed no less important that we should be moving forward in education of the blind, the emotionally disturbed, the cerebral palsied, and other areas. Problems in the several fields not now covered are quite severe.

Finally, may I say that although S. 1576 proposes less than the Council for Exceptional Children itself would wish, it has virtually unanimous support among many groups and agencies concerned with handicapped children. It treats major problems and CEC is happy to join other organizations in urging its support.

Sincerely,

MAYNARD C. REYNOLDS,
Professor, Educational Psychology.

Dr. CONNOR. Now rather than read my prepared statement, I should like to submit this to you and here just briefly summarize it. I know that certainly time is passing.

Mr. ROBERTS. You have earned the plaudits of this subcommittee.

Dr. CONNOR. I will see now if I can keep it brief.

We do believe that S. 1576 will promote significant advances in the care and treatment of mentally retarded children and of children who are mentally ill.

The title to which we speak of course today, relates to training and research in the education of all handicapped children including the blind and the deaf and the mentally retarded and the speech handicapped and the crippled and the neurologically impaired and the emotionally disturbed, and I might say the socially maladjusted, wherever they might be—whether it be in a correction institution, in a hospital, in a school, or if they remain in their own homes.

High quality training programs of an interdisciplinary nature are essential. In the United States, conservative estimates indicate that we need about 200,000 special educators. Presently we probably have between 50,000 and 60,000 of these people available and unfortunately, many of them are actually not prepared adequately for the job that they have undertaken.

In response to parents' desperate requests and community concern about the scarcity of teachers to serve their children, special training programs have been developed in something like 200 colleges and universities. Some of these have reached a stage of excellence and comprehensiveness.

It is evident that handicapped children have also benefited from the two presently operating public laws. For example, as a result of Public Law 85–926, over 200 students have received advanced professional preparation for leadership positions in the field of mental retardation.

Some of these people are presently serving in State education departments across the country. We can go from Maine to Kentucky to Oregon, across to Hawaii, if we will. Others are in colleges and universities, including the State of Maine in New England, and the University of Alabama in the South.

Some are exerting leadership in such key agencies as the U.S. Office of Education and the National Association for Retarded Children.

Similar leadership programs are needed to prepare supervisors, administrators, college teachers and researchers to extend and improve the education for all groups of handicapped children.

Outstanding also last year was the implementation of Public Law 87–276 which resulted in the preparation of almost 400 teachers of the deaf; next year it is expected that about 500 will be receiving their initial specialized preparation under this program.

Forty-six colleges and universities are preparing these teachers; they need highly qualified teacher educators. The demands, for instance, at our college for college teachers are much greater than the supply that we have on hand. We are particularly interested in the provision for research and demonstration projects under section 302 of this bill. Although, for example, classes for the mentally retarded are increasing in number, it is still not clear what causes mental retardation, what the children's characteristics are, how we can best teach them how they best learn.

Yet the number of research projects in mental retardation funded through the U.S. Office of Education cooperative research program decreased from 42 out of 72 awarded in 1957, when the funds were earmarked to 4 out of 97 in 1961.

It is essential that we test some of the recommendations of earlier research and that we develop more effective teaching procedures and materials for use in actual classroom situations.

We appreciate, by the way, the need for research in the total field of education, and we appreciate the need for appropriations which are not specifically earmarked for small groups.

But, we, who are responsible for the education of this segment of the population, and certainly handicapped children represent about 10 percent of those of the general population are vitally concerned. These are the children who are being held back because of serious problems in learning and in communication.

We therefore feel that we need to have special funds available for our researchers who are probing into the problems of the handicapped boys and girls. We have got to help them toward more productive learning and more productive living.

The training and research grants proposed in S. 1576 will not only increase the number of qualified researchers in our field but will also further stimulate competent and interested researchers to study educational problems of handicapped children.

In conclusion, I would like to say the Council for Exceptional Children enthusiastically supports Senate bill 1576. We believe that the provisions for the mentally retarded and mentally ill are all of extremely great importance generally and of extremely great importance to our educational programs.

We are also convinced that title III which would extend the training of personnel, as well as research and demonstration activities in the education of handicapped children, would provide a much needed stimulation to the effective utilization of the growing programs in this field.

We therefore urge this subcommittee and other committees which may consider this legislation, as well as the entire House of Representatives to act favorably upon Senate bill 1576.

Thank you very much for the opportunity to be here today.

Mr. ROBERTS. Thank you, Doctor. You address the committee really in two facets as I understand it: in your capacity as head of the department of special education, Teachers College, and also as the chairman of the council for exceptional children.

Mr. Geer appears as executive secretary of the council.

We are happy to have your endorsement of this legislation.

We recognize that your council represents a large number and a very important part of our population and we feel that this experience you have had in your professional work is very valuable to us, and your endorsement would be valuable in considering this legislation.

I have no questions except I just want to compliment you on the depth and the fine presentation you made. I thank you very much for the committee in working out the details of this legislation.

Dr. CONNOR. Thank you very much.

Mr. ROBERTS. Mr. Nelsen?

Mr. NELSEN. I have no questions.

I wish to add my thanks. I note your letter by Maynard Reynolds from the University of Minnesota, my State. And I am sure we will examine his letter with great care and interest.

I thank you for appearing before our committee.

Dr. CONNOR. Thank you very much.

(The statement of Dr. Connor follows:)

TESTIMONY OF DR. FRANCES P. CONNOR, PRESIDENT OF THE COUNCIL FOR EXCEPTIONAL CHILDREN

Mr. Chairman, and members of the committee, I am Frances P. Connor, head of the department of special education, Teachers College, Columbia University, New York, and president of the council for exceptional children for which I am speaking today. Since it was organized in 1922, CEC has had as its principal purpose the development of the education of exceptional children, including the handicapped and the gifted. Approximately 12 percent of the Nation's schoolchildren are exceptional to the extent that they require special education services.

These children are distributed throughout both rural and urban sections of the United States.

One of the principal concerns of CEC's more than 17,000 members, who are located throughout all 50 States, is the passage of Federal legislation which will assist in the provisions of services for all children, and specifically for all children who, because they are different from what is considered the usual, need special education services. The purpose of our testimony today is to demonstrate our interest in, and concern for, the education and welfare of handicapped children. With the chairman's permission, we would like to place in the record a written statement of CEC's legislative position, and a statement by Dr. Maynard Reynolds, vice president of CEC and chairman of the department of special education at the University of Minnesota.

We believe that Senate bill 1576, recently passed by the Senate, and now before this subcommittee of the House of Representatives, will provide for significant advances in the care of mentally retarded and mentally ill children and adults. We believe that the construction of research centers and facilities for the mentally retarded, as provided for in title I, will greatly advance knowledge about the mentally retarded and result in better care for them. Through provisions for such centers, we feel that the education and habilitation of many mentally retarded children and youth will be greatly improved. The assistance provided to States in title II for the construction and staffing of mental health centers, will provide a great impetus in the treatment and care of mentally ill children and adults. Where such centers already exist, diagnosis and treatment of the mentally ill have been greatly advanced. We in education have experienced the value of good community mental health centers, and are convinced that they are vital in giving proper attention to emotionally disturbed children. In many instances, the schools and mental health centers have worked cooperatively in the education and general welfare of children who have severe emotional problems. We are convinced that the stimulation which title II envisions will be highly significant.

Title III, which relates to the education of handicapped children, is of paramount interest to the Council for Exceptional Children, and it is to this title that I speak today. This title would extend programs which have already proved very worthwhile and would provide additional ways through which qualified professional personnel may be trained. This would guarantee the extension and improvement of education and services for handicapped children. Recent congressional studies and information from the Office of Education have indicated that at least 200,000 special educators of handicapped children are needed in the United States. According to the most recent available data, between 50,000 and 60,000 such teachers are presently available. Many of these teachers have not had sufficient specialized educational training to be professionally qualified for the task which they have undertaken. Almost 200 colleges and universities throughout the country have established programs for training teachers of handicapped children and perhaps 100 of these programs in institutions of higher learning have reached stages of excellent development. Also at least two regional educational agencies, the Southern Regional Education Board and the Western Interstate Commission of Higher Education, have studied the personnel problem and made extensive efforts to secure the establishment of high quality programs for educating teachers of handicapped children. The provisions for assistance to these colleges and universities and to State departments of education in the training of personnel, as envisioned in title III, section 301, would provide important and much needed assistance which will encourage these institutions and qualified students in the field of educating handicapped children. There is already substantial evidence that Federal assistance has provided such stimulation, both to the institutions and to the students, and has resulted in increasing the number and quality of persons engaged in the education of handicapped children.

Public Law 85-926, implemented in 1958, has made it possible for more than 200 students to secure graduate professional preparation which has increased their competence in providing leadership in the education of mentally retarded children. About 19 colleges and universities across the country have participated under title I, teacher education, of Public Law 85-926. Since the beginning of the program practically all of the States have had personnel trained through it who now are engaged in college teaching, research, administration, supervisor, and classroom teaching for the mentally retarded. For example, State department personnel in Maine, Kentucky, Hawaii, Oregon, and other

States, received advanced preparation under this program. College and university leadership positions are, for example, being filled in the University of Alabama in the South and in New England's Rhode Island College. Some of these graduates have also filled leadership positions in the Office of Education, in the National Association for Retarded Children, and other public and private agencies. Practically every State has at least one or two persons who have become better qualified to assume responsible positions in the education of the mentally retarded under this significant act. We believe that similar leadership training, if extended to other types of handicapped children, would provide a substantial impact toward meeting a similar need for the visually handicapped, the crippled, the deaf, the speech defective, and others.

Another program, offered through Public Law 87–276, has resulted in the training of 390 teachers of the deaf during its first year of operation. It is our understanding that more than 500 additional teachers will probably receive their basic specialized preparation through this program during the coming academic year. Forty-six colleges and universities are participating in the training program, which is meeting a great need. We are delighted that teachers of the deaf are thus being educated and would like to see this stimulation program extended. This would be provided for in title III of S. 1576.

We are particularly interested in the provisions for research and demonstration projects in the education of handicapped children as set forth in section 302. There has been a rapid increase in programs for educating handicapped children in recent years. This has been particularly true in the area of the mentally retarded, yet the number of research grants in the area of mental retardation supported under the U.S. Office of Education cooperative research program decreased from 42 of 72 projects in 1957 when funds were earmarked to 4 out of 97 in 1961. Among the other projects funded in 1961 was one for the emotionally handicapped and one in the education of the blind, one in the field of the deaf and one for the speech handicapped. Research efforts must be extended if we are to determine the best ways of educating these children with the greatest profit to themselves and their communities. It is also important that as new knowledge is found, effective demonstration projects be carried out to implement and test instructional procedures and materials for use in actual school situations. We believe that the funds indicated for this program would greatly increase knowledge and skill related to the education of handicapped children.

Although we have been, and still are, supportive of the cooperative research program, we believe that it is impossible for this program to provide all of the assistance for educational research which appears to be necessary. Since the cooperative research program serves the entire field of education, it must be concerned with major studies which deal with the total school population and can allocate only tangentially funds to relatively small areas of education. At the same time we who are responsible for the education of exceptional children, who represent over 12 percent of the school population, recognize, and perhaps more vividly than others can, that there are many problems awaiting resolution through research. We are embarking, for example, on extensive educational programs for emotionally disturbed children. Very few studies have been made in this area and most of those which have been conducted have been under the auspices of other than education organizations. Also, problems of communication for deaf and blind persons have had considerable attention through various sources, including the cooperative research program. However, such research should move forward at a greater rate than presently can be anticipated though existing programs.

Programs for educating mentally retarded children have grown rapidly during the last 15 years. Many of the educational methods and techniques now being used are essentially untried through research. Curriculum research in every field which involves the adjustment of children is of great importance and could be undertaken in great volume if there were available funds and, in some instances, available personnel.

We have also noted through direct conversations with several highly qualified researchers in major colleges and universities, that they have had proposals returned from the cooperative research program with suggestions that they be resubmitted at a later date. In some instances, after a change in focus and orientation, the proposed projects have been funded by noneducation agencies, both public and private. While we are grateful that it has been possible to fund some of these projects through other many educational resources, we feel

that something may be lost of an educational nature when it is necessary to change focus and orientation of projects in order to meet the requirements of organizations which do have research funds to be granted. Although the principle of earmarking funds in the cooperative research program has been discontinued, we believe that there are areas of education for which, due to their nature and the type of problems they must solve, special appropriations may be justified. The field of handicapped children is such a field, attacking as it does some of the more severe problems related to the education of children. There is a sizable number of professional personnel who are particularly knowledgeable and cognizant about these problems resulting from various kinds of learning deficits. Furthermore, specific institutes and centers for research on exceptional children now exist which are in the process of researching some of the major problems in an organized fashion. There is therefore a discreet area which can be identified and a specific professional audience to whom knowledge about available research funds could be directed. Such funds would tend further to stimulate and to improve the performance of researchers in the education of exceptional children. We would hope that this added emphasis in this field might be in addition to a natural flow of research proposals in the cooperative research program.

Section 302 also envisions demonstration of a broader scale of knowledge which already exists or will be found through research. One of the practical problems that is persistent is that of putting into practice knowledge found through research. In some instances the application of this knowledge through demonstration requires additional personnel and facilities which local school boards and State school systems are reluctant to provide from funds sorely needed for existing programs. These same school systems, however, would attempt to bear the costs of programs if the value of these innovations has been adequately demonstrated. We believe that this great need would be met in part through the provisions of section 302.

The Council for Exceptional Children enthusiastically supports Senate bill 1576. We believe that the provisions for the mentally retarded and the mentally ill are all of extremely great importance. We are also convinced that title III, which would extend the training of personnel and research and demonstration in the education of handicapped children, would provide a much needed stimulation to the effective utilization of growing programs in this field. We therefore urge this subcommittee, the full Committee on Interstate and Foreign Commerce, other communities which may consider this legislation, and the entire House of Representatives, to act favorably upon Senate bill 1576.

Mr. ROBERTS. I have some other witnesses who have been very patient with us and have been here all day, Mr. Schloss and Mr. Nagle. Mr. Schloss is with the American Foundation for the Blind, and Mr. Nagle is with the National Federation of the Blind.

Would you gentlemen prefer to go ahead and finish now or would you like to come back at 2 o'clock.

Mr. SCHLOSS. I can summarize my statement very briefly.

Mr. NAGLE. Yes.

Mr. ROBERTS. All right.

Mr. Schloss, if you will come around we will go ahead with your statement and then Mr. Nagle and perhaps we can finish up.

STATEMENT OF IRVIN P. SCHLOSS, LEGISLATIVE ANALYST, WASHINGTON OFFICE, AMERICAN FOUNDATION FOR THE BLIND, INC.

Mr. SCHLOSS. I have submitted a written statement for the record, and I will confine myself to a very brief summary.

Mr. ROBERTS. It will be included in the record.

Mr. SCHLOSS. Mr. Chairman and members of the subcommittee: I am pleased to have this opportunity to appear before you in support of S. 1576, the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963.

In endorsing this urgently needed legislation, I am expressing the views of the American Foundation for the Blind, which is the national voluntary research and constultant agency in the field of services to blind children and adults: the American Association of Instructors of the Blind, which is the professional association of educators and other specialized personnel in programs for blind children; and the American Association of Workers for the Blind, which is the professional association of individuals engaged in providing services of all types to blind persons of all ages.

All three of these national organizations have intensive collective experience extending over most of this century in working directly with blind children and adults as psychologists, vocational counselors, therapists, teachers, research workers, and other types of specialists in all types of programs throughout the country.

As a result of this experience, all three organizations have had an exceptional opportunity to identify pressing unmet needs in services to blind persons.

Consequently, all three organizations can speak as one in endorsing titles I, II, and III of S. 1576 as effective means of meeting some of the most urgent of these needs through construction of facilities, training of essential personnel now in extremely short supply, and research and demonstration projects to experiment with and develop effective techniques for assisting the physically or mentally impaired individuals.

At this point, I should like to describe some of the efforts made by the American Foundation for the Blind over the past several years to meet the acute shortage of highly qualified personnel needed in educational programs for blind children.

The foundation has assisted in the establishment of programs which specialize in the preparation of teachers of blind children at four institutions of higher learning—San Francisco State College, the University of Minnesota, George Peabody College for Teachers in Nashville, and Syracuse University.

At these four schools, individuals preparing to teach blind children have available to them a full range of essential courses, including psychology and anatomy courses.

The foundation has also been making a small number of graduate-level scholarships and fellowships available to teachers to enable them to attend these four institutions, so that they can acquire the special skills and techniques needed to work with blind children.

However, as the foundation is a philanthropically supported organization, these scholarships and fellowships have necessarily been limited in number and small in amount and can only be regarded as token stopgap measures.

If an adequate number of qualified persons to work with blind children is to be made available, Federal aid as provided in title III of S. 1576 is the only satisfactory solution.

The American Foundation for the Blind has also sponsored and staffed summer courses for teachers and other personnel in programs concerned with the highly specialized problems of blind children who have other physical or mental impairments as well. These were held at Northwestern University in 1959, at George Peabody College in 1960, at San Francisco State College in 1961, and at the University of Minnesota in 1962.

In addition to its own staff specialists, the foundation paid for lecturers from among a wide variety of medical specialties to instruct these people who would be working with multihandicapped blind children. Among these medical specialists were ophthalmologists, otolaryngologists, psychiatrists, and pediatricians.

One of the most pressing unmet needs identified by foundation staff members and the individual practitioners who make up the two associations I am also representing today is the need for the development of special programs for the education and training of blind children who have additional physical or mental impairments, such as mental retardation, emotional disturbance, cerebral palsy, and so forth.

Because of their multiple disabilities, these children are usually refused by programs for blind children, for the mentally retarded, for the emotionally disturbed—for whatever specific disability group a special program has been established.

These children literally have no place to go; and too frequently, too hastily, and at great cost to their families or to local and State governments, they are committed to public or private mental institutions to vegetate for life.

I should like to take this opportunity to submit for the files of the subcommittee several copies of a new foundation publication entitled "No Place To Go." This short book, which was edited by two highly qualified foundation staff members, describes in very readable and moving prose the plight of blind children who are emotionally disturbed and the need for programs which will enable them to overcome their problems.

I should like to commend this book to each member of the subcommittee and will be pleased to send each of you a copy.

In some instances, the parents of these multihandicapped blind children have rightfully rejected the idea that their children had to be institutionalized or kept at home without the benefit of a formal training program.

In some localities, parents have banded together and have stimulated the establishment under public or private auspices of small educational programs for their children. There are perhaps a half dozen of these programs throughout the country; and all are handicapped by lack of adequate personnel, lack of funds, and lack of a tested methodology for working with the children.

In effect, they are all experimental programs which are feeling their way.

One such program exists here in the District of Columbia and serves a small group of children from the District and the suburban area. It operates as the Pilot School for Blind Children and occupies two classrooms at Temple Sinai on Military Road.

I should like to submit for the files of the subcommittee several copies of a paper by Dr. Warren Brodey, consulting psychiatrist at the Pilot School, who works directly with the children and their parents.

Dr. J. M. Woolly, superintendent of the Arkansas School for the Blind and current president of the American Association of Instructors of the Blind, has informed me that he is planning to institute a program in the fall for blind children who are mentally retarded.

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However, he is finding it difficult to locate the highly qualified teachers and other specialized personnel he will need to staff this urgently needed new program simply because there is a dearth of qualified people with the training and experience needed to work with children who are both blind and mentally retarded.

Other schools for the blind which are attempting to deal with the problems of multihandicapped blind children are facing the same problem—lack of adequately trained personnel.

Title III of S. 1576 would assist materially in solving this acute shortage of personnel by providing necessary Federal aid to train leadership personnel, teachers, supervisors, therapists, research workers, and other specialists.

In addition, the research and demonstration programs authorized by title III will contribute substantially to the development of effective methods of educating and training handicapped children, particularly those who have several types of handicapping conditions. No comparable research and demonstration program designed specifically to assist in solving the educational problems of handicapped children is presently in existence, and I am confident that the emphasis and visibility this new authorization will give to the needs in this highly specialized area of concern will attract the competent research workers needed to solve the problems which exist.

In conclusion, I should like to restate the complete support for S. 1576 of the American Association of Instructors of the Blind, the American Association of Workers for the Blind, and the American Foundation for the Blind.

All three of these national organizations hope that this bill will be acted upon favorably by the Committee on Interstate and Foreign Commerce and that it will become law.

The programs provided by S. 1576 can substantially reduce costly permanent institutionalization and bring us another major step closer to realizing the great American ideal of providing the opportunity for every individual to achieve his own maximum potential.

Today, in addition to representing the American Foundation for the Blind, which is the national voluntary research and a consultant agency in the field of services to blind children and adults, I am also speaking for the American Association of Instructors of the Blind, which is the professional association of educators and other specialized personnel in educational programs for blind children, and the American Association of Workers for the Blind, which is the professional association of workers in all aspects of services to blind people of all ages.

All three of these national organizations have had extensive collective experience in working with blind children and adults ranging over practically all of this century.

We have had an opportunity to identify some of the pressing unmet needs in our field, and we wholeheartedly endorse S. 1576 as a bill which would contribute in large part to meeting some of the most urgent of these needs.

Title II with its provisions for the establishment of comprehensive community mental health centers would be to an extent an adjunct in the habilitation and rehabilitation of physically disabled persons

through making available as an important resource right in the community adequate mental health facilities.

With regard to title III, the Foundation has assisted in establishing teacher preparation programs for teachers of blind children at four institutions of higher learning: San Francisco State College, the University of Minnesota, the George Peabody College for Teachers in Nashville, and Syracuse University.

In addition, we have made graduate-level scholarships and fellowships available to teachers attending these four institutions to assist them in acquiring the high degree of skill they will need to work in educational programs for blind children.

However, we are philanthropically suported also and this is an endeavor through which we cannot hope to meet the need.

The provision of title III for preparation of leadership personnel, teachers, and other types of specialists in these programs is urgently needed. In addition, we staffed and sponsored summer programs at four universities—Northwestern University, San Francisco State College, University of Minnesota, and George Peabody College—for personnel involved in programs for blind children who have additional physical or mental impairments and providing instructors for them.

We paid for a wide array of medical specialists including psychiatrists, ophthalmologists, and pediatricians to teach this group.

One of the pressing unmet needs in our area is the development of educational programs and adequately trained people to work with blind children who have additional impairments such as mental retardation, cerebral palsy, emotional disturbance. This is a very serious and pressing area at this time, and it is not being met on an adequate basis. There are just not enough qualified people available.

In this connection, I have submitted for the files of the subcommittee copies of a new publication entitled "No Place to Go," which deals with the plight of these children. There are just no educational programs generally available for them.

Dr. J. M. Woolly, the superintendent of the Arkansas School for the Blind and current president of the American Association of the Instructors of the Blind, has informed me that he is planning to establish a special program for blind children who are mentally retarded this fall but is having a great deal of difficulty in finding properly qualified personnel.

In addition to the preparation of personnel under this program, under title III, research and demonstration authorizations are tremendously important. There is no comparable authority that would deal with this in exactly the same way in existing law.

Mr. ROBERTS. Would you reemphasize that, Mr. Schloss? That is a very interesting point which I do not think anyone else has brought out. The demonstration part of the title III is new to the field.

Mr. SCHLOSS. Yes. The wording of it through provision of grants to colleges and universities, State educational agencies and other public or nonprofit agencies to do research in the education of handicapped children is new. There is no comparable authority in existence under present law that covers this same area in this way.

The cooperative research program is limited to colleges and universities and State educational agencies, and any nonprofit organization

which is equipped to do research in this area has to go through a lot of red tape and try to get the college or university to also contribute financially to this research effort.

This is sometimes extremely difficult to do, frequently extremely difficult.

I would like to underscore one thing before I conclude and that is that a well-qualified, well-trained special educator is in a very real sense a paramedical specialist in the same way that a physical therapist or an occupational therapist is; he has to have a therapeutic personality in working with handicapped children, especially those with severe sensory deprivation.

He has got to have a very rounded background, to be well-educated, trained in anatomy and physiology and understands the learning process involved in working with children who, for example, don't have the use of their eyes or their hearing, let's say, for learning purposes.

In conclusion, I would like to again restate our wholehearted support, all three of the organizations I am representing today, for S. 1576. We believe that its implementation will eliminate or greatly reduce the need for costly permanent institutionalization of many of the people who would be served by these programs.

This is true for those under Title III as well—some of the multidisabled blind children who are now being confined to institutions when they could be helped by educational programs.

We sincerely hope that the committee will report this bill favorably very soon and that the Congress will enact it into law.

Thank you.

Mr. ROBERTS. Thank you, Mr. Schloss. I think you have been one of the best witnesses we have had as to the provisions in title III and the handling of that title by this committee which has been in the field of health, I am sure you know, almost since the beginning of the Congress.

I think your statement is very full and forceful and I think it gives us a great deal of comfort coming from you, someone who has dealt with this field for some time.

I want to ask just one question.

Mr. SCHLOSS. Yes, sir.

Mr. ROBERTS. Does the witness also believe the provisions for title III authorizing the appointment of the number of special or technically advised committees, advised on a particular field in education of handicap, is a wise provision or should this be accomplished through one advisory committee?

Mr. SCHLOSS. With the different types of handicapped children who would be involved in the provisions of title III, we believe that there should be these various technical committees that would handle specific aspects. There just are not enough individuals in the country who would be broad gage enough to serve on a small advisory committee that would cover the whole field.

Some of the smaller technical committees with specialists in the individual areas of concern would be extremely helpful, and we would recommend it.

Mr. ROBERTS. The gentleman from Minnesota?

Mr. NELSEN. I have no questions.

I do wish to thank the gentleman for the fine statement. I also wish to reemphasize his analysis of the title III and the very different qualifications of the teachers in this field as contrasted with the qualifications of a teacher in our public school system.

There seems to be some debate as to where this particular responsibility belongs but it would seem to me that your testimony fully emphasizes the committee's analysis of it and that this is quite a different type of education in the therapeutic and psychological and all of these background qualifications, that a teacher requires quite different training than would one in the public schools, and your testimony so clearly brought that ought.

I wish to thank you very much for appearing before our committee.

Mr. SCHLOSS. Thank you.

Mr. ROBERTS. Thank you again, Mr. Schloss.

Mr. SCHLOSS. Thank you.

Mr. ROBERTS. Our next witness is Mr. John F. Nagle, chief of the Washington Office of the National Federation of the Blind, 1908 Q Street NW., Washington, D.C.

I assume you would like to file your formal statement in the record at this point?

STATEMENT OF JOHN F. NAGLE, CHIEF, WASHINGTON OFFICE, NATIONAL FEDERATION OF THE BLIND, WASHINGTON, D.C.

Mr. NAGLE. I would, Mr. Chairman, and I have also attached to that formal statement a resolution of endorsement of S. 1576, the resolution adopted by our national convention last week.

I would like to have that appear in the record following my testimony.

Mr. ROBERTS. I note that resolution and I note also that it was unanimously adopted by the convention.

Mr. NAGLE. That is right, Mr. Chairman.

Mr. ROBERTS. And that you specifically set out not only S. 1576 which passed the Senate but you also set out that title III of S. 1576 is to be considered in public hearings by the House Subcommittee on Public Health and Safety.

You go ahead then and endorse the bill with title III; is that correct?

Mr. NAGLE. That is right, Mr. Chairman.

Mr. ROBERTS. Yes.

You may proceed.

Mr. NAGLE. At the convention were some 500 blind people from all parts of the country taking part and as you say, it was unanimously endorsed.

Mr. Chairman and members of the committee: My name is John F. Nagle. I am the chief of the Washington office of the National Federation of the Blind. My address is 1908 Q Street NW., Washington 9, D.C.

The National Federation of the Blind approves and supports title III of S. 1576.

We believe that its provisions, as Federal law, would go far toward solving many of the problems and eliminating many of the deficiencies

which now exist in the field of special education for exceptional children.

The National Federation of the Blind is a nationwide membership organization.

Our members—primarily blind men and women—are representative, in background and experience, of all aspects and activities of American life, thought, and endeavor.

We, the organized blind, are combined into a single purpose, to be furthered by joint action—and our goal is the improvement of conditions, the equalization of opportunities for all in the Nation disadvantaged by the disability of blindness.

We, blind men and women, possess expert knowledge concerning the problems and difficulties resulting from the loss of sight—for the problems are in our lives, the difficulties confront us daily.

We, blind men and women, possess expert knowledge concerning the educational programs that are available to children without sight—for many of us are products of these programs.

We know of their strengths, for they have helped and strengthened us.

We know, too, of their weaknesses and inadequacies, for they have hindered and handicapped us in our adult lives.

We, blind men and women, know of the overwhelming importance of an adequate education for a child without sight.

With adequate education, with sufficient and competent training in the skills so necessary to eliminate or reduce the limitations of his disability, with sufficient and proper professional and vocational training—with this sturdy foundation, the blind child will evolve into a self-supporting, self-sufficient adult.

He will be able to earn a living commensurate with his talents and aptitudes; he will be able to compete with his sighted fellows, on the basis of equality, for jobs, clients, or customers.

He will be valued as an employee or employer, as a family and community member—he will be valued as a citizen, and his contributions will benefit and strengthen the whole Nation. For, we believe, as each person in America lives and functions fully and productively—as each separate person works gainfully and constructively—the entire Nation benefits from the success of his efforts—the whole Nation is strengthened by his achieved fulfillment.

With adequate education, with fair and equal opportunity for employment the blind person will live with independence gained by self-dependence.

Inadequately prepared, and inadequately educated, denied the chance to work and use gainfully his demonstrated abilities—or denied the chance to do any kind of work at all—such a person becomes a lifetime dependent upon the labors and resources of others. And this is so, not because he is blind—it is so because he has not been equipped to live with his disability, nor has he been given the chance to work by reason of his disability.

We of the organized blind, endorse and support title III of S. 1576 because, we believe, it will not alone benefit blind children, and benefit them greatly, title III, as Federal law, will not alone serve to increase the educational opportunities of blind children but will serve to

benefit all physically and mentally impaired children to enhance their chances for adequate education.

It will serve as a means whereby impaired children, children with a physical or mental difference may be prepared to live as self-reliant, self-responsible adults.

Title III offers the opportunity to make programs of special education in the States as good as they should be, as good as they must be, if they are to equip these children—disabled, and so, disadvantaged—to have a fair and full chance to live.

Title III would serve as a means of bringing qualified new people into the field of special education—of bringing them into the field in the numbers that are required—of bringing new and qualified personnel into the various skills and specialties that are so desperately needed—in every State, in every disability area, in every instructional skill and specialty.

Title III offers the means, through research, of thrusting aside the cobwebbed and mildewed concepts and methods of the past which pervade the education of disabled children.

It offers the means, through research, of discovering new and better ways of thinking, new and different ways of teaching—different and more satisfactory ways of helping impaired children to manage competently and successfully in life with their disabilities.

Title III will do more than provide the means of stimulating research in the field of special education—it offers the means, through demonstrations, of testing and proving by usage, the results achieved from research—of proving, by day-in and day-out usage, that the new ideas have meritorious substance; that the new methods and techniques, the newly devised and developed tools and adaptations are superior to the old.

Mr. Chairman, we earnestly urge you and the other members of this subcommittee, we earnestly urge all of the members of the full Committee on Interstate and Foreign Commerce, to act promptly and favorably on title III—on all titles of S. 1576.

We request and urge the entire Congress to adopt S. 1576 promptly and without change.

Mr. Chairman, we who speak in support of title III of S. 1576 plead the cause of children unable to speak for themselves.

We plead for improved opportunities for them—when there are many who have had no opportunities at all.

We speak of the urgent need to provide physically and mentally disadvantaged children with an equal chance to live with others, to associate and compete as equals with others—unrestricted and unhandicapped by their impairments.

We argue for equality of opportunity—that these children with a difference may have a chance to live with dignity, decency, and independence.

We ask that you approve title III of S. 1576 because today many of these children, lacking adequate education and specialized training, will know only hurt and humiliation, marginal subsistence, and perpetual dependency.

We, blind men and women, know of the wondrous challenges of life—but we know, too, of the bitter frustrations of living without sight in a sighted society.

We speak to you of the needs of impaired children—we ask you to approve S. 1576 that these needs may be better satisfied.

I thank you, Mr. Chairman and members of the committee, for this opportunity to be heard.

Mr. ROBERTS. Thank you, Mr. Nagle. I would also include with your formal statement the resolution you referred to which was adopted by the convention.

(The resolution referred to follows:)

RESOLUTION 63–9

Whereas S. 1576 would greatly increase livelihood opportunities for mentally and physically impaired children and adults by providing Federal funds to assist in the establishment of facilities, centers, and training programs; and

Whereas title III of this bill would provide Federal funds to colleges and universities and to State educational agencies enabling them to establish and maintain and make available specialized training programs and scholarships and thereby stimulate and encourage qualified persons to enter into the field of special education for exceptional children in diverse and much-needed capacities and specialities; and

Whereas title III of S. 1576 would also make Federal funds available for research in the field of special education in order that new and better ways of assisting the disabled to function within and beyond the limitations of their disabilities may be devised and developed; and

Whereas Federal funds would also be provided under this bill in order that such new and better ways of assisting, training, and educating the disabled may be tested by usage, and may be demonstrated and proven for their greater effectiveness; and

Whereas S. 1576 has already passed the U.S. Senate with only a single vote in dissent; and

Whereas title III of S. 1576 is to be considered in public hearings by the House Subcommittee on Public Health and Safety: Now, therefore, be it

Resolved by the National Federation of the Blind in convention assembled in Philadelphia this 6th day of July 1963, That the organized blind urge and request the members of said subcommittee, the members of the full Committee on Interstate and Foreign Commerce of the House of Representatives, and every Member of Congress to support and vote for S. 1576; and be it further

Resolved, That the officers and staff of the National Federation of the Blind are directed to take such actions as are necessary to secure the adoption of S. 1576 by the 88th Congress.

Unanimously adopted by convention.

RUSSELL KLETZING,
President, National Federation of the Blind.

Mr. ROBERTS. I want to tell you how much I appreciate your appearance. I am very sorry that we did not have the full committee in attendance for the sake of hearing you and the gentleman preceding you. They were both very well done and I thank you.

Any questions in the minds of anyone connected wtih this legislation as to the jurisdictional right of this committee to deal with title III you have certainly made the finest arguments in support of that jurisdiction that I have heard.

I am sorry there was not better attendance. I am sure you understand with the House in session we could not prevent it, but I will certainly see that these two statements are called to the attention of the full committee when they consider this legislation in executive session.

Again, I want to thank you for your appearance.

Mr. NAGLE. Thank you, Mr. Chairman.

Mr. ROBERTS. This will conclude the additional hearings on S. 1576, and the committee will be adjourned. The hearing record will remain open for five legislative days.

(The following material was submitted for the record:)

MARCH 23, 1963.

Mr. KENNETH A. ROBERTS,
Member of the House of Representatives,
U.S. Congress, Washington, D.C.

DEAR MR. ROBERTS: I see by the Congressional Record that there will be a hearing before the House Subcommittee on Health in reference to mental health.

I have been active for years in regard to mental health and therefore I thought it advisable to forward to you copies of some of the papers I presented to our Interim Legislative Committee on Mental Health and Mental Retardation on February 22, 1963.

Received several days ago a letter Mr. Ashley L. Camp, the Chairman of the Commitee, in which he expressed the committee's appreciation for my appearance before them.

I can assure you that there will be quite some progress made in the near future especially if we receive some assistance from the Congress and the present administration of the United States.

Thanking you in advance for your cooperation, I remain,

Sincerely yours,

RUDOLPH KERN.

BIRMINGHAM, ALA.

[Washington Daily News, Dec. 12, 1960]

VOICE OF THE PEOPLE—NURSING HOMES COULD CUT HOSPITAL COSTS

In our mental hospitals over the Nation there are 165,000 aged over 65 years. Our superintendent of our State hospital, Dr. J. S. Tarwater, recently stated that the population of our mental hospital could be reduced by one-third if we would have the necessary foster, nursing or other approved homes for placement of our aged citizens.

There are at Bryce and Searcy about 7,600 and at Partlow School for the mentally deficient 1,650 patients. Of a total of over 9,000 about 2,000 are from Jefferson County.

According to his statement there must be around 2,000 for the entire State which includes about 500 from Jefferson County who could be taken care of better outside of our mental institutions.

The expense to operate our mental hospitals is a State obligation. At present it is $2.50 per day or about $76 per month per patient. The legislature at their recent session increased the appropriation to $3.05 per day or about $93 per month. However, the necessary money to put it into effect has never been collected.

By transferring these aged to the pension and security department considerable money could be saved.

If payments to our welfare recipients are less than the maximum Federal participation of $65 per month, and in August, 1960, they were $52.92, such homes could be paid $100 per month at the expense of the State of $30 and the U.S. Government of $69.50. The saving under the present $2.50 per day payments would be $45.50 and under the $3.05 per day as authorized $62.50 per month.

The new Federal medical care assistance law to our States would also make available, if adopted by our legislature, an additional $12 per month—$9.60 in Federal and $2.40 in State money.

An important provision of this law also provides for the payment for service to our general hospitals for 42 days for mental and tuberculosis aged patients who have insufficient money to pay for such service.

I am writing this before our legislature meets so that persons who are interested in mental health or the aged may discuss this with our individual members of the legislature.

A reduction of patients will free some of our doctors and other employees to give more attention to the rest of our mentally sick people and we must realize sooner or later that our mental hospitals are not the place to give custodial care for our aged.

RUDOLPH KERN.

245 BEECH STREET.

This statement was made 4 years ago before our special legislative committee on mental health.

APRIL 14, 1959.

SMALL CLINICS ENVISIONED REPLACING MENTAL HOSPITAL

(By Clarke Stallworth, Post-Herald staff writer)

TUSCALOOSA, April 13, 1959.—Big, jail-like State mental hospitals are on their way out.

In their place—someday—will come small mental treatment clinics, scattered over the State.

This probably will be a long time happening in Alabama, according to Dr. J. S. Tarwater, superintendent of Alabama mental hospitals.

On the one hand are the large mental hospitals, four or five stories high at Bryce, with bars on the windows, and too few personnel to take care of the patients. This makes the patient feel as if he's in some sort of jail, and makes him unlikely to get well.

CLINICS SEEN

On the other hand are the small clinics scattered over the State. They would be close to the patient's home, so that he could be treated intensively and maybe go home after a few days.

"We certainly will start that sort of treatment in the future if the money comes. Our present $4 million from the bond issue is welcome but totally inadequate as to filling our needs," said Dr. Tarwater. "These clinics are smaller and a smaller hospital is more intimate, less impersonal, and it's easier managed. Everybody knows everybody and they are close to their relatives who might want to visit them and take them home for the weekend."

Tarwater said Dr. Harry Solomon, former president of the American Psychiatric Association, wrote in 1958 that large mental hospitals are on the way out.

"He envisioned a number of clinics where people might go for help and support and be able to prevent a break which would require hospitalization. And these outpatients clinics would operate for convalescent, or the patient who had made a recovery, where they might obtain supportive treatment if it was necessary.

"Then I think he certainly envisioned other State agencies that might come into the picture and help with the aged, such as nursing homes scattered over the State to serve particular areas.

"This would relieve the State hospitals of about 33 percent of our present total admissions each year. Then, if adequate facilities were available to properly house and take care of all the mentally defectives requiring hospital care, again our State hospitals could be reduced in size.

NO ROOM

"I think at the present time Bryce Hospital has about 400 mentally deficient patients who would have been in Partlow School years ago, had there been available room.

"Also out of our total of 4,809 patients at Bryce, one-third are 65 years of age or older. Actually, they are mentally sick people in that they are old, childish, feeble, confused, forgetful, and do need close supervision and nursing care * * * but as to any treatment and rehabilitation * * * it is very, very little when they're that age.

"The Alabama mental institutions are a catchall for every sort of patient who poses a problem in the home or community * * * that problem being either nursing care or distrubing behavior. There are no other State agencies that can take these patients. The State hospitals are the only source of care," said Tarwater.

Does he believe scattered clinics will ever come in Alabama?

"I believe it will certainly come in time. I don't envision it happening in the next 4 or 5 years, but I think it will eventually come," he said.

THE AMERICAN PARENTS COMMITTEE, INC.,
New York, N.Y., July 16, 1963.

Hon. OREN HARRIS,
House Office Building,
Washington, D.C.

DEAR MR. HARRIS: I am writing to express my approval of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, as approved by the Senate in the bill S. 1576, which is now before the Subcommittee on Health and Safety of the House Committee on Interstate and Foreign Commerce.

Testimony was presented by the American Parents Committee to your committee on the original bill sponsored by you and is part of the printed record. Enclosed is copy of a letter to Mr. Kenneth A. Roberts for the hearing record on title III of S. 1576.

We believe the addition of the proivsions for the training of teachers of mentally retarded and other handicapped children rounds out the program and shoud be regarded as an essential part of this legislation.

Sincerely yours,

GEORGE J. HECHT, *Chairman.*

THE AMERICAN PARENTS COMMITTEE, INC.,
Washington, D.C., July 16, 1963.

Hon. KENNETH A. ROBERTS,
Chairman, Subcommittee on Health and Safety, House Committee on Interstate and Foreign Commerce, New House Office Building, Washington, D.C.

DEAR MR. ROBERTS: The American Parents Committee, Inc., takes this opportunity to express its approval of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963." As we previously presented testimony to your subcommittee on the construction phases of this legislation, we will confine our comments to the provisions of title III of S. 1576, training of teachers of mentally retarded and other handicapped children.

The American Parents Committee since its formation in 1947 has worked exclusively for legislation to benefit children. The board of directors and national council is composed of 115 outstanding leaders of National, State, and local child welfare organizations across the country. Their interests collectively identify them with programs for all types of handicapped as well as normal children. Our goals for 1963, as approved by the board, include support of the expanded program on mental retardation as recommendation by the President's Panel on Mental Retardation and educational services for handicapped children.

We approve of the broad approach in title III toward reducing the shortage of trained personnel in the field of special education. This area of education, except for the Public Law 85-926 program for training teachers of mentally retarded children and the Public Law 87-276 program for training of teachers of the deaf, has received litle Federal encouragement. By amending, extending, and consolidating these two successful but limited laws, as proposed in title III, we would have a single, workable program for all handicapped children.

We are indeed pleased that your committee is considering the title relating to the education of all handicapped children at the same time as those providing for the construction of facilities. We approve of the entire bill and hope it will be presented for early consideration by the House.

Sincerely yours,

MRS. MARGARET K. TAYLOR,
Executive Director.

UNITED STATES CONFERENCE OF MAYORS,
Washington, D.C., July 11, 1963.

Hon. KENNETH A. ROBERTS,
Chairman, Subcommittee on Health and Safety,
House Committee on Interstate and Foreign Commerce,
Washington, D.C.

DEAR CONGRESSMAN ROBERTS: The United States Conference of Mayors, at its last annual meeting in Honolulu, June 9-12, passed a resolution endorsing the administration's proposed mental health program.

Since your Health and Safety Subcommittee is now holding hearings on S. 1576, the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, we thought it appropriate to make known the conference's support for this important legislation.

A copy of our mental health resolution is attached and we respectfully request that it be included as a part of your subcommittee's hearing record on S. 1576.

Sincerely yours,

JOHN J. GUNTHER, *Executive Director.*

Resolution adopted, 30th Annual Conference of Mayors, United States Conference of Mayors, Honolulu, Hawaii, Wednesday, June 12, 1963.

MENTAL HEALTH RESOLUTION

Whereas mental illness and mental retardation are among the Nation's most critical and complex health problems, afflicting millions of our citizens and placing heavy burdens on their families; and

Whereas overcrowding and inadequacy of many State hospitals and institutions, inadequate financial support and the shortage of professional personnel in both research and service efforts justify concerted action to end this tradition of neglect; and

Whereas many of the existing shortages and problems involving mental illness and mental retardation must be met at the community level with adequate facilities readily available for treating individuals on both an inpatient and outpatient basis; and

Whereas the establishment of programs to accomplish the goal of intensive preventive and treatment efforts centered in the community in which the patient lives requires that priority be given to a substantial construction program effected through Federal grants for community mental health centers, centers for comprehensive research in mental retardation, and facilities for the diagnosis, treatment, and rehabilitation of the mentally retarded; and

Whereas, because few communities have the resources necessary to meet the full cost, responsibility for the support and development of community mental health programs must be shared by local, State, and Federal agencies; and

Whereas professional manpower needed to implement programs of community action is insufficient and must be expanded: Now therefore, be it

Resolved, That the United States Conference of Mayors urge prompt enactment of Federal legislation needed to initiate these programs.

NATIONAL FEDERATION OF THE BLIND,
Washington, D.C., June 14, 1963.

Hon. KENNETH A. ROBERTS,
Chairman, Subcommittee on Public Health and Safety, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

DEAR CONGRESSMAN ROBERTS: No greater grief today burdens the heart and homes of thousands of American families than that caused by the presence of mentally retarded, mentally different children.

No greater economic calamity occurs today in thousands of American homes than that which results when the family provider becomes mentally ill—becomes unemployed, perhaps for months or years—becomes unemployable, perhaps for the remaining years of his life.

With skilled and professionally qualified personnel promptly available in sufficient numbers, with well-known and well-recognized training techniques promptly and adequately provided, many of the mentally retarded might be rehabilitated to normal, self-sufficient living.

With prompt and skilled diagnosis by competent personnel, with adequate care, treatment, and restorative training, many of the mentally ill might be returned to mentally healthy, economically responsible lives.

Today, although the disastrous social and economic consequences of mental retardation and mental illness can be appreciably reduced or totally eliminated, too often this does not happen because there just are not enough facilities available—there just are not enough qualified specialists and technicians available—to provide the skilled help so desperately needed.

There is an urgent need today for adequately trained and professionally qualified teachers and other specialized personnel in the field of special education for exceptional children. This need exists in every program and in every State and for every differently disabled group of children in America.

As blind men and women, we of the National Federation of the Blind know from personal experience of the educational programs available for sightless children—for many of us are products of these programs.

We know of the limited educational opportunities available to the blind child—the grossly inadequate educational opportunities available to the multiply disabled blind child—the child who is not only sightless but has additional physical or mental impairments.

We as blind adults know, too, of the long-neglected need to devise new and better ways of teaching blind children and preparing them to meet the problems of life. We know of the need to develop new and better methods and devices to assist blind and disabled children—new methods and devices for reducing the disadvantages resulting from the disability of blindness, resulting from other physical or mental impairments.

We believe—and we speak from experience gained by living and functioning without sight in a sight-styled world—that the overwhelming majority of blind children, of physically and mentally disabled children, if properly educated and adequately trained, can live worthwhile lives, supporting themselves, contributing to the support of their family, contributing to the strength and welfare of the Nation.

Mr. Chairman, there is no need today that mentally retarded children remain dependently idle, corrosively unproductive throughout their lives; that mentally ill persons of any age remain lost to life—a total waste— a permanent charge upon the resources of others; that blind children, that other impaired children, remain unfulfilled in their lives, needlessly helpless—when they can be trained and prepared to function and live fully, fruitfully, and to the benefit of the entire Nation.

We of the National Federation of the Blind, therefore, wish you to know of our unqualified endorsement and support of S. 1576, the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, which is now before your subcommittee for consideration.

It is our sincere and concerned hope that your subcommittee, the full Committee on Interstate and Foreign Commerce, and the Congress will act promptly and favorably on S. 1576.

We believe that S. 1576, as Federal law, will provide the means for transforming wasted lives into worthwhile lives, not only with immeasurable gain to the individuals and families directly concerned, but to the immeasurable gain of the whole Nation in the benefits which will accrue from dependent and unproductive citizens made whole, productive, and independent.

Sincerely yours,

JOHN F. NAGLE, *Chief, Washington Office.*

THE HOPE SCHOOL,
Springfield, Ill., June 15, 1963.

Representative KENNETH A. ROBERTS,
Chairman Subcommittee on Public Health and Safety,
U.S. House of Representatives, Washington, D.C.

SIR: We wish to go on record that we support bill S. 1576 and ask you to give it your wholehearted backing.

As you may know, there are thousands of handicapped children in this country who are vegetating, due to lack of adequate programing. This bill will help us to alleviate this.

Enclosed are brochures on the Hope School which explain our history and our goals.

Sincerely,

MAURICE TRETAKOFF,
Director.

COLUMBIA, S.C., *June 28, 1963.*

Hon. KENNETH A. ROBERTS,
Chairman, Subcommittee on Interstate and Foreign Commerce,
House Office Building, Washington, D.C.

DEAR MR. ROBERTS: The South Carolina Federation, Council for Exceptional Children, urges you as chairman of the Subcommittee on Interstate and Foreign Commerce to give favorable consideration to Senate bill 1576 which has been referred to your committee. This bill pertaining to facilities for mental health and for the mentally retarded contains title III which makes provision for scholarships for teachers. These scholarships are to be administered through State departments of education and hence will keep the allocation of scholarships close to the public schools. We think that this is an excellent provision. Under Public Law 85-926 we feel that this type of scholarship has made a tremendous impact in this very critical area of teaching top level people for special education purposes.

May I as president of the South Carolina Federation, Council for Exceptional Children, urge your favorable consideration of Senate bill 1576 particularly as it pertains to title III.

Cordially yours,

DONALD C. PEARCE,
President, South Carolina Federation, CEC.

ALEXANDER GRAHAM BELL ASSOCIATION FOR THE DEAF, INC.,
Washington, D.C., June 21, 1963.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.

DEAR CONGRESSMAN HARRIS: Since World War II the Alexander Graham Bell Association for the Deaf has been very concerned over the national shortage of qualified teachers of the deaf. The association, including its affiliated parents' groups, has worked hard to interest capable young people in choosing our profession as a career.

Public Law 87-276, passed in September 1961, has provided a tremendous stimulation of interest. In fact, during this its first year in effect, the number of students in our training centers has doubled. However, more time is needed to overcome the teacher shortage, and to expand our knowledge through research.

Our association supports part B of title V of H.R. 3000, the education bill proposed by the administration. We understand that your committee has under consideration legislation which includes those provisions. We ask that your committee report that legislation with a favorable recommendation. It will assist our profession in a significant way.

Respectfully yours,

GEORGE W. FELLENDORF,
Executive Director.

UNIVERSITY OF ALABAMA,
DEPARTMENT OF SPEECH,
University, Ala., July 2, 1963.

Hon. KENNETH A. ROBERTS,
Chairman, Subcommittee on Health and Safety,
U.S. House of Representatives, Washington, D.C.

DEAR CONGRESSMAN ROBERTS: I am writing to you concerning S. 1576, which I understand has been referred to your subcommittee.

Members of the speech and hearing profession here in Alabama and elsewhere are particularly concerned with title III of this bill. As you may know, there are numbers of children and adults with speech and hearing problems in Alabama and elsewhere who are unable to receive therapeutic and diagnostic services because of a shortage of trained specialists. As I understand title III, the Commissioner of Education would be provided with legislative authority to establish a teaching and training grant program in a number of fields concerned with handicapped children, including speech and hearing disorders. It seems desirable to me that an increase in the availability of teaching and training grants and other support for training programs be enacted.

While some of my colleagues feel that some features of title III are less desirable than others, in general, S. 1576 seems to be a bill which will strengthen speech and hearing training programs and provide an increased number of fellowships for graduate students in this area. I hope it will be possible for you to offer support for this bill and others like it. Those of us in speech and hearing and other rehabilitation fields have been extremely gratified by the congressional and Senate support the Alabama delegation has afforded us, and I will look forward to your comments concerning this bill, and particularly title III.

Sincerely yours,

EDWIN W. MARTIN, Ph. D.,
Coordinator, Adult Division, Speech and Hearing Clinic.

NATIONAL ASSOCIATION OF STATE DIRECTORS OF SPECIAL EDUCATION,
Frankfort, Ky., June 21, 1963.

HON. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN HARRIS: As legislative chairman of the National Association of State Directors of Special Education, I noted with pleasure that the U.S. Senate passed Senate bill 1576 on May 27, 1963.

The national association is composed of officials in State departments of education who are directly responsible for leadership, administration, and supervision of special education programs for exceptional children.

You may be interested to know that the association went on record as favoring the type of Federal legislation as represented in title III, Senate bill 1576, although the long-range goals of the association are somewhat more extensive and include the gifted. These goals are set forth in the association's policy statement that was adopted at the 1963 annual meeting. A copy of this legislative policy statement is enclosed.

We sincerely hope that the two-pronged attack on the teacher shortage in the field of special education, as contained in title III of Senate bill 1576, will receive the strong support of your committee and you, personally.

We want you to know that the association stands ready to provide any possible assistance in providing information or suggesting names of people who might be of assistance. If your committee has hearings on this subject, we would appreciate the opportunity of our association being represented.

Sincerely yours,

STELLA A. EDWARDS,
Chairman, Legislative Committee.

LEGISLATIVE POLICY STATEMENT OF NATIONAL ASSOCIATION OF STATE DIRECTORS OF SPECIAL EDUCATION (UNANIMOUSLY APPROVED AT 1963 ANNUAL MEETING)

The National Association of State Directors of Special Education is the organization of officials in the State departments of education of all States. These officials are directly responsible for leadership, administration and supervision of special education programs for exceptional children at the State level. The nature and administrative provisions of any legislation at the Federal level is of primary interest to this organization and to each of the States.

The National Association of State Directors of Special Education adopts the following statement of principles and recommendations. This statement outlines some of the most urgent needs in special education and suggestions as to ways the Federal Government could aid in their solution.

I. SCOPE OF PROGRAM

Education of exceptional children in the United States is part of the total program of American education. "Exceptional children and youth" are those with significantly different or additional educational needs resulting from physical limitations (including blindness, partial vision, deafness, impaired hearing, crippling or special health conditions); speech defects; mental retardation; mental giftedness; or social maladjustment or emotional disturbance. The purpose of special education is to meet the needs of 6 million exceptional children

and youth who, without special aid, will not have an adequate opportunity for education. Only about one-fourth of these children and youth are now being served by the Nation's schools.

Special education and rehabilitation programs, although related in many respects, through their very nature and legal responsibility, are different enough in their methods of financing, procedures and personnel to require separate administrative organization and supervision.

It is recommended that the administration of these two types of programs be maintained in separate agencies at the Federal level and in separate branches, sections or divisions (as applicable) in State programs.

II. FEDERAL LEGISLATION

We recommend comprehensive overall special education legislation, accompanied by adequate budget, as follows:

1. *Broadening of Public Law 85–926.*—The National Association of State Directors of Special Education appreciates the benefits of Public Law 85–926, an act to encourage expansion of teaching in the education of mentally retarded children, making Federal fellowships available to institutions of higher learning and to State educational agencies for the training of leadership personnel in the area of the mentally handicapped. We are especailly appreciative of section II that affords an unprecedented opportunity to recruit personnel who, with this training will be able to give improved leadership to State and local programs.

We would point out that the need for leadership personnel is also serious in other areas of special education, including the physically handicapped, the speech handicapped, the blind, partially seeing, the deaf and hard of hearing, emotionally disturbed, the socially maladjusted, and the gifted.

We recommend that Public 85–926 be amended, with adequate budget, to provide fellowships for leadership personnel in all other areas of exceptionality.

We further recommend that Public Law 85–926 be implemented, with adequate budget, to provide fellowships for teachers.

2. *Legislation to provide Federal financial assistance for special education programs in the various States.*—We recommend more comprehensive legislation to provide Federal financial assistance for special education programs in the various States. These funds should be administered by State departments of education.

Funds appropriated should be allocated according to the school population of the various States. Receipt of funds should be contingent upon approval of a State plan for expenditures of the funds.

This legislation should include funds for:

(*a*) Salaries for State department special education professional personnel.

(*b*) Support of special education programs for exceptional children and youth in local school districts throughout the various States.

(*c*) Promoting the education of teachers and supervisors of exceptional children and youth through scholarships, grants for higher education, workshops, conferences, and inservice education programs.

(*d*) Research and demonstration projects and pilot studies.

3. *Expansion and improvement program in the various States.*—We recommend that additional funds be granted to the Branch for Exception Children and Youth for stimulation grants to the States for the expansion and improvement of selected programs of special education in the public schools.

4. *Research and studies under Public Law 83–531.*—We recommend the continuation and expansion of Public Laws 83–531, an act to authorize cooperative research in education, with additional funds, to include research on the various types of exceptionality, the effect on the children's ability to learn, and the methods that provide the best educational opportunities for these children.

Furthermore, we recommend a revision of the procedures of reviewing and approving programs for research on exceptional children and suggest such proposals originate from preliminary studies by the Branch of Exceptional Children and Youth, such studies indicating research needs and priorities for special education. We also recommend Federal aid for the cooperative research program be in form of grants rather than reimbursements.

5. *Responsibility for administration of special education legislation.*—We recommend that all Federal funds appropriated to implement the proposed legislation should be administered by the Office of Education, Branch for Exceptional Children and Youth.

III. MULTI-DISCIPLINARY FEDERAL LEGISLATION

The National Association of State Directors of Special Education opposes provision in any multidisciplinary Federal legislation which assigns responsibility to a single State agency. We believe that such legislation would tend to bring about problems and inequities in administration at the State and local level,

IV. MARKED INCREASE IN OFFICE OF EDUCATION BUDGET FOR ADDITIONAL SERVICES

Special education staffs in State departments of education look to the Branch on Exceptional Children and Youth, U.S. Office of Education, for leadership in all aspects of planning and promotion of educational programs for exceptional children. The scope and amount of services rendered by the Branch in the past has been limited by its resources, such as lack of personnel and limited budget.

We recommend that the staff and functions of the Branch on Exceptional Children and Youth, U.S. Office of Education, be expanded. This expansion would not require legislation, but would require a much larger appropriation.

1. *Staff.*—We recommend that the Branch staff be expanded to include a specialist, and supporting staff, in each area of exceptionality.

2. *Consultative services.*—We recommend the expansion of the Branch's consultative services to State departments of education.

3. *Annual conferences for State directors.*—We recommend that funds be provided so that the Office of Education can call and finance an annual conference of special education State directors and consultants.

4. *Regional or area meetings.*—We recommend that funds be provided so that the Office of Education can call and finance regional conferences of special education specialists in each area of exceptionality.

5. *Sponshorship of conferences.*—We recommend that funds be provided so that the Office of Education can call and finance conferences of special education leaders and specialists to assist in the identification of critical issues, trends, problems, and gaps in educational programs for exceptional children and youth.

6. *Clearinghouse of information.*—We recommend the expansion of information services on such matters as State legislation, State support of programs, special education costs, etc.

7. *Recurring studies and surveys.*—We recommend the continuance of recurring studies and surveys such as:

(*a*) College and university programs for the preparation of teachers of handicapped and gifted children.

(*b*) State certification requirements for teachers of handicapped and gifted children.

(*c*) State legislative provisions for exceptional children and youth.

8. *Special studies.*—We recommend that the Branch conduct special studies dealing with the needs of all or several types of exceptional children and youth, such as:

(*a*) Incidence and numbers of various types of exceptional children and youth.

(*b*) Problems and methods of providing for exceptional children in rural areas.

(*c*) Preschool and kindergarten programs for exceptional children.

(*d*) Educational programs for exceptional youth of secondary school age.

NATIONAL ASSOCIATION OF
STATE MENTAL HEALTH PROGRAM DIRECTORS,
Washington, D.C., June 14, 1963.

Hon. KENNETH A. ROBERTS,
Chairman, Subcommittee on Health and Safety,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: During the Health Subcommittee hearings on H.R. 3688 and H.R. 3689, you asked our association to provide the committee with data on what the States have spent on mental health and retardation in the past 10 years.

We furnished the committee information on 40 States and that data is printed on page 228 of the hearings.

The State of Alabama is among those listed in the charts. However, since the hearings were printed, 4 more States have reported and we are now able to give you total data on 44 out of the 50 States.

New totals on State efforts in combating mental illness and retardation are as follows:

Forty-four States reporting: total expenditures over the past 10 years, all mental disorders, $10.9 billion.

Forty-one States: (*a*) mental illness, $7.9 billion; (*b*) mental retardation, $2.3 billion.

In addition to the above data, you will want the facts on how many States have gone on record (through either the Governor or commissioner of mental health) in support of the community mental health center program you will be considering Tuesday.

Twenty-five Governors and sixteen commissioners (in States and territories other than where the Governor made a statement) are on record, before either the House or Senate, in support of the program (a total of 41 States).

Your State mental health director has supported the program (see p. 458 of the hearings).

Sincerely,

HARRY C. SCHNIBBE, *Executive Director.*

AMERICAN PERSONNEL AND GUIDANCE ASSOCIATION,
Washington, D.C., June 28, 1963.

Hon. KENNETH ROBERTS,
House Subcommittee on Public Health and Safety,
House Committee on Interstate and Foreign Commerce,
U.S. House of Representatives,
Washington, D.C.

MY DEAR MR. ROBERTS: This association is very much interested in one of the measures currently before your subcommittee, namely, H.R. 3688 on mental health and H.R. 3689 on mental retardation. These important legislative proposals are of significance not only to the people who would be directly affected by the services made available, but to all American citizens of good faith and good will. We have too long overlooked the needs of our mentally handicapped people, whether they be mentally retarded or mentally ill. Our association felt so strongly on this matter that it adopted the following resolution at our convention, held in Boston, Mass., in mid-April. The resolution is as follows:

Resolved, That the American Personnel and Guidance Association supports an expanded and enlightened program of State and federally aided mental health care services and facilities, and urges that a stronger effort toward early identification and treatment of mental illness be activated.

Your favorable action on these bills currently before your subcommittee would certainly be an act of good legislation and good faith in keeping with the overwhelming action in the Senate regarding their companion bill S. 1576. Your positive approach to this matter will certainly be appreciated by the 17,000 members of this association and certainly by the millions of Americans who will be indebted to you by this progressive legislation.

Cordially yours,

ARTHUR A. HITCHCOCK, *Executive Director.*

OHIO SOCIAL HEALTH COUNCIL,
Cuyahoga Falls, Ohio, June 26, 1963.

Hon. KENNETH ROBERTS,
Chairman, House Committee on Interstate and Foreign Commerce,
House Office Building, Washington, D.C.

DEAR SIR: The Ohio Social Health Council encourages your committee to give favorable consideration to the Mental Retardation Facilities and Community Mental Health Centers Act of 1963, S. 1576, which we understand is now before your subcommittee.

The council believes that the passage of this legislation will be a long step forward in establishing provisions for a comprehensive long-range program of very much needed mental health services.

The council endorses the statement prepared by the National Association for Mental Health on President Kennedy's message to Congress on mental illness and retardation.

Sincerely,

MRS. MARGARET WALGENBACH,
President.
MARTHA LAUMAN, R.N.,
Secretary-Treasurer.

WEST VIRGINIA BOARD OF VOCATIONAL EDUCATION,
DIVISION OF VOCATIONAL REHABILITATION,
Charleston, W. Va., June 27, 1963.

Hon. KENNETH A. ROBERTS,
U.S. Congress,
Washington, D.C.

DEAR MR. ROBERTS: As director of West Virginia's program of vocational rehabilitation, and as a private citizen vitally interested in the health and welfare of this Nation's handicapped population, I would like to request that you give your full support to S. 1576.

I have carefully examined this bill and consider it to be a sound piece of legislation which will do much to combat the serious problem of mental health in the United States. The twin problems of mental illness and mental retardation are of such magnitude and complexity that our individual States have neither the means nor the incentive to come to grips with them at this time. What is needed most at this point is national leadership from the Federal Government to point the way for all States. I feel that S. 1576, if passed by Congress, will pave the way for an effective nationwide program.

Sincerely yours,

F. RAY POWER, *Director.*

STATEMENT BY JOHAN W. ELIOT, M.D., ON BEHALF OF THE PHYSICIANS FORUM, INC.

I am Johan W. Eliot, M.D., assistant professor of maternal and child health at the University of Michigan School of Public Health, and a member of the board of directors of the Physicians Forum. The Physicians Forum, Inc., an organization of physicians concerned with improvement in the distribution and quality of medical care, is impressed with both the wisdom and the urgency of the proposed improvements in medical care for mothers and children embodied in H.R. 3386. We are aware that this legislation has attracted widespread support from both professional and lay groups and seems likely to achieve eventual passage. However, we are very much concerned that this passage be accomplished expeditiously in order that the programs of the many agencies and institutions which will be involved in development of the new activities and improved care programs envisioned in this act may be carried forward without loss of time or loss of personnel.

It cannot be too strongly emphasized that merely to carry on existing programs in maternal and child health, mental health, and care of crippled children and retarded children at their present levels of support will be to slip backward in relation to the rapidly mounting problems. With the number of children rapidly increasing in the country, some States which have maintained only a modest rate of growth will actually receive substantially less funds for maternal and child health services during the coming year than in previous years because of redistribution of fixed amounts of funds amongst all the States. Those States whose populations are increasing less fast than some others are not necessarily free of problems. As a matter of fact, many of them are continuing to produce children at substantial rates but because of lack of job opportunities and because of other economic factors, young people of working age are tending to leave the States. Some of our most acute needs for medical care services, therefore, are obscured by population shifts, due to unemployment and other economic factors.

It is truly difficult to say which of the programs encompassed in this legislation is most urgent. To a family forced to choose between subjecting children to serious emotional upset because of the presence in the home of an emotionally disturbed parent, and the family disruption associated with complete separation

of the parent from the family in a distant institution, there can be nothing more urgent than the portions of the President's program directed toward establishment of community mental health facilities that will render assistance to families without breaking them asunder. To the family bewildered by the problems of raising a mentally retarded and handicapped child in the home, there can be nothing more important than the features of this legislation directed toward adequate diagnosis of handicapping conditions, treatment of whatever can be treated, education of handicapped children to the extent of their capabilities, and assistance to families in their homes in caring for these children and adjusting to the emotional burdens that inevitably accompany the physical problems.

This legislation carries a proper balance between major increased assistance to ongoing programs of care, creation of new patterns of care, and basic research to prevent, alleviate, and provide improved treatment methods for emotional problems, mental retardation, and physical handicaps.

We are in a position where we must run hard to stay where we are and in many cases we must run hard to catch up to the level of services considered as standard and minimum 10 and 20 years ago. This statement applies particularly to maternal health services. We have seen the infant death rate fall dramatically from the turn of the century until 1950, then level out, and in recent years take an ominous upturn. At the present time it is fluctuating and for all practical purposes has been stationary since 1950. While the care of mothers and newborn infants has improved in some areas, it has sharply deteriorated in other areas, especially in the heart of our great cities. Here, there are more and more mothers coming to delivery without any medical care whatsoever. The obstetric care facilities for families of lower income have remained stationary or have expanded only slightly in capacity in the face of frequently doubled caseloads. Facets of desirable prenatal care such as prenatal classes have been allowed to deteriorate and lapse because the help of all personnel was involved in rendering the barest essentials of care. Mothers of newborns who were routinely visited 10 and 15 years ago by public health nurses can expect to see a nurse now only if their economic level is very low and some additional detrimental medical condition is already known in the infant. The talents of first class public health administrators have been devoted to the excruciating task of deciding which elements of service to curtail or abandon, one by one, in the face of the ever mounting population to be served and problems amongst the people.

Yet, this is the richest Nation on earth. We can spend $30 billion to place one man on the moon, while mothers come to childbirth without prenatal care and many hundreds of thousands of homes carry the burden of care of handicapped children with still very meager assistance from public programs. Communist countries may flounder and stumble when trying to accomplish a "great leap forward, but this country has the clearly demonstrated capacity to take giant strides whenever it shows a desire. We can take a giant stride in humanitarian care and, even more important, in the prevention and early alleviation of handicapped conditions in children and adults, by passage of H.R. 3386. We urge that your committee bring this bill before the House at an early date with a strong recommendation for passage in its entirety.

Statement of the American Speech and Hearing Association

The American Speech and Hearing Association is the recognized national professional organization to which most speech pathologists and audiologists belong. For over 30 years, this organization, now with more than 10,000 members, has exercised leadership in developing and improving standards of training and service in the profession which it represents. It is the only national organization to which persons in this, as well as allied professions, look for standards of professional competence in speech and hearing.

SIGNIFICANCE OF SPEECH AND HEARING DISORDERS

Disordered speech or impaired hearing may inhibit an individual's social adjustment, reduce his learning ability, and restrict his economic capacity. Furthermore, the far-reaching consequences of serious disability of communication may leave social and emotional scars on both the individual and his family. Without adequate diagnostic and therapeutic attention it is likely that indi-

viduals with significant impairment in hearing or speech may fail to realize their full mental or vocational potential. Without the ability to communicate effectively with others he may find himself unequal to the requirements of school and, in later life, incapable of holding a position commensurate with his skills and talents. A feeling of isolation may result from the speech or hearing disability which in turn may lead to severe emotional disturbances and make it difficult or impossible for him to achieve a normal social development. Man's highest evolutionary achievement is his ability to communicate. A significant disability of speech creates one of man's most profound problems.

It is important to keep in mind that the hearing and speech disabled may be found in every intellectual, social, and vocational category in society. It is likewise important that we understand that severe speech and hearing disorders interfere or make impossible effective communication. The need to communicate effectively is basic to learning itself. With a significant communication impairment we can expect retardation in educational development. Approximately half of the schoolchildren who have impaired speech and hearing are above average in intelligence, and thousands of them are among the gifted. The neglect of these children may have the result of inhibiting the development of potentially great scientists and mathematicians and perhaps leaving them dependent on a society in which they otherwise might be leaders. Adequate training and research programs in this field are essential if the schoolchildren of the Nation who have speech and hearing impairments are to be given the special help and instruction they must have if they are not to be gravely handicapped, not only while in school but also in adult life.

INCIDENCE OF SPEECH AND HEARING DISORDERS

The 1957–58 national health survey reported that 7 million Americans have hearing or speech impairment. The more commonly used figure for the incidence of handicapping speech and hearing disorders is 8 million. The U.S. Office of Education reports that children with speech and hearing disorders comprise the largest single disability group. According to the most conservative estimate 1½ million school-age children sustain speech or hearing deviations. Also according to the U.S. Office of Education only one child in four is receiving necesdiagnostic and remedial assistance for his speech or hearing difficulty.

THE NEED FOR SPEECH PATHOLOGISTS AND AUDIOLOGISTS

It is estimated that approximately 20,000 speech pathologists and audiologists are needed to provide the speech and hearing services for the 8 million persons with significant speech or hearing handicaps. It is estimated that no more than 5,000 qualified specialists are available at the present time to meet the needs of this handicapped group.

In the United States there are more than 200 universities and colleges engaged in the training of speech and hearing specialists; 85, of the more than 200 training centers, provide only preprofessional undergraduate training. Of the approximately 110 programs offering graduate education and graduate degrees in speech pathology and audiology nearly 40 programs offer the Ph. D. degree or equivalent. The remainder offer a master's degree. To provide for the services needed in this field colleges and universities should be graduating 1,500 speech and hearing specialists each year. At present fewer than 800 are receiving graduate degrees annually. On the basis of present evidence there seems to be an adequate number of institutions committed to training in this field, but assistance in staffing and equipping some of these programs is absolutely essential. The ultimate success of any assistance program to this field rests in the strengthening of existing programs so they can adequately train the additional students needed to meet the demand. At the same time a great deal needs to be done to improve the substandard programs. Major support is needed in the form of graduate fellowships but the strengthening of the training programs themselves is at the core of the problem of increasing the supply of competent speech and hearing specialists.

SPEECH PATHOLOGY AND AUDIOLOGY

Speech pathology and audiology is concerned distinctively with the processes and disorders of human symbolization and communication, and interacts with the biological, physical, behaviorial, and social sciences. Graduate education in this field aims to realize scientific, scholarly, and clinical objectives. More

specifically research, teaching, and clinical activities in this field deal with normal and deviant speech, voice, language, and hearing processes. Speech pathologists are individuals whose primary interest is in the diagnosis of speech disabilities and the habilitation and rehabilitation of children and adults with speech and language handicaps. Audiologists are individuals whose primary interest is in the measurement and assessment of hearing and the habilitation and rehabilitation of children and adults with impairment of auditory functions.

In our field, in particular, there is substantial confusion resulting from the multiplicity of terms used to identify speech pathologists and audiologists. They have been variously referred to as speech correctionists, speech and hearing clinicians, speech and hearing specialists, etc. Each of these terms is in common use. We have chosen the terms speech pathologist and audiologist for this testimony, but other terms would have served as well. Our principal concern with the terminology issue in proposed legislation is that the terminology used be in common use and not inaccurately describe or inaccurately imply what these specialists do, what their training has been or what their professional competencies are. In this regard, S. 1576, title III, would imply that we were "teachers." Unlike professional teachers who are instructional personnel, such as teachers of the deaf, teachers of the mentally retarded, etc., speech pathologists and audiologists are not trained as teachers and generally are not competent to provide instructional services. The services provided by the speech pathologist and audiologist is of a clinical, noninstructional nature and is the same whether it is provided in the public schools, in a hospital or in a community center. We believe strongly that the use of the term "teacher" as used in S. 1576, title III, to describe the speech and hearing specialist is inappropriate and urge that one of the terms mentioned, i.e., speech pathologist and audiologist, speech and hearing specialist, speech and hearing clinician be substituted.

EDUCATION OF SPEECH PATHOLOGISTS AND AUDIOLOGISTS

The education of speech pathologists and audiologists is essentially the same regardless of the context in which they later find employment. That is, a specialist in the speech disability area will receive essentially the same training whether he desires employment in the public schools or in a comprehensive rehabilitation center. The same statement may be made concerning the hearing specialist. Whether the employment environment is a medical one, such as a hospital or a department of public health, or an educational one such as a public school, the academic and clinical training remains about the same. One college or university providing professional preparation in this field requires of its students essentially the same specialized courses as do other colleges and universities. As a consequence, graduates of most programs in this field find it possible to obtain employment in a wide variety of environments. Easy movement from one professional setting to another is characteristic of this field and is important to the optimum use of a limited number of qualified personnel. The heads of training programs in our universities as well as the leading employers of these specialists support, for the most part, a concept of similar training for all personnel. We hold strongly to the idea that a profession should be self-determining. The profession as a whole and the academic programs educating specialists for the profession in particular must retain the responsibility for meeting their obligations to the handicapped persons of their concern. In this regard, S. 1576, title III, designates the U.S. Office of Education as the administrative environment. The administering office is of little concern to us. The Vocational Rehabilitation Administration has, for example, done an exceptional job in administering a broad and vital program in speech and hearing. It has done this without exerting control over our academic programs. The freedom provided the profession by VRA results from the wisdom of the VRA officials responsible for administering the teaching and training grants program and from the degree of responsibility given a technical panel of leading speech pathologists and audiologists. We hope that should a handicapped children's bill pass which would be administered by the U.S. Office of Education that the OE officers would support the self-direction concept of the profession and particularly our universities and colleges.

RECRUITMENT

One of the major problems in this profession is the recruitment of an adequate number of high-caliber students potentially capable of providing the diagnostic and therapeutic services needed by the speech and hearing handicapped. In today's world clinical activities, such as ours, come to increasing disadvantage.

It seems as though there is a decrease in the number of qualified students in a clinical field such as this in proportion to the increase in prestige and status of certain of the basic science fields. As a consequence, even an unlimited grants-in-aid plan to strengthen the college and university training program or an unlimited graduate fellowship program will not solve the problems of this clinical specialty. Assistance will be needed to recruit intelligent young people into training programs designed to serve the handicapped. Even the field of medicine, so long at the top of the status ladder among the professions of this country, has encountered increasing difficulty in recruitment. If the handicapped child or adult is to receive the kinds of services we are capable of providing we must be prepared to exert a maximum recruitment effort. Any legislation intended to be helpful to the handicapped child should be constructed so that projects designed to recruit competent students into the field may receive encouragement. The speech and hearing field, as I am sure is the case with many of the other fields involved with the handicapped child, needs to be helped to tell its story to the public. Unless some assistance is provided we need not expect these relatively unfamiliar fields to become significantly better known—and unless their importance in rehabilitation and education become more widely known we should not expect dramatic results from any grants-in-aid program to institutions or students. Legislation proposed for these fields should give particular consideration to this matter. We presume that the provisions of S. 1576, title III, will be interpreted to include recruitment efforts and activities.

SPEECH PATHOLOGY AND AUDIOLOGY IN THE FEDERAL GOVERNMENT

The Federal Government through the Vocational Rehabilitation Administration, the Office of Education, the Children's Bureau, the Veterans' Administration, the Neurological and Sensory Diseases Services program, the National Institute of Neurological Diseases and Blindness as well as other Federal programs have expressed concern for the welfare of speech and hearing handicapped in this country. Some of these agencies have been concerned primarily with speech and hearing research, some have been concerned with direct clinical services to specific groups of beneficiaries for whom they are responsible and some have been concerned principally with the present critical national shortage of both university faculty and clinical personnel.

Vocational Rehabilitation Administration: The Vocational Rehabilitation Administration has maintained a diverse program in speech pathology and audiology. In 1963, the Vocational Rehabilitation Administration expended funds in the amount of $1,800,000 for teaching and training grants in this field. These fund were granted to 48 colleges and universities (out of approximately 110 offering graduate study) and provided support for 435 traineeships. In 1964, the Vocational Rehabilitation Administration has requested funds in the amount $2,400,000. This amount would, if granted, make possible teaching grants to 63 of the colleges and universities offering graduate study in speech pathology and audiology and the support of 502 trainees. The VRA program has been the principal source of encouragement and support from the Federal Government in the area of training clinical specialists for this field. Without their assistance the plight of the speech and hearing handicapped would be much worse than it is at the present time.

U.S. Office of Education: The U.S. Office of Education whose cooperative research division has, since the inception of its first program in late 1956, supported research in the speech and hearing field in an amount in excess of $1 million. The Office of Education provides no training grants in speech pathology and audiology and in this regard the Office of Education is unique among the major units of the Federal Government which are concerned with the speech and hearing handicapped.

Veterans' Administration: The Veterans' Administration continues to expend in excess of $2 million a year in all phases of its speech pathology and audiology program. The principal expenditure of these funds is for the purpose of providing direct clinical services to speech- and hearing-handicapped veterans. These services are provided mainly through clinics operated within the Veterans' Administration institutions. Because of the critical shortage of personnel required for the staffing of its own as well as contract clinics, the Veterans' Administration has found it necessary to begin a training program which in 1963 provides for 70 trainees at a cost of $237,000. The Veterans' Administration

has been and continues to be genuinely concerned about the quality of services provided veterans and has been consistently unable to employ sufficient qualified personnel to meet the needs of their beneficiaries. Both the VA clinics as well as the community service centers with whom they contract do not have an adequate number of competent speech pathologists and audiologists. As the veteran population continues to age, there will be an increasing number of individuals requiring speech and hearing services. The extent of the potential need for speech pathologists and audiologists in the Veterans' Administration is not yet clear, but it is certain that unless there is a major change in the anticipated supply many veterans will not receive the services they require.

Children's Bureau: The Children's Bureau has also developed a program in the speech and hearing field. In 1958, the Children's Bureau reported that in 34 States 20,000 children received care for hearing problems through crippled children's agencies. In 52 States and territories they report 15,000 children received services for cleft palate and cleft lip alone. In addition, 28,000 children received care for cerebral palsy conditions, many of whom required services of a speech pathologist. In 1963 the Children's Bureau expended approximately $228,000 in the speech and hearing area. These funds were distributed to 5 institutions and included 24 graduate fellowships.

National Institute of Neurological Diseases and Blindness: The National Institute of Neurological Diseases and Blindness has developed a substantial interest in the speech and hearing field. Their efforts have been directed to the training of specialists for research and academic positions. Whereas the VRA program has been a substantial effort to meet the need for qualified clinical specialists, this beginning effort to NINDB has been directed to meet the need for academicians and researchers. In fiscal year 1963 the NINDB made graduate training grants to four universities. The directors of those university programs, in turn, designated seven students as NINDB trainees. Unfortunately, only two of these seven trainees were at the predoctoral level. The remaining five were at the postdoctoral level. The cost of these seven trainees was $30,295. A fifth school has been awarded a graduate training grant but, as yet, no trainees have been designated.

The NINDB also has provisions for special and postdoctoral fellowships awarded to graduate students sponsored by a university. These fellowships are awarded on an individual basis by the National Institutes of Health. In fiscal year 1963 five schools sponsored a total of nine special and postdoctoral fellows for a total cost of $78,000.

National Institute of Dental Research: In 1963, the National Institute of Dental Research made grants to 3 universities totaling approximately $146,000 and providing 14 fellowships. The NIDR program is new but it may be expected to make a significant contribution to the training of speech pathologists (particularly for research) during the coming years.

Neurological and Sensory Diseases Service Program: In 1963 funds totaling approximately $160,000 were granted 3 universities for 12 traineeships. The NSDP also has a "central selection" individual traineeship program and awards within this program are just now being made. Within the past weeks the NSDSP awarded 17 individual traineeships and it is our understanding that more such awards will be made soon.

STANDARDS OF THE SPEECH AND HEARING PROFESSION

The speech and hearing profession has been developing standards of clinical competence for speech pathologists and audiologists for more than 30 years. These standards have been developed to improve training and to identify individuals competent to provide clinical speech and hearing services to handicapped children and adults. The essential purpose of these standards is to protect the public and in particular the speech and hearing handicapped.

We are certain the Subcommittee on Health and Public Safety will share our concern that these standards not be jeopardized by legislation designed to help the handicapped child. S. 1576 authorizes the Commissioner of Education to appoint advisory committees to assist him in administering the provisions of of title III. Should S. 1576, title III, be enacted into law we would hope that the Commissioner would choose to establish a panel of leading educators in speech pathology and audiology to advise him on a graduate fellowship program in this field. S. 1576 provides no other safeguards for the profession's standards than this authority granted the Commissioner. We would hope that such a panel

would guarantee to the public and the speech and hearing handicapped that Federal funds will be used to assist only those students who attend training programs which meet nationally recognized standards in this field.

GRADUATE FELLOWSHIPS

A second matter of importance to us is that involving the academic background of the student applying for training grant support. From both professional and economic points of view it is important that training grant funds for speech pathologists and audiologists be made available only to graduate students. The master's degree has been established as the minimum academic level for full full participation in this profession. Thus, from a professional point of view it would be unsound to utilize Federal funds for the support of undergraduate preprofessional training. In addition, however, past years of experience in this field have indicated that grant support to undergraduates would be an unwise economic policy. This field is attractive to many young women, a high percentage of whom obtain training only to the B.A. level and never actively participate in the profession. No matter what action is taken by Congress, there will always be a limit to the number of dollars available for support of students in training. The funds that are made available should then be put to maximum use. Maximum use of student grant funds will result only if they are restricted to graduate fellowships. S. 1576, title III, as we interpret its provisions, does restrict speech pathology and audiology support to the graduate level.

CONCLUSION

The American Speech and Hearing Association is particularly gratified to see consideration being given to the administration's proposals for aid to handicapped children. Title III, of S. 1576, has the potential for strengthening our university and college training programs and for increasing substantially the available supply of speech and hearing specialists qualified to meet the needs of speech and hearing handicapped children. We hope—and we urge—that, if S. 1576 or a similar measure is enacted into law, that the Commissioner of Education will utilize his authority to establish an advisory panel in speech pathology and audiology composed of responsible leaders from university and college graduate training programs in this field.

BIRMINGHAM, ALA., *June 24, 1963.*

HON. OREN HARRIS,
Chairman, House Committee on Interstate and Foreign Commerce,
Washington, D.C:

The Alabama Association for Mental Health and its 48 local associations urge full approval of President's program on mental health and retardation. We request that you restore full amounts as called for in Senate bill 1576. This program of vital interest to citizens everywhere. Will appreciate your consideration and that of your committee.

JOHN K. WILLIAMS,
Executive Director, Alabama Association for Mental Health.

WILSON, N.C., *June 25, 1963.*

Representative OREN HARRIS,
Chairman, House Committee on Mental Health,
Washington, D.C.:

Urge favorable action for full appropriation as recommended on mental health bill before House at present time, Senate bill 1576.

Dr. JOHN MCCAIN,
President-elect, North Carolina Mental Health Association; Chairman, Mental Health Committee, Medical Society, State of North Carolina.

KANSAS CITY, MO., *June 26, 1963.*

Hon. OREN HARRIS,
Chairman, House Committee on Interstate and Foreign Commerce,
Washington, D.C.:

Kansas City Association for Mental Health heartily endorses Senate bill 1576 and urges your committee act favorably on this legislation and restore appropriations which were cut by subcommittee.

LOWELL L. SMITHSON,
President, Kansas City Association for Mental Health.

BROOKLINE, MASS., *June 25, 1963.*

Hon. OREN HARRIS,
Chairman, House Committee on Interstate Commerce,
House Office Building, Washington, D.C.:

Brookline Mental Health Association urges full support of S. 1576 and restoration of all original terms.

Dr. HERBERT HOFFMAN,
Executive Director.

ALBUQUERQUE, N. MEX., *June 25, 1963.*

Congressman OREN HARRIS,
Chairman, House Committee on Interstate and Foreign Commerce,
House Office Building, Washington, D.C.:

We urge favorable action on bill S. 1576 on President's program on mental health and retardation restoring Senate terms.

Mrs. ROBERT LYTLE,
President, New Mexico Association for Mental Health.

MADISON, WIS., *June 25, 1963.*

Congressman OREN HARRIS,
Chairman, House Committee on Interstate and Foreign Commerce,
Washington, D.C.:

Urge your committee restore cuts made on S. 1576 by House subcommittee. Entire amounts are needed to support a full mental health and retardation program through Federal aid to States. Imperative this legislation passed to spur future mental health programs.

ELI TASH,
Public Policy Chairman, Wisconsin Association for Mental Health.

ST. PAUL, MINN., *June 7, 1963.*

Congressman KENNETH ROBERTS,
Chairman, Subcommittee on Health,
Interstate and Foreign Commerce Committee,
U.S. House of Representatives,
Washington, D.C.:

Wish to notify you of my enthusiastic support for Senate bill 1576, the administration program to expand facilities for treatment of mental disabilities, please be assured this measure has the full support of the State administration in Minnesota and hope this measure is enacted into law.

KARL F. ROLVAAG,
Governor of the State of Minnesota.

TOPEKA, KANS., *June 18, 1963.*

KENNETH ROBERTS,
House of Representatives,
Washington, D.C.:

In Kansas we urge immediate passage of Senate bill 1576 scholarships and fellowships are urgently needed for teachers and teacher trainers of exceptional children.

JAMES E. MARSHALL,
Director, Division of Special Education.

BERKELEY, CALIF., *June 14, 1963.*

Hon. KENNETH A. ROBERTS,
Chairman, House Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.:

Urgently request your support for S. 1576 providing essential improvements in services for handicapped children.

Respectfully,

BERTHOLD LOWENFELD, Ph. D.,
Superintendent California School for the Blind, Chairman Legislative Committee, East Bay Chapter Council for Exceptional Children.

URBANA, ILL., *June 13, 1963.*

Hon. KENNETH A. ROBERTS,
House of Representatives, Washington, D.C.:

I have studied S. 1576 and H.R. 3689 and 3688. It is my opinion that S. 1576 is most appropriate for the needs of this country since it includes title III. I urge you to lend your influence toward the inactment of S. 1576 by the Subcommittee on Public Health and Safety.

SAMUEL A. KIRK,
Director Institute for Research on Exceptional Children, University of Illinois.

CHICAGO, ILL., *June 14, 1963.*

Representative KENNETH A. ROBERTS,
Subcommittee on Public Health and Safety Committee on Interstate and Foreign Commerce, U.S. House of Representatives, Washington, D.C.:

Parents of The Blind, Inc., strongly urge passage of S. 1576 as a measure to improve the education foundation on which the future of handicapped children is built.

Mrs. MARIE PORTERE,
President, Parents of the Blind, Inc.,
180 North Wabash Ave.

DETROIT, MICH., *June 17, 1963.*

Hon. KENNETH A. ROBERTS,
Chairman, Subcommittee on Public Health and Safety, Committee on Interstate and Foreign Commerce, Washington, D.C.:

Understand your committee considering S. 1576 June 18. Bill provides for training teachers of handicapped and grants to universities for research and demonstration project in educating handicapped children. Urge favorable consideration. If training grants are limited to 3 years that is too short a time to assist universities adequately.

Respectfully,

JOHN J. LEE,
Chairman, Department of Special Education and Vocational Rehabilitation, Wayne State University, Detroit, Mich.

TOPEKA, KANS., *June 18, 1963.*

KENNETH ROBERTS,
House of Representatives,
Washington, D.C.:

As past president of Kansas State Federation of the Council for Exceptional Children, I urge your affirmative support when voting for the passage of S. 1576.

Dr. ETHEL M. LEACH,
Director of Programs for Orthopedically Handicapped Children.

LAURELTON, N.Y., *June 15, 1963.*

Representative KENNETH A. ROBERTS,
Chairman, Subcommittee on Public Health and Safety, on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.:

As parents of blind and blind multihandicapped children we are too well aware of the deprivation suffered by our children through the lack of adequate facilities for their training and education and the apalling lack of qualified workers in this area. There is no greater pain than watching a child who cannot develop to his full capacity because there is no place for him to go nor anyone equipped to work with his multiple problems. This is the stonewall that our parents have met at every turn of the road. If equality of opportunity to all American children is to be more than a slogan than passage of S. 1576 is an absolute must, for many of our children who have had to grow up in a vast wasteland, it is already too late, but for many, many others S. 1576 is their last hope. We urge your committee to do everything in its power to enact the provisions of S. 1576 into law.

SELMA SHENKIN,
President, Executive Committee, Association for the Advancement of Blind Children.

(Whereupon, at 1:20 p.m., the subcommittee adjourned.)

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