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ADMINISTRATION AND OPERATION OF ST. ELIZABETHS HOSPITAL

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HEARINGS

BEFORE THE

AD HOC SUBCOMMITTEE ON ST. ELIZABETHS
HOSPITAL

OF THE

COMMITTEE ON EDUCATION AND LABOR
HOUSE OF REPRESENTATIVES

EIGHTY-EIGHTH CONGRESS

FIRST SESSION

ON

H.R. 9072

TO PROVIDE FOR THE ESTABLISHMENT OF A COMMISSION ON
THE IMPROVEMENT OF ST. ELIZABETHS HOSPITAL

HEARINGS HELD IN WASHINGTON, D.C.,

NOVEMBER 12, 13, 14, AND 20, 1963

Printed for the use of the Committee on Education and Labor

ADAM C. POWELL, *Chairman*



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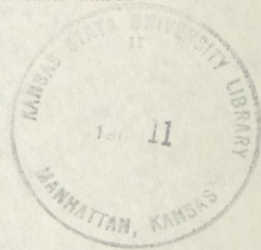
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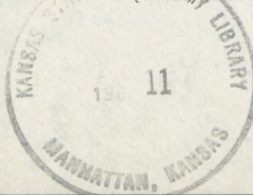
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ADMINISTRATION AND OPERATION OF ST. ELIZABETHS HOSPITAL

TUESDAY, NOVEMBER 12, 1963

HOUSE OF REPRESENTATIVES,
AD HOC SUBCOMMITTEE ON ST. ELIZABETHS HOSPITAL
OF THE COMMITTEE ON EDUCATION AND LABOR,
Washington, D.C.

The ad hoc subcommittee met, pursuant to notice, at 10 a.m., in room 429, Cannon House Office Building, Hon. Dominick V. Daniels presiding.

Present: Representatives Daniels and Goodell.

Also present: Hon. Durward G. Hall, a Representative in Congress from the State of Missouri; Emory W. Reisinger II, counsel for the subcommittee; Ray Rodgers, minority counsel; Dr. Deborah P. Wolfe, education chief; and Gail Smith, subcommittee clerk.

Mr. DANIELS. The subcommittee will come to order. We have for consideration H.R. 9072.

(H.R. 9072 follows:)

[H.R. 9072, 88th Cong., 1st sess.]

A BILL To provide for the establishment of a Commission on the Improvement of Saint Elizabeths Hospital

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

DECLARATION OF PURPOSE

SECTION 1. It is hereby declared to be the policy of Congress that a program should be undertaken for the improvement of Saint Elizabeths Hospital in the Nation's Capital so that such institution will provide an example to other institutions throughout the Nation which are engaged in treatment of the mentally ill.

ESTABLISHMENT OF COMMISSION

SEC. 2. In order to assist the Congress in determining the action which must be taken to accomplish the purpose set forth in section 1, there is hereby established a Commission to be known as the Commission on the Improvement of Saint Elizabeths Hospital (hereinafter referred to as the "Commission").

MEMBERSHIP OF THE COMMISSION

SEC. 3. (a) The Commission shall be composed of five members appointed by the President, by and with the advice and consent of the Senate. Of the members of the Commission, one shall be a person representative of the field of psychiatric medicine, one shall be a person representative of the field of psychiatric social work, one shall be a person representative of the field of hospital administration, one shall be a person representative of the field of psychiatric nursing, and one shall be a person representative of the public.

(b) The Commission shall elect a chairman and vice chairman from among its members.

(c) Three members of the Commission shall constitute a quorum.

(d) Members of the Commission shall, while serving on the business of the Commission, be entitled to receive compensation at the rate of \$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.

COMMISSION STAFF

SEC. 4. The Commission shall appoint a staff director who shall receive compensation at the rate of \$15,000 per annum. The Commission is also authorized to appoint, and prescribe the duties of, such other employees as it may find necessary to carry out its functions.

DUTIES OF THE COMMISSION

SEC. 5 It shall be the duty of the Commission to make a full and complete investigation and study of all phases of the operation of Saint Elizabeths Hospital with a view to determining the steps which must be taken to accomplish the policy stated in section 1. Within one year after the enactment of this Act, the Commission shall transmit a report to the Congress. Such report shall contain the results of the Commission's investigation and study and the Commission's recommendations. Six months after such report is transmitted the Commission shall cease to exist.

APPROPRIATIONS AUTHORIZED

SEC. 6. There is hereby authorized to be appropriated the sum of \$150,000 to carry out the purposes of this Act.

Mr. DANIELS. This subcommittee, consisting of my colleagues, Mr. Sickles of Maryland—Mr. Sickles cannot be with us today as he is tied up in his district—and my colleague from New York, Mr. Goodell, will proceed with the hearing.

My colleagues and I are meeting today to inquire into the organization and administration of St. Elizabeths Hospital. Supervision of these activities is the responsibility of the Committee on Education and Labor. The chairman has directed this inquiry as a result of recent developments which affect the hospital.

On February 5 of this year the President forwarded a special message to the Congress covering many phases of the critical and immediate problem of mental health. Thereafter the Congress enacted Public Law 88-164 with a view toward placing the full power of the Federal Government behind a bold new approach at virtually every level of this problem.

St. Elizabeths Hospital, the sole federally maintained mental hospital providing comprehensive care for the general public, is naturally destined to play a major part in the implementation of the President's program. Accordingly, I have introduced H.R. 9072, which is under consideration here today.

In the past several years enforcement officials, the general public, and Members of Congress have become increasingly concerned over the number of escaped patients from St. Elizabeths who have been involved in the commission of crime. It is apparent that the treatment of prisoner patients must be consistent with both the goal of rehabilitation of the patient and protection of the public from the dangerous criminal. Thus it is that we are here today for the dual purpose of inquiring into the most appropriate method of determining the future

of St. Elizabeths Hospital and seek a way to minimize the threat to the public safety presented by the escape of mental patients.

Our first witness today is Mr. Boisfeuillet Jones, Special Assistant to the Secretary of Health, Education, and Welfare. You may proceed, Mr. Jones.

STATEMENT OF BOISFEUILLET JONES, SPECIAL ASSISTANT TO THE SECRETARY (HEALTH AND MEDICAL AFFAIRS), U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. JONES. Mr. Chairman and members of the committee, the Department of Health, Education, and Welfare appreciates the opportunity to appear before this committee as it undertakes an investigation of St. Elizabeths Hospital. We are aware that the committee's inquiry into St. Elizabeths Hospital was prompted by its concern about the security aspects of the hospital's programs, as they affect the welfare and protection of the community, and of the patients. Although these and other aspects of the hospital's program will be presented in greater detail by Dr. Dale Cameron, the hospital superintendent, I should like to offer some general observations on that subject, then discuss the relation of the hospital to the Department and the national mental health program.

The Department shares the concern of the committee over the unfortunate occurrences which have followed the unauthorized absences from the hospital of certain prisoner patients. With support and encouragement from the Secretary, as well as of this committee, the hospital is currently exploring ways of minimizing avoidable repetition of the types of unfortunate occurrences which stimulated the appointment of this committee. The hospital has taken certain steps and is exploring additional steps to achieve this purpose.

I understand that the committee has already visited the hospital and obtained a firsthand look at its facilities and met some of the staff. This has enabled you to understand the three principal types of security which are maintained at the hospital. The great majority of the patients of the hospital are there for treatment, not restraint. They would present no significant hazard to the public if they were to leave the hospital on their own volition. It would be both unwise therapeutically and sheer waste of money to subject this large group of patients to unnecessary restraints.

At the opposite end of the security scale are the patients who definitely would present a serious hazard to the public if they are not placed under conditions of restraint. Most of these have already committed one or more antisocial acts and until their mental condition is appreciably improved there is at least a strong possibility that they might continue their pattern of antisocial behavior. We have an excellent modern facility—the John Howard Pavilion—which your committee saw during your recent visit to the hospital, to house this group of patients while they are under treatment. The record of the hospital in maintaining the security of the John Howard Pavilion is, we believe, unusually good. Only two escapes have occurred from that facility in the 5 years it has been in operation.

In between these two groups lies a third group which presents our most difficult problem. These are patients who are best typified by a man who has committed an antisocial act, who has been found not guilty by reason of insanity and sent to St. Elizabeths, has undergone treatment, and who now appears well on his way toward what is hoped will be complete recovery. Such a man needs and should have a gradual transition from a status in which he is restrained in a maximum security ward to a status in which he lives under minimum surveillance and restraint. The need for this type of transition is recognized and accepted in both progressive penal institutions and progressive mental hospitals. For the group which is in this type of transition, various intermediate security measures are appropriate. These are composed of certain types of restraints in the facilities where the patients live, and certain measures of counseling, of supervision and of surveillance by the hospital which are designed to fit the needs of this group. With the most ideal combination of these measures the hospital staff can never be completely successful in knowing which of these patients have sufficiently recovered so that they are ready for the next stage of freedom. This is one of the most difficult of all the difficult assignments which we ask a mental hospital staff to perform.

Within this general framework of the problem, we are anxious to take whatever steps seem called for to strengthen our capacity to identify accurately the stage of recovery of patients who have committed or shown a tendency toward performing antisocial acts, and to apply a combination of treatment, restraint, and surveillance which is appropriate to their stage of recovery. With the fullest encouragement of the Department, as well as of your committee, Dr. Cameron and his staff are reviewing with great care the steps which they can take to perform these functions to the fullest degree their resources will permit. Dr. Cameron will, of course, discuss these matters in detail with you.

May I now turn to the relationship between the Department and the hospital. St. Elizabeths Hospital was established in 1855 to care for certain Federal beneficiaries and residents of the District of Columbia. It has treated prisoner patients from its inception. It is a unique institution of deep tradition and international reputation. St. Elizabeths has been a part of the Department and its predecessor, the Federal Security Agency, since 1940. Prior to that time, it was a part of the Department of the Interior. Except for a very brief interval in the early 1940's when the hospital was a part of the Public Health Service, it has been, organizationally speaking, a departmental operating agency whose Superintendent reports to the Secretary.

St. Elizabeths Hospital differs from most of the Department's other operating agencies in that its program operations are all centered in Washington with rather close local community contacts. The hospital's treatment, research, and training programs, however, like the programs of other agencies in the Department, have national implications.

In respect to longer range issues having to do with the future of St. Elizabeths Hospital I should like to include in my statement at this

point—and read, if I may—a letter which Secretary Celebrezze addressed last week to this committee. It reads as follows:

NOVEMBER 7, 1963.

Hon. DOMINICK V. DANIELS,

*Chairman, Ad Hoc Committee on Investigation of St. Elizabeths Hospital,
House of Representatives, Washington, D.C.*

DEAR MR. DANIELS: As your committee begins its inquiry into the operation of St. Elizabeths Hospital, I would like to assure you of the Department's complete cooperation. My staff as well as Dr. Cameron and the hospital staff will be available throughout the committee's inquiry to provide any information or other help the committee may desire. I am designating Dr. William H. Stewart of the Office of the Special Assistant for Health and Medical Affairs as liaison officer in the Office of the Secretary to assist in providing information to your committee.

I believe that it is important that your committee know of a study of St. Elizabeths Hospital which is currently underway. The Department of Health, Education, and Welfare has been involved since late last spring in a study to analyze alternatives and make recommendations concerning the future role of St. Elizabeths Hospital. The results of this study should be presented to me by January 1964.

On February 5, 1963, the President sent to the Congress his special message on mental illness and mental retardation in which, among other things, he proposed and sought legislative support (which Congress subsequently gave, in part) for a national mental health program—one which envisages a wholly new emphasis and approach to care for the mentally ill. Among the many objectives of this program are these which have direct or indirect relationship to St. Elizabeths Hospital: The ultimate replacement of the large, old, custodial-type State mental institution by substantially smaller, better staffed, more comprehensive, community-based mental health centers; a major demonstration, during the program's early years, of this community mental health center concept; during the transitional period, improvement in treatment provided by existing State mental institutions, with those which are propitiously located becoming open institutions serving their local communities; expansion of research into the nature, cause, prevention, and treatment of mental illness; and a substantial increase in the training of scarce mental health professional and auxiliary personnel.

Late in February 1963, the President requested that the District government, with "every possible help" from the Department of Health, Education, and Welfare, become a leader in adopting and demonstrating the new concepts in the treatment of mental illness. He further requested the "development of reciprocal policies between St. Elizabeths Hospital and the District which will facilitate the placement in nursing homes and foster homes of a large number of patients who no longer need to be in a mental hospital but for whom there are not at present suitable alternative facilities."

In addition, consideration has been given for some time to the idea of legislation designed to alleviate the legal rigidities associated with the admission and outplacement of patients, and to permit the treatment on an outpatient basis of patients who have not been previously resident patients of the hospital. This question is one which is intimately bound up with the long-range role of the hospital.

Against this backdrop, in late May 1963, I established an "Advisory Group on the Future of St. Elizabeths Hospital" and requested that it provide me with conclusions and recommendations concerning the long-range role(s) and organizational relationships of the hospital. The professionals and Government officials who comprise this group represent, in composite, a range of responsibilities and concerns which should insure exposure and consideration of every significant facet of the St. Elizabeths problem. Membership includes Dr. Jack Ewalt and Dr. Walter Barton, president and medical director, respectively, of the American Psychiatric Association; Dr. Ray Trussell, commissioner of hospitals of New York City; Dr. Murray Grant and Mr. Schuyler Lowe, Directors of the Health and General Administration Departments, respectively, of the District of Columbia government; Dr. Robert Felix, Director of the National Institute of Mental Health; Dr. Dale Cameron, Superintendent of St. Elizabeths Hospital; Mr. Rufus E. Miles, Jr., Administrative Assistant Secretary of the Department of Health, Education, and Welfare; and, serving as chairman of the group, Mr.

Boisfeuillet Jones, the Secretary's Special Assistant for Health and Medical Affairs. Staff support for the Group is provided by the Secretary's Office.

At its first meeting, on June 24, 1963, the Advisory Group approved a study design which incorporated these essential purposes: To review the various functions which St. Elizabeths could perform and the means by which the hospital could serve, most effectively, both District of Columbia and Federal purposes; to arrive at organizational conclusions and recommendations; to determine the most effective set of relationships, procedures, and understandings with other units of Government and of the District community with which the hospital must deal in achieving its mission; and to recommend the principal steps for putting into effect the conclusions of the study. An essential objective, regardless of hospital roles to be recommended, was specified to be "strong concentration on outplacement of patients who would not need to be in the hospital if other facilities were available."

Based on staff work of the following weeks, the Advisory Group met again on October 9, 1963, at which time there was wide-ranging discussion on alternative approaches to the future role of St. Elizabeths. Within the next 2 or 3 months, it is expected that the Advisory Group will meet again to develop its final recommendations concerning the future of St. Elizabeths. Once the final report has been submitted to me and I have had an opportunity to consider its recommendations carefully, I shall of course be in a better position to make basic recommendations about the hospital to your committee.

I would again like to extend to you our complete cooperation and to assure you of the Department's concern with making St. Elizabeths Hospital a model mental institution of the highest caliber.

Sincerely,

ANTHONY J. CELEBREZZE,
Secretary.

Mr. Chairman, I simply wish to add my own expression of desire to be of any possible assistance to your committee. Dr. Cameron has already indicated his full readiness to assist your committee. Dr. Stewart, my assistant, will also stand ready to obtain any desired information which may be available in other parts of the Department.

Mr. DANIELS. Thank you, Mr. Jones. Was the advisory group set up as a result of the letter that the President sent to the Secretary on February 15?

Mr. JONES. It was set up as a result of that, although the Department has had a longstanding concern about the relationship of the hospital to the departmental activities. But the immediate result of the appointment came after the President's letter.

Mr. DANIELS. Was this advisory group set up as a result of consultation with Mr. Tobriner?

Mr. JONES. Yes, sir; in full consultation with him.

Mr. DANIELS. What is the budgetary allowance for your committee study?

Mr. JONES. There is no budgetary allowance except as comes out of the general expenses of the Office of the Secretary. We are providing staff from the Office of the Administrative Assistant Secretary, a staff analyst is assigned to the committee. The members are serving as consultants, those not in Government are serving as consultants with expenses and per diem paid out of the consulting budget of the Department.

Mr. DANIELS. There is also another study going on in the District of Columbia, is there not, another study of St. Elizabeths Hospital?

Mr. JONES. Yes, sir; not of St. Elizabeths but of the District community mental health program. This is the District's responsibility—for its mental health service other than that which is conducted at St. Elizabeths. But the two studies are fully coordinated in that Dr.

Murray Grant is a member of this study commission and is responsible for the District study.

Mr. DANIELS. Is there any conflict between the two studies?

Mr. JONES. None whatsoever.

Mr. DANIELS. What is the purpose of the District study, then?

Mr. JONES. The purpose of the District study is to determine what the District, under its District Health Department, should do in developing a comprehensive community mental health program. This does take into account the fact that St. Elizabeths serves as the institution to which those who need to be in an institution are sent. But the comprehensive plan that is envisioned in the program which the Congress has adopted, based on the President's recommendations, contemplates establishing in the District, as is true in most of our major metropolitan and smaller areas, facilities, and services in which mentally and emotionally disturbed people can receive treatment in their home environments comparable to the services rendered by the physically disabled. It is in this context that Dr. Grant and the District are studying the needs in the District.

Mr. DANIELS. St. Elizabeths Hospital is a Federal facility?

Mr. JONES. That is correct.

Mr. DANIELS. It serves the needs of the District of Columbia?

Mr. JONES. It serves not only the needs of the District of Columbia but those of Federal beneficiaries. Most of the patients come from the District of Columbia. This has been a traditional service of St. Elizabeths.

Mr. DANIELS. Mr. Goodell, any questions?

Mr. GOODELL. Mr. Jones, I understand that you are working with the present staff employees on loan. Can you give us a better idea of how many people are working full time on this study that is underway now?

Mr. JONES. Full time, there are about one or two. There is one full-time staff director with assistance provided throughout the Department, the Office of the Secretary primarily, in analyzing the various programs. There is one full-time man committed to the program with whatever additional assistance he may require.

Mr. GOODELL. One full-time man, but you say the equivalent of two or three full time?

Mr. JONES. I would say so; yes, sir. It all depends on what is needed to back up the study.

Mr. GOODELL. I am somewhat troubled by the existence of two studies. I can understand there are different jurisdictions involved, your study is the Health, Education, and Welfare Department study, representing the Federal Government, and the other is a District of Columbia study.

Basically, it seems to me the intent of those who are administering the St. Elizabeths Hospital is to return these patients to a home environment as quickly as possible. One of their most acute problems is that they feel there are a great many people at St. Elizabeths who now could be in a home environment. Therefore, I think a great percentage of our immediate problem at St. Elizabeths seems to be the problem of providing such circumstances that these people can get back into a home environment.

Mr. JONES. Mr. Goodell, the difficulty is that St. Elizabeths lacks the authority to develop the facilities within the District to which these people can be referred. This is why the District of Columbia is undertaking its own study of the District's responsibilities with reference to the mentally ill and emotionally disturbed.

Mr. GOODELL. I understand that, but why is there a separate study?

Mr. JONES. There is no conflict at all in these two studies. They are well coordinated. They stand on their own and represent no contradiction.

Mr. GOODELL. If there is no conflict, I wonder if there is not a considerable degree of overlap. I am sure you have coordination, but we are a little bit intolerant up here of two or three studies being done by groups that talk with each other but really could more effectively be combined into one study and make some hard-hitting and direct recommendations to all the various Government agencies involved so we get some action.

Mr. JONES. We expect this is to be a result of these studies, Mr. Goodell. But we must recognize that St. Elizabeths Hospital is a direct operating responsibility of the Federal Government and has been since 1855; whereas, the District program is the responsibility of the District government.

Mr. GOODELL. Fine. Can we not have one study group which combines these?

Mr. JONES. We in effect have one study in that the District is concentrating on its own responsibilities in terms of developing community mental health service centers.

Mr. GOODELL. Are you saying now that the District Committee, set up to make a report, is not going to be directly involved with the whole philosophy of St. Elizabeths institution and the future of St. Elizabeths institution?

Mr. JONES. Very much so.

Mr. GOODELL. Is not this the key to their whole report and study?

Mr. JONES. Dr. Murray Grant is the District Health Officer and has responsibility under the Commissioners for the District program and the District study. Both Dr. Grant and Mr. Schuyler Lowe, as administrative representative of the Commissioners, are on this study committee.

Mr. GOODELL. I understand that.

Mr. JONES. Therefore, they avoid unnecessary duplication, but these two studies have purposes that are parallel, not necessarily overlapping. I think we are just as much concerned as you are to avoid unnecessary duplication or to avoid two separate studies that will not result in effective answers to some of these problems.

Mr. GOODELL. Are you prepared to assure us at this point that these two study groups are not going to come up with conflicting recommendations and conclusions?

Mr. JONES. I cannot assure you this. I cannot assure you that even one study will avoid minority reports, but I am saying the mechanisms for these two studies are as reassuring as we can provide that there will not be conflicting reports by virtue of the mechanics of the study.

Mr. GOODELL. Just because you have an overlap in personnel, but beyond that it seems to me in order to have an effective study you must articulate a certain role of the mental institution, St. Elizabeths, a cer-

tain future, a certain philosophy of treatment. This is so completely intertwined with other District of Columbia mental health problems that you would be much better off with a single study group, saving the overlap, saving whatever waste is involved, and coming up with a more direct and effective report when you get through.

Mr. JONES. We just do not agree with you, sir, on this ground. If you take the situation of a State, for example, where you have a State mental institution which has traditionally served the role of caring for the emotionally disturbed throughout the State, and you have the situation of a State health department or a State mental health authority undertaking to assist communities in developing services for the emotionally disturbed in their own environment, then you have the question of how these services in a particular community can make it unnecessary for individuals who are disturbed to be transferred to a State mental institution.

In this context the State institution is not involved in the provision of services in the community. It is involved only to the extent that these services become a substitute and then you cut down the need for the State institution being the sole service to the mentally disturbed.

In any event, your point is very well made, but I think I can assure you, sir, we have guarded against the problem you raised about as effectively as it can be done through the two mechanisms.

Mr. GOODELL. There are some proper analogies to be made between State and local relationships and Federal and District relationships, but as we all know, there are some very unique features of the Federal-District relationship.

Mr. JONES. This is quite correct.

Mr. GOODELL. For one thing, the State government is dealing with a variety of local communities, and in this case we have an institution primarily dealing with the District of Columbia, although it takes some purely Federal patients, admittedly. St. Elizabeths is obviously at the very core of any local programs for mental health treatment. It seems to me that it should more properly be one study, but you have two of them underway.

Let me ask you this: What is the timetable on these two studies?

Mr. JONES. I cannot speak for the District study, but I know Dr. Grant is moving rapidly toward developing plans for the District. We expect the study the Department has responsibility for to be completed and recommendations made by the end of this year, or by the end of January.

Mr. GOODELL. Do you have any notion about the District of Columbia study?

Mr. JONES. I should think it is moving about along the same schedule, but I cannot say with complete assurance.

Mr. GOODELL. Thank you.

Mr. REISINGER. Perhaps it might be helpful to clarify this. If I am correct, the District of Columbia study is under a grant made by the National Institute of Mental Health; is that not correct?

Mr. JONES. Only in part, Mr. Reisinger. The National Institute of Mental Health has made available to the District a sum of money, I think about a quarter of a million dollars, to develop a demonstration project for a community mental health service. This would involve the establishment of a comprehensive center serving probably about one-

fourth of the District of Columbia geographical area as one. It is in conjunction with the development of plans for this demonstration project, also, that the District, under Dr. Grant, is developing a comprehensive program for the District involving all areas of the District. Thus, District planning for a comprehensive community mental health program and for a demonstration center are both involved in a study of the District program. These are going rapidly, and I think they will be well along by the end of this calendar year.

Mr. REISINGER. I have been advised that there is a \$50,000 grant which has been specifically earmarked for the overall planning study of the District program, and that, I believe, is for the year terminating September 1 of 1964. Do you know if I am correct in this?

Mr. JONES. You probably are. I do not have the details. This is under the planning program that was envisioned.

Mr. REISINGER. This would then presuppose some form of report as of September 1, 1964, would it not?

Mr. JONES. Yes, it would, in terms of a comprehensive plan. But I think in terms of St. Elizabeths and its relationship to District planning, the general outlines of the recommendations, which is what Mr. Goodell is particularly concerned about, I think, should be pretty clear by the end of this calendar year, although the full comprehensive plan for the District would probably take some time longer.

Mr. REISINGER. Let me see if I understand you, sir. The advisory committee, the Secretary's study we will call it, contemplates having a fairly fixed idea of the results of its work as of roughly January 1 of 1964?

Mr. JONES. That is our plan.

Mr. REISINGER. The study, which we call the District study, which is being carried forward, presumably will wind up with a report sometime in September; that would be a comprehensive plan for the District of Columbia?

Mr. JONES. Yes.

Mr. REISINGER. Is it then the case that one of the primary aspects—indeed, one of the primary purposes of the President's initial program—was to develop comprehensive care plans which would reduce the number of people in hospitals; is that correct?

Mr. JONES. That is correct.

Mr. REISINGER. So that in effect the study which will be completed in September of 1964, will give some definition of the number of District of Columbia patients who can be diverted from St. Elizabeths Hospital to other institutions?

Mr. JONES. That would be oversimplifying it, I think. Its purpose would be to define the locality and the type of comprehensive mental health service at community centers other than the hospital, so that people who normally are referred to a hospital such as St. Elizabeths or State mental institutions can receive care while staying at home.

Mr. REISINGER. This reduces the caseload at the hospital does it not?

Mr. JONES. This is a preventive measure which makes it unnecessary, because the services are available at home, for these people to be referred to an institution which has to hospitalize them. It is in this regard that the ultimate goal is to reduce the patients in these large institutions by, say, half in the next 10 years. That is one aspect.

The other, the one to which you refer, has to do with the fact that there are patients at St. Elizabeths now who could be released if there were foster homes or nursing homes or other types of facilities to which they could be referred. It is at that point that you are quite right that the study will determine the extent to which such facilities can and should be made available. The two things will then result in reduction.

Mr. REISINGER. Does it not follow from this that the results of the District of Columbia study will bear materially upon the ultimate utilization of facilities at St. Elizabeths Hospital?

Mr. JONES. Only in terms of numbers.

Mr. REISINGER. That is pretty vital; is it not?

Mr. JONES. Oh, yes. This is well taken into account in both these studies.

Mr. REISINGER. Basically, what I am driving at is this: Would it not make more sense for the Secretary's study to take place after you know what the District's problems are?

Mr. JONES. I do not think so, necessarily. I think it all depends on what the recommendations may be, what the concepts may be, because these things are going along concomitantly and will not be done independently of each other.

Mr. GOODELL. Mr. Jones, in other words, at any rate, we can expect the HEW report by the end of the year?

Mr. JONES. This is our anticipation; yes, sir?

Mr. GOODELL. I think I speak for the members of the subcommittee. We took a tour of St. Elizabeths Hospital and looked into the problem. Initially, I think we were all very much impressed with the enlightened approach of the personnel out there and of Dr. Cameron and all of his assistants. They are doing a very fine job under complex circumstances.

One of the things that I think troubled all of us was this great problem, the number of so-called nonpsychiatric patients that they had to cope with, which diverted their attention necessarily from the real psychiatric problems. Presumably this, in turn, makes it more difficult to cope effectively with the psychiatric problems. Do you agree?

Mr. JONES. Yes, quite.

Mr. GOODELL. Is it your view that there is any immediate need for more buildings, more personnel, or what have you? What do you feel is the greatest need at St. Elizabeths right now?

Mr. JONES. I think I would prefer, if it is all right, to let Dr. Cameron answer that and explain it since he is the professional.

Mr. GOODELL. I want your view. I know Dr. Cameron's view on this.

Mr. JONES. I think for the kind of professional care that the psychiatric field is now able to give additional professional personnel would be very useful for the treatment of those who could respond to treatment.

On the other hand, the increase in personnel has been rather encouraging for the treatment of these patients in recent years. Congress has been very generous in providing more adequately than ever before for support of the treatment there. I think the picture is much better now than it has been for a long time.

The question of where the line is drawn is still a difficult point. We are in better shape than we have been for a long time. I still think we need more.

Mr. GOODELL. You directed all your comments to personnel. Have you any comment with reference to the physical facilities there?

Mr. JONES. Some of the buildings there are quite antiquated as you well know. If we could anticipate the removal of some 3,000 people who could be put into other kinds of facilities, probably at less expense, then we would not need additional facilities.

We need replacement of some of the buildings that have been there a long time, but I think the program—well, I have no specifications as to what we need at the moment.

Mr. DANIELS. What has been done prior to this date with regard to the transfer of patients from the hospital to other institutions?

Mr. JONES. The only limitation, Mr. Chairman, which has been experienced, has been the fact there is no place to which these people can be transferred. There have been placements in foster homes. I don't remember the figure. Dr. Cameron can give them to you. I shall not try to recall exactly but there have been a number of placements in foster homes.

Mr. REISINGER. Approximately 60?

Mr. JONES. Sixty is the figure I remember in recent months. The problem there is that the payments for care in foster homes is so small relatively as to not encourage many opportunities of this kind. This is a problem being looked into.

Mr. DANIELS. You refer to it as a limitation. I wanted to know whether or not your Department gave any serious consideration to the problem of effecting transfers of patients from the hospital to nursing homes or foster homes.

Mr. JONES. Yes, but the only consideration we could give is the availability of a place to which these people can be transferred. Not having responsibility for the District program in our Department, we have no authority to create nursing homes and foster home opportunities and the like in the District. This is why we are so very happy that the District is moving toward a study for itself of the need for such facilities and why we are glad that the Federal Government has been able to provide for the District some support in this regard.

Mr. DANIELS. But you have Federal patients there?

Mr. JONES. Yes, sir.

Mr. DANIELS. They are not residents of the District?

Mr. JONES. That is correct, yes.

Mr. DANIELS. With respect to those patients does your Department have jurisdiction to effect their transfer?

Mr. JONES. We do transfer them back, but they come from all over—Federal prisons, veterans, and so on. We refer them back to the sources from which they come when they no longer need to be hospitalized in a mental institution.

The major problem is those people who need home environments.

Mr. DANIELS. Have you any idea of the cost per patient at St. Elizabeths Hospital?

Mr. JONES. I think I have it here. It is about \$11.50 a day average.

Mr. DANIELS. What is the cost for the maintenance of a patient in a foster home or nursing home?

Mr. JONES. It would be considerably less than that. I think the amount that is allowed is about \$60 a month.

Dr. CAMERON. For a public assistance home it is \$67 a month plus \$10 for the recipient, and a foster home approved by the District of Columbia runs \$100 a month for the vendor and \$10 for the patient. The same rate applies to nursing homes.

Mr. GOODELL. What is the \$67 figure?

Dr. CAMERON. Straight public assistance.

Mr. DANIELS. How many transfers have been made from the hospital to a nursing home or foster home since the 1st of January of this year?

Dr. CAMERON. I cannot answer precisely, Mr. Chairman.

Mr. DANIELS. Dr. Cameron, you will have an opportunity to testify.

Mr. JONES. They have the specific information. I do not know specifically.

Mr. DANIELS. Other questions?

Mr. GOODELL. I just want to reiterate, Mr. Jones, that I read on page 10 of your statement about the first meeting of your study group. There was a study design which incorporated your central purposes.

As I read that description, I must say that I am inclined to agree with the comment by way of question from our counsel. So much of this study which HEW now is undertaking is dependent upon what the District of Columbia study finally decides, what kind of a role the District of Columbia can take in providing more out-patient type of environment, home environment, nursing home, and whatever else, a foster home. It would seem to me a more effective and sensible approach would have been to see what the District of Columbia Committee comes up with, and seeing there is representation on that committee for Federal authorities and St. Elizabeths authorities.

Then perhaps, based upon their recommendation and the action of the District government, we could determine what the Federal role is to be.

I am afraid that, although you may not have any conflict in your reports, you will end up with an essentially useless report.

Mr. JONES. We would hope not.

Mr. GOODELL. And action based on the other report.

Mr. JONES. One might also take the position that the extent to which St. Elizabeths might modify its program so it will serve the District more effectively—

Mr. GOODELL. This is interrelated and should be done in one study group with an interchange of opinions by the authorities involved, not two separate study groups with one or two overlapping members so that you see to it that the final outline of the report and conclusions do not seem to be openly in conflict.

Mr. JONES. All I can say is what I said before—we think we have guarded against this to the maximum we can.

Mr. GOODELL. I am sure you guarded against having an outright open conflict. What I am talking about is what would have been the most effective way of approaching the problem.

Mr. JONES. We had to do the best we could with the circumstances at hand. We moved ahead, and I think it will work out to be as effectively coordinated as if it had been one study at the time.

Mr. GOODELL. Just before I yielded you made a comment which went something like this with reference to the need for buildings and facilities at St. Elizabeths—you said: "If we could anticipate a reduction of some 3,000 patients this would make a rather considerable difference."

Mr. JONES. Yes.

Mr. GOODELL. This is the whole point I am trying to get at. You cannot anticipate a reduction of 3,000 patients there unless there are presumably decisions made at the District of Columbia level and by some other people to make that possible.

Mr. JONES. The problem is that you are getting into questions of specific needs of the hospital. We are trying to develop the protocol for the role of the hospital. That is, if it is determined by both studies that the role of St. Elizabeths is such that it should be limited only to those people who can be effectively treated, or who have to be maintained in a hospital under restraint, then the next step would be for alternate facilities for people who do not have to have this kind of treatment.

Mr. GOODELL. You have stated something with a big "if" which to me has an obvious open answer. Every authority we have talked to says that is not an "if." Obviously St. Elizabeths does not want to waste the taxpayers' money and they waste their time with patients who should be treated elsewhere more effectively.

You say "if" this is going to be the philosophy of the institution. The only question is "How do we do it organizationally?" That is already the philosophy of the people out there now.

Mr. JONES. I am not trying to anticipate the nature of the report, Mr. Goodell. I think it would be unfortunate to try to do it.

Obviously it is an accepted proposition by all the professional people I have talked to and you have talked to that we should reduce the people in these institutions who can be better treated elsewhere, not only from an economic standpoint but from the therapeutics of the matter.

Perhaps I should not have said "if," I should have said "assuming this is to be a recommendation." I do not think we are in conflict at all.

You are concerned and I am concerned just as much as you are that we not have two different recommendations on the same subject that are in basic conflict when this may have been avoided in the beginning.

I think you are so right about this and I agree with you so thoroughly about it that the chance of such conflict has been extremely minimized.

Mr. GOODELL. I appreciate your courtesy, Mr. Jones, and your conclusion that we are in complete agreement. I must say I don't think we are.

Mr. JONES. I think we are in agreement on the objectives and not mechanics. You would like one study. I say we have two.

Mr. GOODELL. Let me state one simple fact and ask for your comment:

Is it not true that the District of Columbia today is paying somewhere around \$340 to \$350 a month for each of a variety of patients who are being housed at St. Elizabeths who do not need to be

there and who should not be there in the opinion of psychiatric authority and who could be taken care of at a much reduced rate elsewhere?

Mr. JONES. That is correct. I don't know the figures but that is approximately correct.

Mr. GOODELL. And the District of Columbia figure for public assistance is \$67 a month per patient and for foster and nursing home it is a \$100 a month, and this economically is not sufficient to support these patients or to induce private enterprise to move into this field and provide them with facilities. Therefore we are paying better than three times that cost?

Mr. JONES. That is correct.

Mr. GOODELL. I say "we are." I am also a taxpayer of the District of Columbia as well as bearing my share, as all American taxpayers do, of the amount of money the Federal Government gives to the District of Columbia to meet their expenses—so we are paying three times as much for a number of patients out there as we should be paying.

Mr. JONES. I think that is quite correct.

I might say it is not true only of St. Elizabeths. It is true of many of the State mental institutions. It is what we are trying to combat and this is why the President and the Congress are concerned to develop a really comprehensive national mental health program, because this kind of situation just does not make sense.

Mr. GOODELL. I do not accept the inclusion of analogous problems at the State level here, Mr. Jones. I think we have a unique situation in the District of Columbia which you will agree is unique in most of its parts. We could cope with this problem, and any way we decide to cope with it is not necessarily going to be applicable at the State level and local level. We have to cope with it here as to the relationship between the Federal Government and the District of Columbia and we should set an example.

Mr. JONES. This is very much the objective of the Department and the President in his messages both to the Department and the District Commissioners, related to a comprehensive national mental health program.

All I am saying is that you are quite correct in your analysis here regarding the District, but this is likewise a situation in many parts of the country to which this total program is directed.

If we can bring about the results you are seeking, if I understand your analysis correctly, then we will have made very real and substantial progress.

Mr. GOODELL. You and I can draw some real simple conclusions. It seems everybody on the subcommittee can draw simple conclusions as to what is needed.

For the life of me I don't see why we have to go on with a variety of studies in order to come up with recommendations and conclusions that you and I and everybody associated with the problem can tell you right now.

It is particularly perturbing that we have to have two different studies going on. Whether or not the lines of conflict are eliminated in this thing, you and I know the bureaucratic friction that goes on inevitably in something of this nature. I don't want to belabor the point and I appreciate your testimony.

Mr. JONES. Things have been done to help encourage this transfer to foster homes in the District by virtue of the appropriations this year, endorsed by the Appropriations Committees of both Houses. One has to do with the fact that a budget for St. Elizabeths now has been fixed as a total with the appropriation open end so that when payments received by St. Elizabeths from the District and from other agencies is subtracted from the total, the appropriation of the Federal Government would be the difference. This has eliminated a major problem and results in a financial advantage to the District in transferring patients out.

Mr. GOODELL. I think this is very good. I am aware of that and it makes for a much more efficient and a much better operation in terms of St. Elizabeths.

Mr. JONES. Yes.

Mr. GOODELL. I am afraid that perhaps we have pulled the cork at the wrong end. Now we have made it much easier to work out the budget setup for patients who go to St. Elizabeths when, as a practical matter, the District will pay about \$350 for every patient there, and there still seems to be a strict control over the amount of money they will pay for foster home-nursing home care.

Mr. JONES. This new arrangement helps in that the District can receive the advantage of the difference in cost for other accommodations for patients who are now at St. Elizabeths, so it would help encourage the transfer as facilities are made available.

Mr. REISINGER. You mentioned earlier, Mr. Jones, that the Department and St. Elizabeths have no authority to make foster home arrangements of any kind?

Mr. JONES. They do not have authority to develop nursing homes and this kind of facility. The District does have the authority—

Mr. REISINGER. There are small categories; for example, the Virgin Islands send patients to St. Elizabeths Hospital; the armed services have. There is also the category of Federal citizens who have no State residence.

Mr. JONES. That is right.

Mr. REISINGER. These people would not logically be the responsibility of the District of Columbia.

Mr. JONES. That is right.

Mr. REISINGER. If this is true, is it not desirable that St. Elizabeths have some authority to make foster home or nursing home arrangements for categories other than not District of Columbia patients?

Mr. JONES. Yes, we would prefer that the Virgin Islands work out something so these people do not have to come to St. Elizabeths in the first place, or if they do they could be sent back there.

There are categories of patients for which the District is not responsible and could be treated otherwise.

Mr. REISINGER. What I am driving at is this: Is there not some necessity for legislative authority so that you can make these arrangements separate and apart from the Virgin Islands and the District? Let us take the narrow area of Federal citizens who are not residents of any State where there is no other responsible authority. Would it require legislative authority for you to make these arrangements?

Mr. JONES. I think it would.

I am not sure.

Mr. REISINGER. This is an area we should study?

Mr. JONES. I am not prepared to answer specifically. I do not know.

Mr. REISINGER. The second question: Are you engaged in negotiations with the Bureau of the Budget in terms of budgetary requirements, and so forth, or is that in your operation?

Mr. JONES. In general, yes.

Mr. REISINGER. I may be asking the wrong man the question and that is the reason I ask, Mr. Jones. I notice beginning in the fiscal year 1959 to date there has been a consistent reduction in the request for increased personnel by the Bureau of the Budget.

Has this been the subject of conversation between you and the Bureau?

Mr. JONES. Yes, it has. This is true of many of our programs, of course.

Mr. REISINGER. Since everyone seems to agree we need additional positions, has the Bureau of the Budget given you any reason for its consistent pattern of reducing your request?

Mr. JONES. It would depend on the particular year and the particular circumstances and the particular justification.

I would say in general the problem of the Bureau of the Budget is the problem of how the Federal dollars can be best utilized for the many purposes for which there is demand. Whereas the Department may have a position as to what is needed, the Budget Bureau exercises the responsibility of providing a Federal budget which the President submits to Congress, so it exercises its judgment after our judgment on these many matters. We do discuss them in great detail and justify as best we can the position we take.

This is a typical problem of the budgetary process of Government.

Mr. REISINGER. They have not, for example, suggested that perhaps the most desirable approach is to first reduce the number of patients and then determine the proper utilization of personnel?

Mr. JONES. The Bureau of the Budget is very much aware of this study I mentioned, not only the study of the Department but the study of the District.

Mr. REISINGER. We speak now of a 6-year period but these studies have been in existence only 1 year.

Mr. JONES. That is correct, but the Budget Bureau is constantly reviewing operations at St. Elizabeths as it does other programs.

Mr. GOODELL. Can you give us the exact date that the HEW study was authorized?

Mr. JONES. I cannot give you the date of the District of Columbia study, but the date of the HEW study, as stated in my testimony, is late May 1963.

Mr. GOODELL. You haven't the District of Columbia?

Mr. JONES. No.

Mr. GOODELL. Do you know approximately?

Mr. JONES. I would guess about April, May, or June of this year. I don't know precisely.

Mr. GOODELL. About the same time as HEW?

Mr. JONES. Yes.

Mr. GOODELL. Do you know which one came first?

Mr. JONES. I think perhaps ours came first, that of the Department.

Mr. GOODELL. Yours was May of 1963 and you think theirs was some time after that?

Mr. JONES. I think so. We can find out and I shall provide it for the record.

Mr. GOODELL. Any particular reason why yours will take about 7 months and theirs will take 18 to 19 months?

Mr. JONES. Yes. Ours is a broad policy determination. Theirs is a detailed study of how to provide comprehensive community mental health services. This is the essential difference. I do not know. I cannot speak to their study.

Mr. DANIELS. Congressman Hall?

Mr. HALL. I have no questions, Mr. Chairman.

I appreciate your letter and your invitation to be present. I am an interested observer and a loyal alumnus of the intern staff of St. Elizabeths Hospital.

Thank you, sir.

Mr. DANIELS. It would be appropriate at this time to introduce in the record letters sent by the President to Commissioner Celebrezze and to Mr. Tobriner, the Chairman of the District Board of Commissioners.

Without objection we shall insert these.

(The letters referred to follow :)

FEBRUARY 15, 1963.

HON. ANTHONY J. CELEBREZZE,
Secretary of Health, Education, and Welfare,
Washington, D.C.

DEAR MR. SECRETARY: I am today requesting the Commissioners of the District of Columbia to play a leadership role in adopting and demonstrating the new concepts in the prevention, treatment, and care of mental illness and mental retardation presented to Congress in my recent special message on mental illness and mental retardation.

It is my desire that you provide every possible help to the Commissioners in this important endeavor, so that in this significant area of human need the Capital of the United States may become, as I indicated last month in my special budget message, on the District of Columbia, a city of which the Nation may be proud—an example and a showplace for the rest of the world. To this end, I am pleased to learn that the National Institute of Mental Health is planning to use demonstration funds in its 1964 budget as a first step in financing one or more model comprehensive community mental health centers operated by the District Health Department.

Sincerely,

JOHN F. KENNEDY.

FEBRUARY 15, 1963.

HON. WALTER N. TOBRINER,
President, Board of Commissioners of the District of Columbia,
Washington, D.C.

DEAR MR. TOBRINER: We have the knowledge and the capacity to relieve great suffering and to rehabilitate untold numbers of our fellow citizens affected with mental disabilities. But to attain these goals within a reasonable span of time, we must act promptly and wisely. I have recently set forth my views on the subject in a special message to the Congress on mental illness and mental retardation. It sets forth recommendations for important legislation and budgetary action.

Basic to a sound program for improving the lot of the mentally ill and the retarded is comprehensive community planning and action, making use of the rapidly growing body of scientific knowledge.

The States and the Federal Government should work principally with the urban communities of the Nation by providing leadership, technical assistance,

and matching funds to develop and execute effective community plans. In the field of mental health, Federal funds to assist the States and the District of Columbia to develop such plans are available this year through the National Institute of Mental Health. Funds will be available to the District for this purpose as soon as the District government submits, and has approved, a plan for their utilization.

It is my earnest hope that the District of Columbia will be a leader in adopting and demonstrating the new concepts in the treatment of mental illness. These concepts call for a community-based program providing a range of services to meet community needs. They involve greatly increased preventive work; early diagnosis and outpatient treatment in comprehensive community health centers close to the homes of patients; prompt and intensive treatment when hospitalization is necessary; rapid restoration of patients to useful life using followup treatment techniques wherever necessary; and flexible use of day care and residential treatment centers to handle patients who are on their way out of hospitals and those who might otherwise be on their way into hospitals. Rehabilitation efforts would be enhanced with a well-functioning foster care program, counseling and training programs, and close liaison with community employment services. Schools, health and welfare agencies, and the courts, as well as the professional schools and societies and the research organizations, need to develop new patterns of cooperation and action.

A community mental health program should be centered around comprehensive community mental health centers providing both a focus for community resources and better community facilities for all aspects of mental health care. It should also be committed to the belief that most mental illness can either be cured or ameliorated so that long hospitalization is not needed. Such a program should go far toward reducing the tragedy of thousands of long-term patients in mental hospitals and the consequent heavy financial burden.

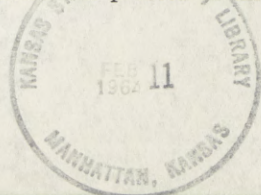
I am gratified to learn that the Commissioners have already started surveying the mental health problems and needs of the District and developing a comprehensive community mental health plan. I trust that both the pending grant of funds to aid in this planning and the program recommended in my special message will be of major assistance to the District in moving toward its objectives.

I am asking the Secretary of Health, Education, and Welfare to be of every possible help to the District in this important endeavor. Your planning should include the development of cooperative policies which will minimize the hospitalization of patients as well as the development of reciprocal policies between St. Elizabeths Hospital and the District which will facilitate the placement in nursing homes and foster homes of a large number of patients who no longer need to be in a mental hospital but for whom there are not at present suitable alternative facilities. It should also provide for the systematic and expeditious transition in the care of the District's mentally ill to the new comprehensive community mental health center approach as a demonstration to the Nation of how the program I have proposed to the Congress can be effectively carried out. In addition, your plans should enlist the many local institutions in related training programs to assure that needs for professional and supporting manpower can be met.

Mental retardation is the second devastating mental disability which we must vigorously attack—and here, too, a comprehensive community-centered approach is necessary. Because mental retardation usually strikes in childhood and because its effects tend to be permanent once the damage is done, prevention must be given a high priority. This is especially necessary in areas which contain a substantial concentration of economically and culturally deprived families among whom the incidence of retardation is likely to be exceptionally high. Success in prevention will require a combination of improved maternal and child health, welfare, and educational measures of the sort outlined in the recent report of my Panel on Mental Retardation.

Action must also be taken to improve the care, the training, and the rehabilitation of those who are already afflicted by retardation. This is not only a duty but offers real and heretofore untapped possibilities for returning many such individuals to a more useful and happy life.

I hope that the District can move forward toward the goal of preventing much of the retardation which now occurs and in demonstrating how services for those who are retarded can be improved. Proposals to authorize new Federal programs for planning grants and for various action programs are now before the Congress. However, it is my hope that the District will proceed in initiating



plans and action on its own accord for the broad spectrum attack necessary to make progress against mental retardation. Here again, the Department of Health, Education, and Welfare, as well as other Federal agencies, will stand ready to assist in every way possible.

There would appear to be no better place for these forward-looking programs to be started than in the Nation's Capital. I would urge, therefore, that the Commissioners consider these matters of the utmost importance. The District of Columbia thus can and should serve as a model for the Nation in these important areas of human need.

Sincerely,

JOHN F. KENNEDY.

Mr. DANIELS. Thank you, Mr. Jones.

Mr. JONES. Thank you, Mr. Chairman.

Mr. DANIELS. Our next witness will be Dr. Dale C. Cameron, superintendent, St. Elizabeths Hospital.

Dr. Cameron, I notice you have a lengthy statement. You may testify from the statement or you may summarize it if you so desire.

**STATEMENT OF DR. DALE C. CAMERON, SUPERINTENDENT,
ST. ELIZABETHS HOSPITAL**

Dr. CAMERON. Thank you, Mr. Chairman.

With your permission, I should like to present the statement in its entirety. It will take me approximately 25 minutes.

Mr. DANIELS. As you desire.

Dr. CAMERON. Mr. Chairman and members of the committee, Mr. Jones has told you about the relationship of St. Elizabeths Hospital to the Department of Health, Education, and Welfare, and something of its broad programs and objectives. With his comments in mind, I shall discuss certain characteristics of the patients served, the types of treatment utilized, and the resources with which the hospital works in performing its functions. In so doing, particular attention will be given to those patients who are in the hospital as a result of criminal proceedings and the special problems associated with their treatment. Finally, in accordance with suggestion of the committee, I shall offer some recommendations for the improvement of services to all patients at St. Elizabeths Hospital.

Let me observe at the outset that many members of the public apparently believe that most mental patients are dangerous. As you well know, this is not true. Dr. Jack Ewalt, the president of the American Psychiatric Association, once said in trying to put this matter into perspective, "Of course, there are dangerous patients among the mentally ill. The proportion of such patients within the total is about the same as airplanes that crash as compared with those that fly." It is a tragedy when a plane crashes just as it is when a person, whether mentally ill or not, commits an unlawful act that threatens the well-being or the life of another person. I regret deeply even the relatively few acts of violence by patients while on escape or elopement from St. Elizabeths Hospital, and wish to assure you that we are doing everything possible, within the resources available, to minimize such occurrences without jeopardizing unduly the treatment program for the remaining thousands of patients.

PATIENTS TREATED AT ST. ELIZABETHS

In describing the patients treated, I shall divide them into two broad categories—those who come to the hospital as a result of criminal proceedings, and those who come voluntarily or by civil commitment. Numerically, patients in the second grouping exceed the first category in an approximate ratio of 8 to 1. The vast majority of patients admitted as a result of criminal proceedings fall into one of the following groups: (1) for examination, before trial, in connection with questions of their competence to stand trial, and the relation between the illness, if any, to the alleged act; (2) for treatment until competent after having been found incompetent for trial; (3) for treatment after having been found “not guilty by reason of insanity” (these patients remain in the hospital until such time as the court concurs in a recommendations for their release); and (4) for treatment if found to be mentally ill while under sentence. The majority of criminally committed patients admitted to St. Elizabeths come as a result of unlawful acts in the District of Columbia, but some have committed acts in other parts of the country in violation of Federal statutes.

As indicated before, the civil patients who come voluntarily and by commitment constitute by far the larger portion of our patient population. They are simply mentally ill persons in need of treatment, some of whom have recognized this need themselves. They are residents of the District of Columbia or Federal beneficiaries eligible by law for treatment at St. Elizabeths.

Attachment I shows the number of “prisoner” and civil patients admitted, and the average number in the hospital by fiscal year from 1950 through 1963. You will note that there was no dramatic increase in the number of admissions of “prisoner” patients in 1954, the year of the *Durham* decision. There was, however, a substantial increase in the number of admissions, and of resident patients in fiscal year 1960, the new maximum security facility (John Howard Pavilion) was opened. It has a larger bed capacity (396) than the previous maximum security facility (186) which has since been demolished. Prior to 1960 there was a waiting list, but none since. However, if admission pressure continues at the present level, we may either have to acquire additional professional staff and/or establish a waiting list. The increase in admissions in 1960 was more marked than the increase in resident patients, since many “prisoner” admissions are for examination with relatively short stays. However, the number of both admissions and resident patients has increased quite substantially during the 14-year period shown.

Attachment II shows the number and percent of criminal and civil patients on elopement at the end of each year for the same time period. You will note that there has not been a remarkable change in the percent of civil patients on elopement, but there has, in the last few years, been a substantial increase in the number and percent of criminal patients so involved. As the patients involved in criminal proceedings increased, both in number of admissions and in the hospital, the problems of providing suitable treatment and security have increased at an even more rapid rate. The strain of an overload on personnel and facilities affects all the patients involved, not just the

final additions that resulted in that overload. I do not wish to imply that all the elopements were due to shortages of personnel and inadequacies of buildings. There is certainly an important element of professional judgment involved when a question arises as to the readiness of patients to assume increasing responsibility for their own actions. It is clear that the possibility of errors in judgement must be considered.

Perhaps this is the place to invite your attention to the comment of Mr. Jones that St. Elizabeths is, first of all a hospital for mentally ill persons, some of whom have been charged with or found to have committed unlawful acts. The purpose of the hospital, as established by society, is to provide "the most humane care and enlightened curative treatment" of the mentally ill patients for whom it is responsible, whether admitted under civil or criminal procedures. This means that as patients respond to treatment they must be given an opportunity to learn to assume and to demonstrate increasing responsibility for their own behavior. A prerequisite for the return of most patients to the community is their ability to assume essentially full responsibility for their own actions. The ability of patients to assume such full responsibility is not achieved in a sudden and dramatic manner, but it is accomplished, if at all, by treatment and rehabilitation programs carried out over a period of time. Such programs necessarily must include the gradual assumption of self-responsibility. In such a process, the staff is called upon to make human value judgments about the present and future behavior and motivations of mentally ill human beings. Such judgments are quite difficult in connection with normal people, and much more difficult with the mentally ill. Even if all of the recommendations I shall later enumerate were carried out, there would still be some unauthorized absences attributable to the difficulty, if not impossibility, of making correct judgments in all instances. There inevitably will be some disappointments. However, if a program based on a treatment and rehabilitation philosophy results in a lower recidivism rate than that achieved by other programs, and the indications are that it does, both society and the patients involved are well served.

To complete the broad picture of the number of admissions, discharges, and patients in the hospital and on its rolls, please refer to attachments III, IV, V, VI, and VII. These show the growth in the number of patients served. It will be noted that in the last few years as the admissions to the hospital have tended upward, the discharges have increased at a more rapid rate. The number of resident patients in the hospital has declined since 1954, though the total number of patients treated (i.e., total inpatients and outpatients) has, except for 1963, continued to increase (attachment VII).

TYPES OF ILLNESS AND IMPLICATIONS FOR TREATMENT

In general, most civil patients have major mental illnesses or psychoses. Relatively few have neurotic or character disturbances. Well over 30 percent are 65 years of age and older. Many of these have structural brain changes. Among the civil patients, men and women are about equally represented. These patients have, for the most part, not been involved in any antisocial activity, and it may be predicted with reasonable confidence that during their illnesses, and as they im-

prove, they will not be so involved. They often need to learn to accept and exercise increasing responsibility for themselves, and trials in this direction can be made with essentially no hazard to society. If they are not ready for the increased responsibility afforded them, their behavior may regress, but they rarely act out against other people in a dangerous way. Thus, the staff can rehabilitate such patients as rapidly as possible without hazard to others.

Patients admitted through criminal proceedings, on the other hand, have quite different behavioral characteristics, and additional types of mental disorder are presented. In general, these patients are much younger than the civil patients, tend to be predominantly male, and have a history of antisocial behavior. A substantial proportion of these patients have psychoses comparable to the civil patients, but with the added feature of antisocial behavior. Because of their younger age, relatively few suffer from structural brain damage. Many of these patients have character disorders which, if severe enough, constitute mental illness. Patients with character disorders, unlike many with psychoses, are well aware of the time and place in which they live, and who they are. However, their emotional development is often retarded, they have difficulty in learning from experience, are unable to put off present pleasure for future gain, find difficulty in forming lasting, meaningful human relations with other persons, and their behavior appears to be little regulated by their intellect. Such patients are often quite bright, affable, and pleasant persons with whom to talk. Though not all patients with character disorders become involved in criminal activities, such patients present their principal difficulties in the interpersonal and social spheres.

Because of their antisocial behavior, which in the case of some patients may, on occasion, be dangerous, prisoner patients generally require more environmental controls during their treatment process than do civil patients. This is at the heart of our elopement and escape problem. It is difficult to provide the necessary type of environmental controls for prisoner patients in a setting which is designed primarily to treat patients who do not require such controls, and for whom such controls are detrimental to their rehabilitation. To be sure, we have good environmental control for patients in the maximum security service. However, not all patients admitted via criminal procedures require maximum security for extended periods, nor should they remain in such a setting when they have improved to the point that, in the interest of eventual rehabilitation, they are ready to learn and demonstrate progressively increasing responsibility for their own actions. I shall have more to say under the general heading of "Recommendations" about this particular problem.

Before discussing the types of treatment provided hospitalized patients, let me briefly indicate the results of a survey of all patients conducted about 1½ years ago. Each patient was reviewed and classified as to his suitability for release, assuming appropriate facilities and services were available in the community—which, of course, there are not. We found that only approximately 50 percent of the patients then hospitalized really required hospitalization in a mental institution. Many could quite appropriately be cared for in suitable nursing or foster homes, or in chronic disease hospitals were they available. To be sure, those who could have been cared for elsewhere had mental

disturbances, but their mental difficulties were not so severe as to require hospitalization, granted the availability of suitable alternative facilities. For many older patients, the primary need was found to be for physical rather than psychiatric care. St. Elizabeths now devotes large amounts of staff time to such patients. Attachment VIII shows the definitions used in that study, and attachment IX reflects the results. We have no reason to believe that the situation has materially changed since that study, though a gradually increasing number is now being placed in foster homes.

TYPES OF TREATMENT

There are three basic treatment approaches for hospitalized mental patients. They are:

(1) Somatic: Soma means body. Somatic treatment means doing something to or with the patient's body. This is considered first because it is the type of treatment usually thought of in connection with the services of a physician. It includes the prescribing and administering of medicines, physical therapy, or medical and surgical treatments for specific ailments. Scientific advances in the past 10 years have made it possible for the psychiatrist to help his patient gain better control of his thinking and behavior through the administration of tranquilizers and other psychoactive drugs. Various form of shock therapy, although reduced in frequency of use, continue to be given for specific indications. We have staff enough to assure that most of our patients who need psychiatric somatic therapies, indeed, do receive them.

Our medicine and surgery branch provides complete medical and surgical service for all patients. This is our "hospital" within the hospital. The staff in the newly opened physical medicine and rehabilitation building is providing expanded services in the area of physical rehabilitation, particularly for those patients, increasing in number, whose continued hospitalization results more from physical rather than psychiatric disability.

(2) Psychotherapy: The purpose of this treatment modality is to help a patient come to as full an intellectual and emotional understanding of his particular mental difficulty as possible. Stated another way, the objective is to assist the patient to full recovery or, short of that, to help him learn to live as useful and productive a life as possible with his handicap.

There is little or no excuse for hospitalizing a patient if psychotherapy is all that is required. This can be provided in private offices and public clinics. Hospitalization is indicated only when the patient cannot handle his responsibility to himself and society because of mental illness. He then requires a structured daily living and learning experience for a significant part of each day, a program that can be provided only in a hospital. Of course, most of our patients should have individual or group psychotherapy in addition to other treatments. Not over one-seventh of the patients in the hospital receive such treatment because of shortages in the professional staff.

(3) Milieu therapy: In this, probably the major area of hospital treatment, the objective is to create an environment, through proper facilities and experienced personnel, conducive to the development

of an understanding of the patient's living problems with emphasis on assets, learning, and the acquisition of better habits. Through participation in such a program, patients may gain or regain confidence and motivation for socially acceptable living. A number of activities are included in milieu therapy depending upon the needs of particular patients. These activities are designed to help a patient learn, or relearn, such things as (a) proper personal hygiene and grooming, (b) vocational skills essential to acquire a livelihood, and (c) social skills essential to allow some interchange with others.

A proper treatment environment prevents some patients from withdrawing into their unreal world. For others, a proper treatment environment limits exposure to stimuli to which they appear to be unduly sensitive. Although the core of this treatment is provided by nurses and nursing assistants, various programs including occupational and recreational therapy are also employed to create an environment conducive to improvement. In some sections of St. Elizabeths, and many other hospitals, lack of facilities and personnel seriously limit this treatment. I would estimate that approximately half of our patients live in wards where both the facilities and programs clearly provide an environment that is conducive to getting well.

TREATMENT RESOURCES—BUILDINGS AND STAFF

Buildings are certainly less important than the people who inhabit them. No matter how well constructed and appointed a hospital building may be, there can be no hospital without a staff. Properly designed and furnished buildings can, of course, greatly help a staff to carry out its functions. The buildings now in use at St. Elizabeths Hospital were completed in various years between 1855 and 1963. Attachment I shows the number of patients in various buildings by the age of the buildings. You will note, on the left, that fewer than 50 percent will be housed in buildings less than 25 years old even after completion of a new 450-bed unit, the construction on which is to begin next spring. There is also marked overcrowding of the patient buildings, as I shall indicate in a moment. You will see on the right side of attachment X, the proportion of patients that would be housed in buildings of various ages if we could reduce the patient population to the point where overcrowding is eliminated. Even if the overcrowding were eliminated, only slightly more than half of our patients would be housed in buildings now less than 25 years old. If, on the other hand, we could reduce the patient population to approximately 3,000 from the current 6,700—and I believe such reduction is possible within 15 to 25 years, granted the implementation of the recommendations I shall make—we could then house our entire population in reasonably acceptable facilities.

Attachment XI shows the hospital bed capacity and percent overcrowding based on conservative minimum and optimum standards. There are 7,258 beds currently in place of which an average of 6,700 are occupied. The unoccupied beds which are scattered throughout the 150 wards of the hospital are needed to take account of housing patients of different ages, sex, physical and mental condition, and of new admissions and patients on temporary visit away from the hospital. Based on conservative minimum standards, we have space for

only 5,100 beds. If we were to follow conservative optimum standards, we would have space for only 4,200 beds, which would provide for just under 4,000 patients. Overcrowding, as shown in attachment XI, is 41 percent, based on minimum standards, and 72 percent, based on optimum standards. There is less overcrowding in the admission services than in the so-called continued treatment services.

John Howard Pavilion, our maximum security unit, provides 396 beds, and is not overcrowded by minimum standards. It has been in operation between 4 and 5 years, and the physical facilities are, for the most part, quite satisfactory. Some changes, however, would be needed in this facility were it to be used to house medium and minimum security patients, as I believe it should be. I shall comment on this point later.

The old Center Building, in which most of the male prisoner patients housed outside of John Howard Pavilion are located, was built for civil patients in the 1850's. That and other physical facilities leave much to be desired, as the members of the committee saw during their visit to the hospital. Attachments XII and XIII show the site plan of St. Elizabeths Hospital, and a summary of the results of a building survey undertaken in 1945 by the Public Building Service.

Under the general heading of "Treatment Resources" I have left to last the most important factor, viz., staff or people. For your convenience, attachment XIV contains material previously submitted informally at the request of the committee. It shows the number of staff positions for which appropriations were made for fiscal years 1953 through 1964. For the current fiscal year, it will be noted that appropriations were made for approximately 4,000 employees to provide services to approximately 6,700 resident patients, and an additional 1,000 outpatients. Attachment XV shows the distribution of these personnel by percent and number among the major categories, such as nursing assistants, nurses, physicians, maintenance, et cetera. Although nearly 40 percent of the hospital's employees are nursing assistants, the total staff is characterized best by the wide variety of disciplines that are represented. There are 170 different occupational classification series in use, reflecting the exceptional variety and scope of our activities.

It may be helpful to take a moment to relate these rather substantial numbers of personnel to the patients they must serve. Attachment XVI shows, for the hospital as a whole and selected clinical services, the number of minutes per week and per day that a physician has, on the average, to spend with each patient, and the number of minutes per day that nurses and nursing assistants have, on the average, to spend with each patient in the selected areas. I trust you will agree with me that if a person is sick enough to be hospitalized, it might be expected that he would legitimately require more than 25 minutes of a physician's time per week—the hospital average. You will note that the average on various clinical services ranges from almost 2 hours per week in the general medical and surgical service to 9 minutes per week, per patient, on one such service in which some 50 prisoner patients are housed. Physician time per patient is further reduced on wards treating prisoner patients by the necessity that these physi-

cians spend substantial time preparing for and testifying in court. I shall not elaborate on the situation in regard to nurses and nursing assistants, other than to invite your attention to the fact that the minutes per day shown are the minutes within the entire 24-hour period of each day, since the hospital must operate three shifts a day, 365 days per year, and that many aged patients are indeed quite helpless. Obviously, some patients receive less attention than the average figures indicated, while others get more time from the personnel indicated in attachment XVI.

PROBLEMS RELATED TO ELOPEMENTS AND ESCAPES

At the time of my first informal meeting with this committee, the chairman, noting the most unfortunate activities of some of our "escaped patients," asked whether the escapes were due to lack of personnel, inadequacies of buildings, or errors in judgment. I indicated that all three were involved, and I repeat that statement today. I have, doubtless, already said enough about the shortages of personnel. I might only add that a staffing survey, conducted by the hospital within the past year, indicates a realistic need for approximately one employee per patient. This includes not only those staff members working directly with patients three shifts a day, 365 days a year, but also those involved with food preparation and service (21,000 meals each day), laundering (50,000 pounds of bed linens and body clothes daily), building operation and maintenance, and housekeeping (over 100 buildings having a total of nearly 3 million square feet), grounds maintenance and farm operation (over 600 acres), and with medical and administrative records, and so forth. Such a staff would be able to provide about the same quality of treatment for the mentally ill as may now be obtained by a physically ill patient in the less well-staffed, non-university general hospitals of the country. I believe that mental patients are entitled to a quality of treatment comparable to that of the physically ill.

As to the adequacy of buildings in relation to escapes, I shall only invite your attention to the final section on "Recommendations."

On the question of errors of judgment, I must say that some have been and doubtless will continue to be made no matter how ideal the staff, though I hope and fully expect with decreasing frequency. That the amount of time a professional person has to work with a patient affects the quality of his judgment, there can be no question. Increases in the quantity of staff will improve the quality of judgments. But no matter how many staff members there may be, there is always the question of the competence of the persons employed. We have, at St. Elizabeths, a higher proportion of qualified psychiatrists than the vast majority of State mental hospitals. Further, I am confident we are above the national mean in the ratio of personnel to patients. I believe the competence of the physicians immediately responsible for making judgments about a patient's readiness for increased responsibility is well above the average of most other hospitals. Such judgments are of obvious importance in relation to elopements, since most of the prisoner patients who have absented

themselves from the hospital, have done so while unaccompanied on the campus. In short, the majority of the patients who eloped did not escape from locked wards. A few have escaped from a locked situation, but such escapes have been relatively infrequent.

You must judge what I have to say about the quality of staff, understanding that since coming to the hospital 3 years ago, I have participated personally in almost every decision involving a prisoner patient's increase or decrease in freedom of movement. Questions of freedom of movement are involved in many of the determinations of a patient's readiness to learn and demonstrate increasing responsibility for his own actions. The hospital's regulations require that treatment plans which increase or decrease freedom of movement of prisoner patients be reviewed and endorsed through channels for the Superintendent's approval. While I do not, and cannot, know personally each of the 6,700 patients in the hospital, nor even each of the over 700 prisoner patients, as Superintendent I assume final responsibility after review of each recommendation and the endorsements attached.

RECOMMENDATIONS

May I now offer some fairly specific recommendations for the improvement of the treatment and rehabilitation programs for all patients at St. Elizabeths Hospital. In general, and prisoner patients in particular. The latter can hardly be achieved without the former.

A. Improvement of staff-patient ratio: The staff-patient ratio should be increased to 1 to 1, exclusive of full-time research and training personnel. This may be accomplished by increasing the number of staff members and by reducing the number of patients in the hospital.

1. It is recommended that additional personnel be added to the staff (a) by providing budgetary appropriations necessary to support personnel involved in the treatment, rehabilitation, and care of patients at the ratio indicated, and (b) by implementing the announced policy to upgrade Government salaries so they will be comparable to those elsewhere, thereby facilitating recruitment.

2. It is recommended that, without reduction in hospital staff, the patient load be reduced through the development of improved community facilities and resources as alternatives to hospitalization. Specifically, I have in mind the following:

- (a) Increase the District of Columbia Welfare Department's rate of payment for indigent patients in nursing homes from the present \$100 per month for the vendor, to an amount that will stimulate the private sector of the economy to provide beds. Experience elsewhere indicates that this probably would require a minimum of \$200 to \$250 per month, with provisions for extra payment for patients requiring special services. It is virtually impossible to find a suitable nursing home bed for \$100 per month. Consideration might also be given to an increased subsidy for the construction of nonprofit nursing homes in the District of Columbia and surrounding areas.

(b) Increase the rate of payment for vendors by the District of Columbia Welfare Department for foster home placement from the current welfare rate of \$67 per month, and the "District of Columbia Health Department approved home" rate of \$100 per month, to the amount necessary to stimulate the public to make available such homes. Experience elsewhere would indicate that a possible maximum of \$175 per month may be necessary.

(c) Increase the number of chronic disease hospital beds in the District of Columbia by at least 400—the approximate number of patients now in St. Elizabeths who would be better served in such a specialized facility than they now are in a mental hospital.

(d) Enable St. Elizabeths Hospital to pay for the care of patients in alternative facilities when indicated, and when no other agency nor any political subdivision has financial responsibility for such care. Some patients now in the hospital are Federal beneficiaries without legal residence in any State, though they are American citizens. Others have a legal residence, but are, by law, eligible for treatment in St. Elizabeths Hospital at the expense of the Federal Government. The hospital's appropriations are now available only for treatment costs directly related to hospitalization. The hospital lacks legal authority to pay foster or nursing home costs. Ordinarily, care in alternative facilities can be provided at a lower per diem cost than continued hospitalization.

(e) Increase the quantity of homemaker and home nursing services in the District of Columbia to the end that additional patients may be cared for in their own and foster homes.

(f) Increase the community mental health services throughout the city to the end that patients may be treated in facilities appropriate to their needs. The District of Columbia Health Department is now in the process of formulating plans toward this end. Those plans will be worthy of very serious study and consideration.

B. Improved physical facilities: As the patient population is reduced, it will first be necessary to decrease the current overcrowding before any buildings can be demolished. If the population can be reduced beyond that necessary to relieve overcrowding, further reductions could be followed by the demolition of some of the more obsolete buildings. Though such population reductions are believed to be achievable in 15 to 25 years, new facilities are nevertheless needed for the environmental control and continuity of treatment of prisoner patients. John Howard Pavilion is quite satisfactory as a maximum security unit. Needed are approximately 400 additional beds for medium and minimum security, so located in relation to maximum security facilities that there can be a free and ready flow of patients among maximum, medium, and minimum security areas without a change in the professional staff responsible for their treatment and supervision. This means that John Howard Pavilion should be so modified that it can provide all three levels of security within that building, and the staff involved take care of patients in that facility throughout their entire period of hospitalization. Two addi-

tional smaller, but comprehensive units are required. To state more precisely the number of beds needed, a more definitive study than we have been able to make is needed. Such a study should include such factors as the population trends of the District of Columbia, and the anticipated proportion of the population that we might expect to receive as a result of criminal proceedings.

We have recommended that funds be appropriated in the next fiscal year to develop a program statement directed to this end. Ideally, a security hospital with a completely separate subcampus should be available at St. Elizabeths. I recommend its location at St. Elizabeths in order that the security hospital staff may have the opportunity to consult with other staff members in the larger portion of the hospital, and to participate in joint training and research activities. Failing this, the next best solution would be the construction of an entirely new facility on a different site. The third and least desirable solution is the present one.

Additional buildings are recommended for research and training, and for the use of employees. Included in the latter should be a new employees' cafeteria, and additional housing for certain personnel. Also, needed urgently is a new residential treatment center of approximately 75 beds for the treatment of children and adolescents. There are now living on the wards with adult patients about 30 children from 11 to 16 years of age and about 60 from 17 to 20. Only a limited special treatment program is now available to about one-third of these.

C. Revision of commitment laws to become admission procedures: Time does not permit me to say much about the current civil commitment laws in the District of Columbia. Suffice it to say, they leave much to be desired in the light of modern programs for the mentally ill. A bill (S. 935) is now being considered by the Congress to improve this situation. The following are principles that should underlie any revision of civil commitment statutes:

1. Admission to a public mental hospital of patients who do not object to hospitalization, should be on the same basis as admission to general hospitals. That is, if a nonobjecting patient presents himself, or is presented, and the hospital staff concurs that he needs hospitalization, he should be admitted without necessarily requiring

written formalities on the part of the patient. Such patients would, of course, have to be released promptly on request.

2. Objecting patients should be admitted only after judicial determination. There should be no recourse to jury trial to determine if a person is sick enough to require hospitalization.

3. Any commitment law should also provide for prompt access for a patient to a facility appropriate for his particular needs, on an emergency or continuing basis.

As for the statutes and procedures carried out in connection with persons presumed or found to be mentally ill and involved in unlawful acts, I shall not repeat here what I said on October 15, 1963, before the Senate Subcommittee on the District of Columbia, with respect to H.R. 7525.

IN THE MEANWHILE

My recommendations have been directed, primarily, to the long-range solution of the problem of the patients and staff of St. Elizabeths Hospital. Most of them will require a considerable time for their implementation. In the meanwhile, what can we do to reduce the number of escapes and elopements by persons, whether criminally or civilly committed to the hospital, who are likely to commit acts of violence? I repeat that the number of such persons is very small indeed in relation to the total number of patients hospitalized. We can, and are, shifting a few nursing assistants from already understaffed wards for civil patients—wards from which they can ill be spared—to those services where so-called prisoner patients are treated outside the maximum security area. The number that we can shift will be inadequate to the task. We can and are reducing the rapidity with which patients admitted as a result of criminal proceedings are allowed an opportunity to assume increasing responsibility for their own behavior. In so doing, we are well aware, that while we may enhance somewhat the protection of society in the short run, we will inevitably work an injustice on many additional patients.

Thank you, Mr. Chairman.

Mr. DANIELS. Dr. Cameron referred to numerous attachments which are part of his presentation. Without objection, we shall insert those attachments in the record.

(The documents follow:)

ATTACHMENT I

Admissions and average number of patients in the hospital, prisoner patients, fiscal years 1950-63

NUMBER OF ADMISSIONS

[illegible]

AVERAGE NUMBER OF PATIENTS IN THE HOSPITAL

All patients.....	6,587	7,780	6,915	7,079	7,117	7,216	7,120	6,994	6,965	6,900	6,983	6,976	6,838	6,668
Civil patients.....	6,213	6,356	6,488	6,641	6,683	6,755	6,640	6,486	6,435	6,335	6,340	6,243	6,090	5,932
"Prisoner" patients.....	374	424	427	438	434	461	480	508	530	565	643	733	748	736
District of Columbia prisoners.....	268	297	294	288	274	285	319	369	397	450	536	648	692	667
Sex psychopath.....														35
For examination.....							19	22	28	36	43	41	40	40
Mentally incompetent.....													66	63
Under sentence.....													241	234
Not guilty by reason of insanity.....							300	347	369	414	493	607	89	86
U.S. prisoners.....	67	91	97	115	126	143	131	111	106	90	83	63	256	249
For examination.....													35	49
Mentally incompetent.....														8
Under sentence.....														15
Not guilty by reason of insanity.....														23
Military prisoners.....	39	36	36	35	34	33	30	28	27	25	24	22	21	20

¹ John Howard Pavilion, with a bed capacity of 398 beds, opened Sept. 12, 1959.

³ Mentally incompetent.

⁴ Not guilty by reason of insanity.

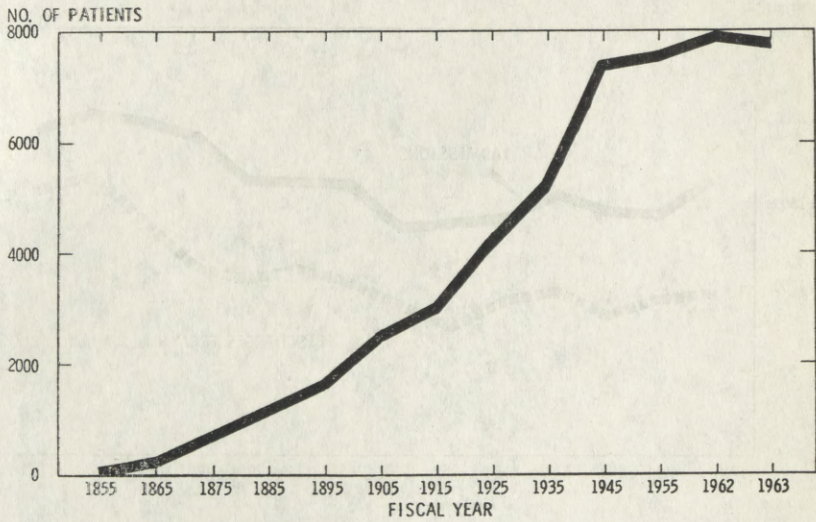
² Unusually large numbers of patients were received from the District of Columbia municipal court as not guilty by reason of insanity in fiscal years 1960 and 1961 (51 and 48 admissions, respectively). In contrast, there had been a total of 20 such admissions from fiscal 1955 through 1959, and 21 in fiscal year 1962.

ATTACHMENT II
Trends in total civil and prisoner patients on the rolls and on unauthorized leave, fiscal years 1950-63

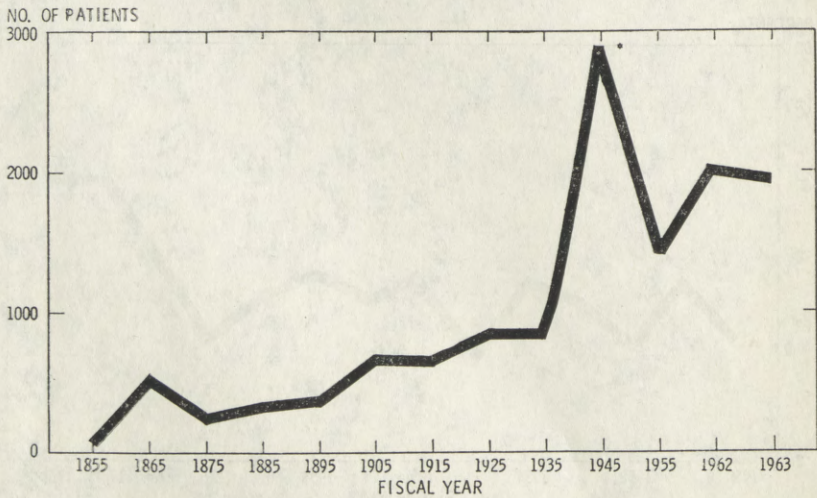
	Fiscal year													
	1950	1951	1952	1953	1954	1955	1956	1957	1958	1959	1960	1961	1962	1963
Total on rolls.....	7,018	7,078	7,271	7,382	7,430	7,529	7,372	7,466	7,463	7,557	7,846	7,992	7,884	7,742
Number on unauthorized leave.....	(1)	(1)	(1)	(1)	(1)	(1)	(1)	35	34	39	65	85	69	² 96
Percent on unauthorized leave.....	(1)	(1)	(1)	(1)	(1)	(1)	(1)	.47	.46	.52	.83	1.06	.88	1.24
Civil patients on rolls.....	6,598	6,629	6,828	6,938	6,960	7,032	6,872	6,919	6,890	6,953	7,085	7,154	7,031	6,894
Number on unauthorized leave.....	(1)	(1)	(1)	(1)	(1)	(1)	(1)	31	28	23	47	49	32	45
Percent on unauthorized leave.....	(1)	(1)	(1)	(1)	(1)	(1)	(1)	.45	.41	.33	.66	.68	.46	.65
Prisoner patients on rolls.....	420	449	443	444	470	497	500	547	573	604	761	838	853	848
Number on unauthorized leave.....	(1)	(1)	(1)	(1)	(1)	(1)	(1)	4	6	16	81	36	37	² 51
Percent on unauthorized leave.....	(1)	(1)	(1)	(1)	(1)	(1)	(1)	.73	1.05	2.65	2.37	4.30	4.34	6.01

¹ Unavailable.² As of Nov. 7, 1963, this number was 90.³ As of Nov. 5, 1963, this number was 49.

ATTACHMENT III

**PATIENTS ON THE ROLLS
END OF FISCAL YEAR, 1855-1963**

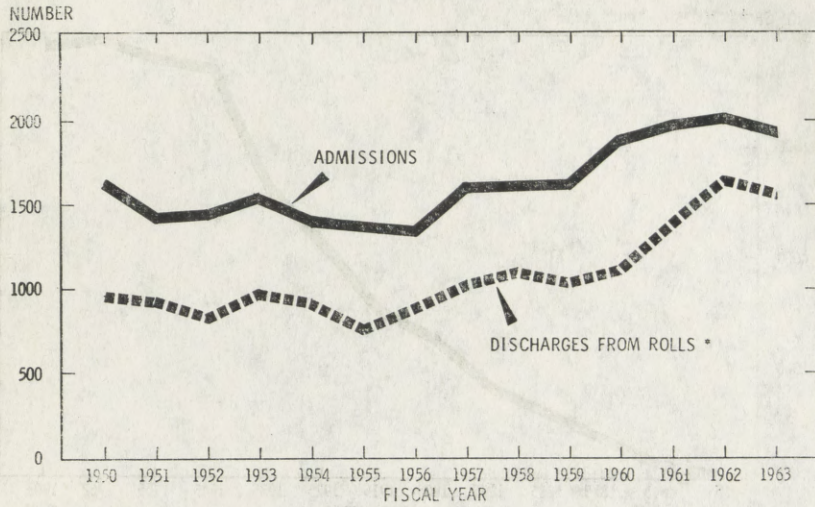
ATTACHMENT IV

**ADMISSIONS TO ST. ELIZABETHS HOSPITAL
FISCAL YEAR 1855-1963**

* HIGH 1945 ADMISSIONS INCLUDE WORLD WAR II MILITARY PERSONNEL

ATTACHMENT V

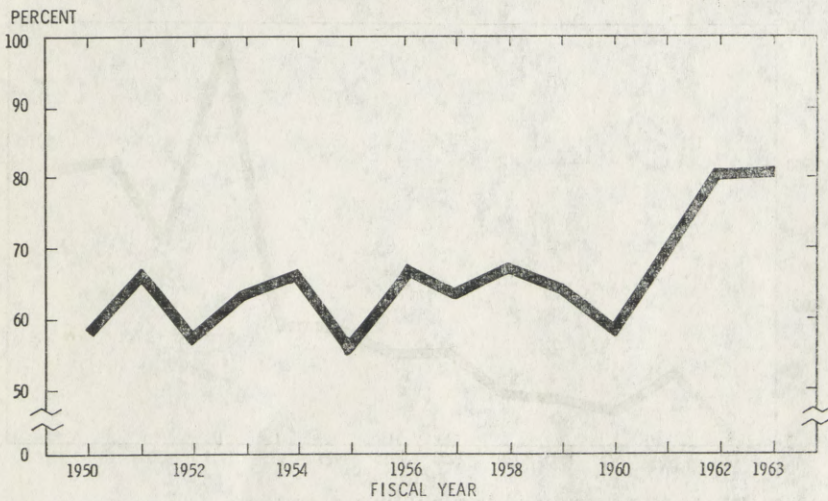
ADMISSIONS AND DISCHARGES **FISCAL YEAR 1950-1963**



* EXCLUDES DEATHS

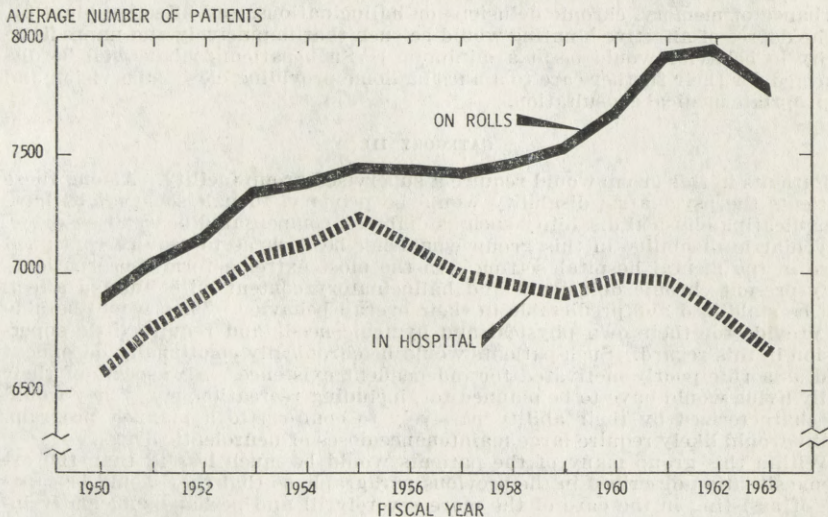
ATTACHMENT VI

DISCHARGES AS PERCENT OF ADMISSIONS* **FISCAL YEAR 1950-1963**



* EXCLUDES DEATHS

ATTACHMENT VII
AVERAGE NUMBER OF PATIENTS
 FISCAL YEAR 1950-1963



ATTACHMENT VIII

CLASSIFICATION OF PATIENTS WHO COULD BE CONSIDERED ELIGIBLE FOR RELEASE
 FROM ST. ELIZABETHS HOSPITAL

The following classifications of patients are by no means mutually exclusive; that is, there will be a great deal of overlapping in terms of the type of patients that fall in the various groups. An attempt has been made simply to describe the most extreme type of patient that could be considered for each group. Of course, in proposing this classification it is recognized that it must go hand in hand with a well developed and organized therapeutic program.

CATEGORY I

Patients in this category would be confined to bed or wheelchair by virtue of physical incapacity and all physical needs and personal hygiene must be provided by nursing care. Examples of patients with such disability would include severe hemiplegics, advanced cardiacs, certain cancer patients, and those with severe neurological disorder. Although such patients may show psychiatric impairment (such as delirium, irritability, impulsivity, noisiness, confusion, etc.), the principal cause which they require derives from their physical incapacity and physical nursing needs. Because of the severity of their physical incapacity, their psychiatric symptoms seldom require specialized psychiatric attention. Patients in this category might well be discharged to a chronic disease hospital for their continued care.

CATEGORY II

This group would include semiambulatory to fully ambulatory patients requiring close nursing supervision because of chronic physical illness. Such patients would be similar to those of category I except that they would be able to assume more responsibility for self-care (e.g., ability to feed themselves and assist in their own personal hygiene). Members of this group probably

would require regular medication and medical supervision for their physical disability. Psychiatrically, such patients might be quite ill but with stabilized and predictable symptoms and behavior so that with good supervision they would not be regarded as a danger to themselves or others. Among the psychiatric symptoms which such patients might exhibit would be: mild confusion, disturbance of memory, chronic delusions or hallucinations, and affective blunting. (The degree of affective blunting would be such that impulsively and unpredictability in behavior would be at a minimum.) Such patients might well be discharged for their further care to a nursing home providing close supervision and appropriate medical consultation.

CATEGORY III

Patients in this group would require a supervised group facility. Among these patients the psychiatric disability would be primary, though some might have complicating physical disability such as diabetes, compensated heart disease, etc. Psychiatric disability in this group would not be such as to require continued care in the mental hospital setting. In the most extreme form these patients may present chronic delusional and hallucinatory content with blunted affect, but be stabilized and predictable in their overall behavior. They would be able to provide for their own physical and hygienic needs and require little supervision in this regard. Such patients would be chronically emotionally dependent and as a rule poorly motivated for independent existence. All aspects of their daily living would have to be planned for, including recreation, etc. They would be characterized by their ability passively to conform to a planned program. Many would likely require large maintenance doses of neuroleptic drugs.

Within this group many of the patients would be much less ill than the extreme situation described in the previous paragraph, so that they would be capable of assisting in the care of the more severely ill and perhaps sufficiently integrated to carry out routine tasks of the facility and even work part time outside of the facility, thus helping pay for their own care. It is felt that such patients could be discharged from the mental hospital for care in a nursing home situation providing moderate supervision and psychiatric and medical consultation.

CATEGORY IV

Patients in this group would be suitable for foster home or own home care. Members of this group would in many respects be similar psychiatrically and physically to those described in category III, but would differ in that they could be left more to their own devices and require less regular supervision. Such patients, among their psychiatric symptoms, might well show some eccentricity of behavior and dress and might present some chronic physical disability that would require medical supervision. The primary difference from category III is that patients in this group require a tolerant environment but without the same degree of structuring. Patients in this category must be sufficiently integrated so that they may obtain any necessary medical care in a clinic, although they may require assistance and supervision in meeting such obligations.

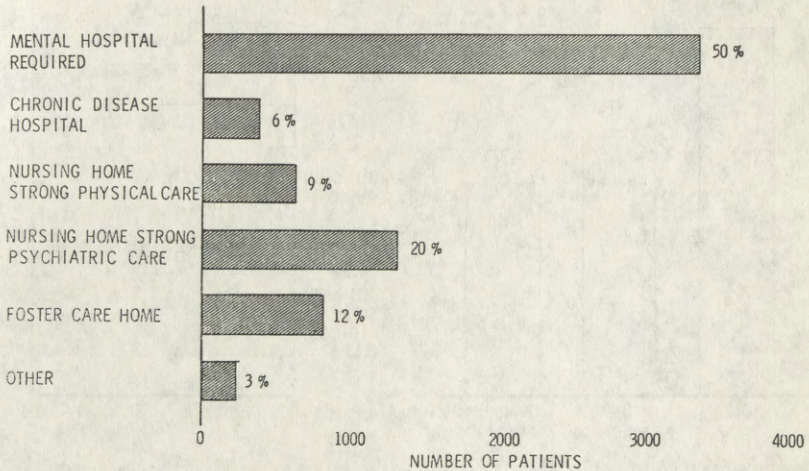
CATEGORY V

Patients in this group would be capable of independent existence in the community and, in general, would compare well to our present social recovery group. Psychiatrically, members of this group may be just as ill as in some of the previous groups but differ in that they would be able to be financially independent (or could live on public assistance) and their general behavior and dress would be socially acceptable to the community.

Patients not assigned one of the above categories were tabulated in a sixth category, "No other appropriate facility."

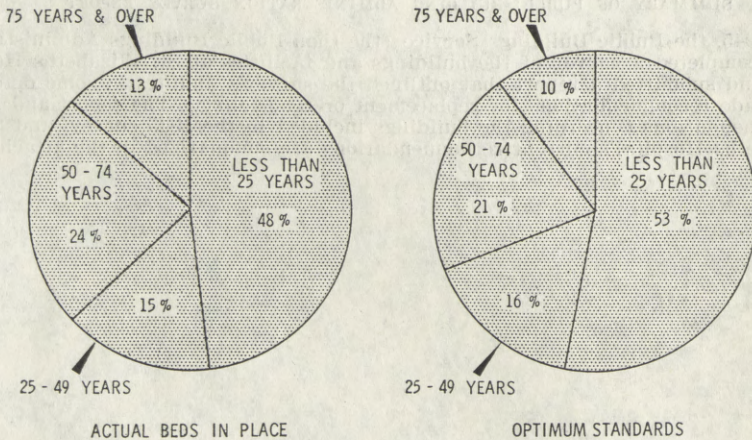
ATTACHMENT IX

NUMBER OF PATIENTS IN HOSPITAL BY RELEASE CLASSIFICATION (AUGUST, 1961)



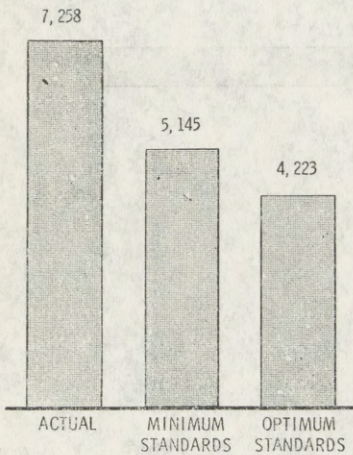
ATTACHMENT X

HOSPITAL BED CAPACITY BY AGE OF BUILDING*

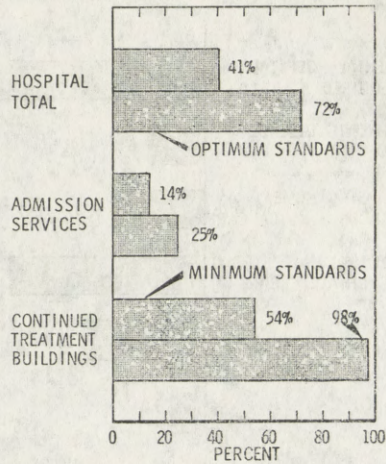


* Includes Physical Medicine & Rehabilitation Building and Psychiatric Rehabilitation Building

ATTACHMENT XI

HOSPITAL BED
CAPACITY

OVERCROWDING



ASSUMES NEW BUILDINGS CONFORM TO OPTIMUM AND MINIMUM STANDARDS RESPECTIVELY

(Attachment XII, site plan of St. Elizabeths Hospital, appears in the subcommittee files.)

ATTACHMENT XIII

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ST. ELIZABETHS HOSPITAL

SUMMARY OF PUBLIC BUILDING ADMINISTRATION SURVEY REPORT

In 1945, the Public Buildings Service (the then Public Buildings Administration) completed a survey of the buildings and facilities at St. Elizabeths Hospital and submitted a report that outlined the survey's findings in some detail and made recommendations for replacement or remodeling. The report and its recommendations concerning the buildings included in the 1945 survey, and St. Elizabeths Hospital's current recommendations are summarized in the attached statement.

The PBS survey made some observations concerning bed capacity which are no longer pertinent because of the changes (new construction, demolition projects, etc.) which have taken place in the nearly 20 years since the report was prepared. The current bed capacity situation may, however, be summarized as follows:

Actual number of beds now in place.....	7,258
Capacity—Minimum space standards.....	5,145
Capacity—Optimum space standards.....	4,223

About 24 percent of the patients are housed in buildings, more than 50 years old, in fact 13 percent are in buildings 75 years or more old. Only about 50 percent of all patients are in buildings less than 25 years old.

Concerning mechanical and electrical facilities, the PBS report states in part as follows:

"The mechanical equipment of the institution, like the buildings, ranges from the antiquated to the modern. Much of the equipment is in bad condition, not from lack of proper servicing, but because it has been improvised from unsuitable materials or has not been discarded or renewed when its efficiency has become impaired. Taken as a whole, the mechanical equipment, particularly in the older section, shows the effect of continued lack of sufficient maintenance funds.

In general, plumbing fixtures in toilet rooms throughout the older buildings, while maintained in good condition, are grossly inadequate in number. The principal cause is that the buildings have been enlarged to increase patient capacity without a corresponding increase in toilet facilities."

(Comment: \$45,000 plumbing and sanitary facility study is now underway.)

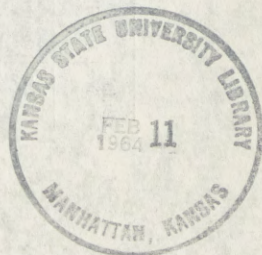
"The entire water system should be surveyed and all mains and valves should be definitely located and mapped. Any unnecessary interconnections (between domestic water and fire mains) should be removed."

(Comment: This recommendation has been carried out.)

"In all but the newer buildings the illumination ranges from poor to very poor. In some buildings there are lighting fixtures that were obsolete 35 years ago. The so-called 'dayrooms' are so poorly lighted that on cloudy days they are gloomy and depressing to a normal individual and probably would be even more so to the mentally deranged person who has no escape from the surroundings in which he is placed."

(Comment: Relighting and improvement of electrical facilities generally are being undertaken in \$2.9 million project begun with 1964 appropriation of \$354,000.)

The PBS report recommends further that the fire protection system be improved by adding more staff and modern equipment. This has been done. Beyond that, \$865,000 has been appropriated for installation of an automatic sprinkler system in the older buildings. The necessary engineering studies are in progress. The installation contract should be awarded within a few months.



ST. ELIZABETHS HOSPITAL
Part 1. List of buildings to be demolished

INSTITUTIONAL BUILDINGS—REPLACEMENT RECOMMENDED

Build- ing No.	Building name	Date erected	Area square foot	Public Buildings Service recommenda- tion, 1945	St. Elizabeths Hospital recommendation, 1963	Remarks
1	Center	1859	123, 748	Replace	Demolish existing structure after replacement is constructed.	Presently used for offices and quarters.
2	West wing, 8 wards	1853	94, 259	do	do	White and gray ash planned for replacement in CT-10.
3	East wing, 8 wards	1858	67, 584	do	do	Planned for replacement as part of CT-10.
4	Garfield	1872	(1)	do	do	Planned for replacement as part of CT-9 project.
5	Pine	1884	(2)	do	do	
6	Dawes	1871	(1)	do	do	
7						
8	Willow	1895	6, 723	do	do	
23	Allison D, C, B.	1899	40, 564	do	do	
28	Linden	1893	4, 116	do	do	
29	Holly	1893	10, 006	do	do	
31	Atkins Hall	1878	12, 064	do	do	
32	Relief	1879	48, 381	do	do	
36	Home	1883	32, 136	do	do	
47	West lodge	1856-98	34, 951	do	do	
89	R Building	1902	31, 278	Complete remodeling	Demolish existing structure to permit new medical and surgical building construction.	The plan is for a new medical and surgical building to be on site of R Building and Blackburn Laboratory.

OTHER INSTITUTIONAL BUILDINGS—REPLACEMENT RECOMMENDED

33	Detached dining hall	1885	18, 108	Replace	Demolish existing structure after replacement is constructed.	
34	Detached kitchen	1900	4, 939	do	do	
39	Canteen	1916	637	do	Demolish existing structure after replacement is under contract.	
45	General kitchen	1883-90	40, 120	do	Demolish existing structure after replacement is constructed.	
46	Bakery	1878	(c)	do	Demolish existing structure in conjunction with general kitchen No. 45.	

SERVICE BUILDINGS—REPLACEMENT RECOMMENDED

12	Mechanical and electrical shops.	1920	26,827	Replace-----	Demolish existing structure after consolidation of all branches into maintenance shop building.
16	Pumping station.	1895	5,460	do-----	Replacement in progress as part of the Anacostia Freeway construction.
19	Toothouse.	1908	1,528	do-----	Replace and demolish existing structure.
49	Construction shops.	1899	26,170	do-----	Demolish after consolidated maintenance shop is constructed.
53	Toothouse.	1895	982	do-----	Replace and demolish existing structure.
71	Employees cafeteria.	1924	5,085	do-----	do-----
81	Garage.	1921	10,400	do-----	do-----
88	Blackburn Laboratory.	1923	22,590	Complete remodeling.	Structure inadequate. Demolition required to complete plan for C-T-10. New garage planned for consolidation in maintenance shop.
91	Glenside.	1923	9,434	Replace-----	Temporary building built as a cadet nurses quarters.

STORAGE BUILDINGS—REPLACEMENT RECOMMENDED

11	Storage shed.	1925	5,934	Replace-----	Demolish after new maintenance building is constructed and building 12 converted.
44	Old storeroom.	1900	17,975	do-----	Demolish after new facility is constructed.
82	Dry barn.	1884	21,840	do-----	Demolish as part of C-T-10 project.
83	Horse barn.	1901	23,156	do-----	do-----

Mechanical and electrical storage.

Used for storage of construction and grounds supplies.
Used for storage of construction supplies.

HOUSING BUILDINGS—REPLACEMENT RECOMMENDED

25	Allison A.	1899	6,936	Replace-----	Demolish after replacement is constructed.
30	Detached nurses home.	1861-87	15,059	Retain, subject to developing replacement plan.	do-----
79	Electrical engineer's cottage.	(¹)	2,161	do-----	do-----
80	Mechanical engineer's cottage.	(¹)	2,969	do-----	do-----
85	Construction engineer's cottage.	(¹)	2,140	do-----	do-----
86	Grounds and farm superintendent's cottage.	1881	1,801	do-----	do-----

Used for physicians' apartments.

¹ Included in building No. 3.² Included in building No. 4.³ Included in building No. 45.⁴ Date not known.

Part 2. List of buildings needing major renovation

BUILDINGS TO BE RENOVATED—INSTITUTIONAL

Building No.	Building name	Date erected	Area square feet	Public Buildings Service recommendation, 1945	St. Elizabeths Hospital recommendation, 1953	Remarks
60	J Building	1902	17,485	Complete remodeling	Extensive renovation recommended.	
64	L Building	1902	13,640	Remodel	do	
66	K Building	1902	13,494	do	do	
68	Q Building	1902	40,732	do	do	
72	M Building	1902	11,908	do	do	
73	C Building	1902	44,718	do	Major renovation and improvement of utilities needed.	
75	B Building	1902	41,971	do	Major renovation and major repairs needed.	
90	W. W. Eldridge Building	1931	107,566	Minor remodeling	Major alterations after a new medical and surgical building is constructed.	Severe settlement on north end needs repair (major). Convert to an intermediate medical care facility as part of the plan for a new medical and surgical facility.
92	Nichols Building	1936	111,930	do	Minor remodeling alterations and utility improvements.	
93	W. A. White Building	1934	139,926	do	Extensive remodeling and renovation.	
94	N Building	1902	13,869	Remodel	do	
95	I Building	1902	18,275	do	do	
100	P Building	1902	39,099	Minor remodeling	do	
106	Goddling 3	1938	41,331	do	do	
107	Goddling 4	1939	41,753	do	do	
108	Goddling 5	1940	35,123	do	do	
110	Goddling 6	1940	35,164	do	do	
111	Richardson 1	1933	41,207	do	do	
112	Richardson 2	1933	41,268	do	do	
115	East Side 8	1943	41,317	do	do	
116	East Side 7	1943	41,317	do	do	

OTHER INSTITUTIONAL

21	Gatehouse No. 1	1874	1,428	Remodel, repair	Major repairs and improvements to modernize this old building.	Usable, but needs renovation.
38	Red Cross House	1942	11,650	Retain	Minor improvements needed.	
40	Patients' library	1882	6,870	Retain subject to a plan for replacement.	Improvements and numerous minor repairs needed to modernize.	Building antiquated but serviceable as a library.
69	E Building	1902	26,657	Remodel and renovation	Minor renovation	Presently used for offices and quarters.
102	T.B Building	1932	33,920	Retain	Alterations and improvements needed.	Used for research and youth center.

SERVICE BUILDINGS

20	Greenhouses.....	1882-1925	17,400	Partial replacement and repair.	Minor improvements and major repairs needed to keep in usable shape.
41	Firchouse.....	1890	2,442	Remodel.....	Recommend remodeling and renovation repairs.
52	Iceplant.....	1892	5,034	Retain subject to replacement plan.	Minor alterations and major repairs needed to keep building usable.
56 57	} Powerhouse.....	1902-10	23,436	do.....	Continual extensive repairs needed to keep in usable, operable condition.
96	Comfort station.....	1922	206	do.....	Alterations and repairs to plumbing facilities needed.

HOUSING BUILDINGS

15	Cottage No. 1.....	1924	2,924	Retain subject to replacement plan.	Renovation needed.....
17	Cottage No. 2.....	1924	2,924	do.....	do.....
18	Burroughs cottage.....	1891	5,508	do.....	Repair and completely renovate.
27	Cottage No. 3.....	1924	2,924	do.....	Renovation needed.....
67	Cottage No. 5.....	1924	2,924	do.....	do.....
76	Cottage No. 4.....	1924	2,924	do.....	do.....
99	Cottage No. 7.....	1924	2,924	do.....	do.....

ATTACHMENT XIV

History of appropriations and budget requests (excluding supplementals)

	Estimate to Budget Bureau	Estimate to Congress	House allowance	Senate allowance	Appro- priated
Fiscal year 1964:					
Total budget.....	\$27,916,000	\$27,413,000	\$27,413,000	\$27,413,000	\$27,413,000
Direct appropriation.....	\$27,916,000	\$9,716,000	\$7,354,000	\$7,354,000	\$7,354,000
Total permanent positions.....	4,263	3,957	3,957	3,957	3,957
Position increase.....	300	50	50	50	50
Fiscal year 1963:					
Total budget.....	\$25,495,000	\$24,270,000	\$25,467,000	\$25,467,000	\$25,467,000
Direct appropriation.....	\$25,495,000	\$5,974,000	\$6,332,000	\$6,332,000	\$6,332,000
Total permanent positions.....	4,021	3,655	3,971	3,971	3,971
Position increase.....	400	34	350	350	350
Fiscal year 1962:					
Total budget.....	\$23,296,000	\$22,145,000	\$22,858,000	\$22,858,000	\$22,858,000
Direct appropriation.....	\$5,620,000	\$4,939,000	\$5,105,000	\$5,105,000	\$5,105,000
Total permanent positions.....	3,621	3,471	3,621	3,621	3,621
Position increase.....	300	150	300	300	300
Fiscal year 1961:					
Total budget.....	\$19,924,000	\$19,350,000	\$20,075,000	\$20,075,000	\$20,075,000
Direct appropriation.....	\$5,761,000	\$3,947,000	\$4,095,000	\$4,095,000	\$4,095,000
Total permanent positions.....	3,323	3,173	3,323	3,323	3,323
Position increase.....	300	150	300	300	300
Fiscal year 1960:					
Total budget.....	\$18,818,000	\$18,230,000	\$18,230,000	\$18,230,000	\$18,230,000
Direct appropriation.....	\$3,838,000	\$3,715,000	\$3,715,000	\$3,715,000	\$3,715,000
Total permanent positions.....	3,123	3,023	3,023	3,023	3,023
Position increase.....	350	250	250	250	250
Fiscal year 1959:					
Total budget.....	\$16,872,000	\$16,019,000	\$16,019,000	\$16,019,000	\$16,019,000
Direct appropriation.....	\$3,323,000	\$3,154,000	\$3,514,000	\$3,154,000	\$3,154,000
Total permanent positions.....	2,991	2,773	2,773	2,773	2,773
Position increase.....	274	56	56	56	56
Fiscal year 1958:					
Total budget.....	\$16,486,000	\$16,590,000	\$15,240,000	\$15,669,500	\$15,669,500
Direct appropriation.....	\$3,317,000	\$3,265,000	\$3,000,000	\$3,085,800	\$3,085,800
Total permanent positions.....	3,003	3,003	2,717	2,717	2,717
Position increase.....	286	286	0	0	0

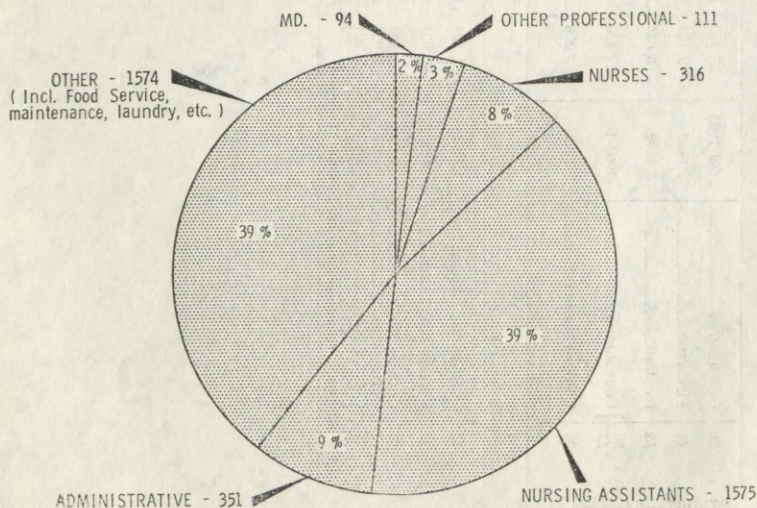
NOTE.—During preceding 5-year period (fiscal years 1953–57), new position requests totaled as follows:

To Bureau of the Budget.....	478
To Congress.....	367

ATTACHMENT XV

FULL - TIME EMPLOYEES

JUNE 30, 1963



ATTACHMENT XVI

Physician time and nursing time, per patient, hospital total and selected services, Sept. 30, 1963

Service	Resident patients ¹		Minutes per physician		Minutes per nurse and nursing assistant per day
	Total	Prisoners	Per week	Per day	
Hospital, total.....	6,596	743	25	4	73
Medicine and surgery branch.....	352	13	113	16	183
Dix.....	365	² 28	40	6	92
John Howard Pavilion.....	395	352	30	4	104
West side.....	443	175	21	3	57
Detached.....	779	50	9	1	45
Geriatric.....	813	8	19	3	60

¹ Resident patients are those in the hospital plus those on temporary visit. On Sept. 30 there were 62 patients (5 prisoners) on temporary visit.

² Females.

Mr. DANIELS. Dr. Cameron, how large a facility is St. Elizabeths Hospital?

Dr. CAMERON. We have approximately 6,700 patients in residence plus about 1,000 in outpatient treatment.

Mr. DANIELS. How large an area does the hospital itself occupy?

Dr. CAMERON. The main campus on which the buildings are located is approximately 340 acres.

There is also a farm of approximately 300 acres south of the hospital, which has been turned over, I believe, to the National Park Service, but we continue to farm it for the present.

Mr. DANIELS. Are patients permitted to go to this farm?

Dr. CAMERON. Yes, sir.

Mr. DANIELS. What type of patient do you send to the farm?

Dr. CAMERON. These are, for the most part, civil patients hospitalized for a rather long time.

Mr. DANIELS. Your maximum security building is John Howard Pavilion?

Dr. CAMERON. Yes, sir.

Mr. DANIELS. In the light of modern buildings utilized for maximum security and "prisoners," would you consider the John Howard Pavilion an A-1 facility?

Dr. CAMERON. One of the best in the country.

Mr. DANIELS. Comparable to what other institutions?

Dr. CAMERON. I cannot answer that directly. I only know how it came into being and how it works. Dr. Addison Duvall, former Assistant Superintendent of the hospital, who was there at the time John Howard Pavilion was built, visited most of the maximum security hospitals throughout the country and tried to gain ideas as to what should go into a new and modern facility and incorporated them in the plans for this building.

I know how he and Dr. Overholser went about building it, and I have been trying to operate it. It works well.

Mr. DANIELS. Confined in the John Howard Pavilion are just criminal patients; is that right?

Dr. CAMERON. There are approximately 30 civil patients in that building, plus about 350 patients there as a result of criminal proceedings.

Mr. DANIELS. Why the 30 civil patients?

Dr. CAMERON. A few civil patients are difficult and assaultive.

Mr. DANIELS. Out of a population of approximately 6,700, just 30 civil patients?

Dr. CAMERON. There are a very few other difficult civil patients elsewhere, but that is about right.

Mr. DANIELS. You said that the John Howard Pavilion is an A-1 facility, but there have been two escapes from the John Howard Pavilion?

Dr. CAMERON. Yes, sir.

Mr. DANIELS. Can you tell this committee how these escapes came about?

Dr. CAMERON. I can tell you how one of them came about. In the case of Mr. Smallwood, it was just plain human error, nothing wrong with the building.

In the case of Mr. Frazier, our assumption is that he was somehow able to fashion a key. We are still a little puzzled how that was accomplished, but he has since been apprehended and is in that building now.

Mr. DANIELS. Would you say that these two escapes came about by reason of negligence on the part of the personnel at the hospital?

Dr. CAMERON. I would not call it negligence. I would call it, however, a matter—certainly in the case of Mr. Smallwood—of error in human judgment, not necessarily negligence.

Mr. GOODELL. Have you changed the lock there?

Dr. CAMERON. No, sir.

Mr. GOODELL. You are sure you have got the key?

Dr. CAMERON. We are pretty sure he did not have one of our keys in the first place. Every key in the John Howard Pavilion is accounted for at the end of each shift, as no key may leave that building. Those keys are kept locked in an office which is on a floor on which no patients are located.

Mr. DANIELS. You said there are errors of human judgment or there was one made which enabled Mr. Smallwood to escape?

Dr. CAMERON. Yes, sir.

Mr. DANIELS. On whose part was this human error committed?

Dr. CAMERON. It was a combination, a failure of communication, but the kind of thing one can understand having happened. Mr. Smallwood went to a dance. We bring women patients to that building at intervals for recreational activities and dancing.

Mr. Smallwood approached one of the employees who did not know him and told him that he was from another building on the grounds. That employee knew that if this were true one of the members of our recreational department would have brought him and would be responsible for returning him to the outside building. He took Mr. Smallwood to a recreation department employee and says he said, "This man says he is from Dix," one of our other buildings. The recreation therapist thought he heard him say, "This man is from Dix." A failure of communication occurred between these men and the recreation man took him to the door and waved him through, taking the word of the other employee as to what he thought the other employee had told him.

Mr. DANIELS. The John Howard Pavilion accommodates about 396 patients?

Dr. CAMERON. Yes, sir.

Mr. DANIELS. How many patients are there today?

Dr. CAMERON. I cannot give you the precise number but I would not be far wrong if I tell you that there are 390. In other words, there are usually from 5 to 15 vacant beds in the building to take account of new admissions, transfers between wards, et cetera.

Mr. DANIELS. Once a patient is committed to the John Howard Pavilion, are any of them, at a future date, transferred to any other portion of your facility?

Dr. CAMERON. Mr. Chairman, the patients are committed to St. Elizabeths Hospital and not to John Howard Pavilion. We ordinarily house them there at the outset, but we move them from John Howard to other facilities in the hospital when, in our judgment, they are ready for such a move.

Mr. DANIELS. They are transferred then to your medium security facility?

Dr. CAMERON. Ordinarily; yes, sir.

Mr. DANIELS. What measures are imposed in order to prevent such a prisoner from escaping from the premises?

Dr. CAMERON. He moves to one of the medium security wards only after the doctors in the maximum security unit have made such a recommendation and that recommendation has been reviewed by the doctors on the ward to which the patient would be sent, and by myself. He may not be transferred until the superintendent has finally approved that transfer.

When he goes to the new ward, he would ordinarily be kept in a locked situation for several days until the personnel on that new ward can get acquainted with him and know more about him at first hand, rather than simply relying on the record sent with him.

Once they get acquainted with him, based on their own judgment and the recommendation of the staff from John Howard and with my concurrence, he would be given what we refer to as "accompanied privileges." This means that he may then move about the hospital campus in the company of an employee to work, to recreation, to church, to therapeutic activities, but always in the company of an employee.

We well know that in accompanying patients, it would be possible for a particular patient to bolt and run. We also well know that the employees may not have their eye on him during an 8-hour work period each and every second of the time, so we try not to give this "accompanied status," if you will, until we believe that the patient will be trustworthy in handling it. If he acquits himself satisfactorily in this relationship, then we would afford him the opportunity to show increased responsibility for his own actions, by allowing him to go unaccompanied from the ward to his place of work, but usually to return to the ward by 4 or 5 o'clock in the afternoon. As he acquits himself satisfactorily in this way, we may allow him some privileges on the grounds in the evening after the regular workday is over, because, certainly, he is going to have leisure time on his hands if he ever returns to the community and he needs to learn how to utilize this time well, and he cannot unless he has a chance to try.

Mr. DANIELS. Have a significant number of accompanied patients escaped?

Dr. CAMERON. Not from the accompanied status. The principal number of elopements occur from unaccompanied status, usually within a month or two after receiving this status.

This is the point of greatest likelihood for elopements.

Mr. DANIELS. The medium security buildings do not have walls or other safeguards to prevent a prisoner from escaping from the premises?

Dr. CAMERON. No, sir. We are aware of that and take that into account when we accord the patient the opportunity to assume increased responsibility for his own actions in the company of an employee.

Mr. DANIELS. How many escapes have occurred since the beginning of the year?

Dr. CAMERON.

Since January 1 through October 31 of this year, 147 "prisoner" patients escaped of which 15, or 10 percent, returned the same day, usually voluntarily. Thirty-one, or 21 percent, returned the next day, and eight, or 5, percent returned the second day. Sixty-four, or 44 percent, returned after 72 hours. Many of the latter were with police help.

As of October 31, 29 of those persons were still at large.

Mr. DANIELS. Were criminal charges pending against these 147?

Dr. CAMERON. No, sir.

Mr. DANIELS. How many had criminal charges pending?

Dr. CAMERON. They had all come to the hospital as a result of criminal proceedings. As I tried to indicate earlier, when a patient comes in for examination while charges are pending, for our opinion as to his capability of standing trial and for an opinion as to the relation of the act, if committed by him, to an illness, if it exists, he is ordinarily sent in for a period of 90 days and is kept in the maximum security facility throughout the time, that is while charges are pending against him.

He would be transferred to the medium security area only after having been found not guilty by reason of insanity, after having been admitted as a result of becoming ill while serving a sentence or after having been found incompetent to plead. In other words, there are no charges pending against these men unless they have a detainer in some other jurisdiction.

Mr. DANIELS. If a criminal charge is pending against a prisoner, do you authorize that prisoner to be transferred from the John Howard Pavilion?

Dr. CAMERON. Once in a while we may have a patient we move out of John Howard Pavilion even though he has a detainer from another jurisdiction, but this is taken into account in making the transfer.

I might tell you that the vast majority of the detainees from other jurisdictions, if any, are lifted by those jurisdictions before the patient finally leaves the hospital.

Dr. CAMERON. Excuse me; might I add one thing further?

We have some patients, for example, who have been in trouble with bad checks and some of these have been moved to medium and minimum security while still having detainees for bad checks outstanding

and some have been granted conditional release with the concurrence of the court. Some have thus earned money and made restitution. As they make restitution the detainers are usually lifted.

Mr. DANIELS. Of the 29 still at large, how many have criminal charges pending?

Dr. CAMERON. They all had some criminal record or they would not have been there as the result of criminal proceedings.

Mr. DANIELS. Are charges pending against them at the present time?

Dr. CAMERON. Not in the District of Columbia. They may have, a few of them, detainers elsewhere but I cannot answer that question. I could get it for the record if you would like.

Mr. DANIELS. How does the number of 147 escapees which occurred since the beginning of this year, compare with escapees in the past on an annual basis?

Dr. CAMERON. As I indicated earlier, the number of persons escaping has risen during the past several years so I can only assume that if we were to make a comparable study of a previous time period, the number now is somewhat higher than it was in a previous time period.

For example, you will see on attachment I of my testimony, if I may redirect your attention to that, the number of people admitted as a result of criminal proceedings and the number of people who are at risk of escape are obviously more than they were in previous years.

So, it becomes important to look at rates, not actual numbers alone, and then if you look at attachment II, you will see for prisoner patients in 1957—this is not quite the same figure you asked for before but rather the number of persons on unauthorized leave at the end of a fiscal year—for 1957, it was 4 and, as you see, at the end of 1963, it was 51. I might tell you that as of midnight last night for prisoner patients, it was 49; civil patients, 38, for a total of 87 on unauthorized absence from the hospital as of midnight last night.

Mr. REISINGER. Pertinent to the annual rise in escaped prisoner patients, I note, for example, what I judge is referred to in attachment I, the second category, the average number of patients in the hospital on a fiscal basis in 1955, which was the year following the *Durham* decision, it shows 461 as the total number of prisoner patients?

Dr. CAMERON. Yes, sir.

Mr. REISINGER. In 1963, it shows 736 prisoner patients?

Dr. CAMERON. Yes, sir.

Mr. REISINGER. Does this increase, by chance, reflect a correlation between verdicts of not guilty by reason of insanity and the *Durham* rule?

Dr. CAMERON. I think not.

Mr. REISINGER. You do not think the increase is there?

Dr. CAMERON. No, sir; if you look at the entire timespan, you will see there was a gradually increasing number in residence from 1950 through 1953, and that there is no perceptible change in the rate of increase in 1954 and thereafter—time of the *Durham* decision.

Mr. REISINGER. I think the experience of the committee and myself as lawyers would indicate—and I am certain the chairman's experience as a judge—would indicate that it takes the criminal several years to become aware of the effectiveness of a new rule of this kind?

Dr. CAMERON. As a matter of fact, I believe I don't have the data with me but if you were to look at the number committed as "not guilty by reason of insanity" for the last few years, you will see there was a decrease in the last year as compared with the previous.

Mr. REISINGER. Your data only give breakdowns for 1962 and 1963 of those "not guilty by reason of insanity." They do not provide information for earlier years.

Dr. CAMERON. I might call your attention also to the number of patients admitted as shown in the top half of attachment No. I. There has been a very substantial increase through this 14-year period. This is simply a reflection of the courts sending to us additional numbers of patients for observation, many of whom we returned to the court with an opinion of being not mentally ill.

They come in usually for a 90-day period so we would have in the hospital at any given time, since our admissions are about 40 per month to this unit, around 100 to 120 patients in the hospital simultaneously for examination. Well over half of them are returned to the court with an opinion that they are without mental disorder.

I am also told that in the past few months, the courts have started sending us all persons accused of capital crimes, whether or not there has been a question raised by either the defense or the prosecution as to their mental condition. I learned this because I was becoming aware, as the cases went across my desk, of a substantial number of persons charged with capital offenses who we were reporting to the courts as without mental disorder, whereas in a former time period, most of the persons charged with such crime and examined by us were thought to have mental disorders.

So, I inquired as to what was happening and discovered that the court was now sending us everyone in that category.

Mr. REISINGER. Were you advised this was in anticipation of the defense of insanity under the now existing *Durham* doctrine?

Dr. CAMERON. No, sir; I was not. I do not know why the courts decided to do that.

Mr. GOODELL. Would the gentleman yield?

If I understood you correctly, Doctor, earlier you indicated you did not feel there was an increase in the rate of prisoner admissions?

Dr. CAMERON. Was not what?

Mr. GOODELL. I think figures can be made up so that you can come to almost any conclusion but the way I look at it, in the last 6 years, you had about a 40-percent increase in admissions. In the previous 6 years, there was about a 20-percent increase. I'm not at the moment concerned by whether this is attributable to any particular rule or any particular reason, but there does seem to have been an increased rate of prisoner admissions in the last 6 years as compared with the previous 6 years. It is about twice as many?

Dr. CAMERON. There are certainly more admissions. There is no question about that.

My statement a moment ago was that in the year 1954-55 there seemed to be, to me, no dramatic change in the previous trend. Whether or not this trend was affected as a result of the *Durham* decision, I would assume with you there might have been some, but from the data here presented, I think we are unable to determine. Rather, we need more precise data and such a study is now under-

way by the Judicial Conference. We would anticipate that within the next few weeks there probably will be some more specific data available directed to the question which you raised.

I think it would be fruitless to speculate when we have better data coming out.

Mr. GOODELL. I think the record is clear, however, that the rate of increase of admissions for the past 6 years is about double what it was in the previous 6-year period, for whatever reason.

Dr. CAMERON. That is right.

This is what has caused our problem because, as I tried to indicate, once you get an overload, it involves the entire group and not just those last patients admitted; who were, to use a metaphor, the straw that broke the camel's back.

Mr. REISINGER. Doctor, the effect of the Durham rule is to, I think we might agree, bring a category of patient into the hospital who would not be brought there prior to its being laid down by the court; that is, they are not legally insane in the sense of the old *McNaughton* rule and in the right-and-wrong text?

Dr. CAMERON. There is no question but there is a difference in the character of the patients coming—of the types of illness presented. They are legally insane in the District of Columbia or else they would not have come in. That is, as “not guilty by reason of insanity.”

What is happening is that persons with character disorders are now being found “not guilty by reason of insanity” who, if tried under the *McNaughton* rule, would have been found guilty.

You can discuss as to whether this is good or bad. I am sure that those who set up the *Durham* rule felt this was a desirable result—that we were sending to prison many persons obviously ill. That this was happening is well evidenced by the fact that the Federal Bureau of Prisons, to which Federal prisoners who have been found guilty as charged in jurisdictions throughout the rest of the country, has had to establish a medical center for Federal prisoners at Springfield, Mo., where mentally ill persons are treated.

Mr. REISINGER. What I am directing my questions to is this, Doctor: Subsequent to the adoption of the *Durham* rule in the District, the category of patients, “prisoner patients” we will call them, who are committed to the hospital after a verdict of not guilty by reason of insanity has been enlarged. Is that correct?

Dr. CAMERON. As I indicated before, I should dislike to use the word “enlarge” because there are better data coming out. I think we can get an answer to that.

That it has changed the nature of the difficulties with which the patients suffer when they come to us, there is no question. We have more people now with character disorders, sociopathic personality, and so on, than we had prior to the establishment of the *Durham* rule. No question about that. These persons need a different type program than do the traditionally psychotic patients who were the only ones who came under the *McNaughton* rule.

Mr. REISINGER. They in turn would be the only ones put in the medium or lesser security bracket earlier?

Dr. CAMERON. Not necessarily earlier; we are slow about putting them in such brackets because these people are in pretty good contact with reality, and they are the fellows who, very often, give us the most trouble about escapes.

Mr. REISINGER. This is what I am directing my attention to.

The reason I raise my next question is basically this: In effect, this is not a defendant but simply a patient who has been found not guilty of the crime committed.

Dr. CAMERON. That is correct.

Mr. REISINGER. As such, yours is the only institution to which he may be committed because he should not be committed to a prison.

Dr. CAMERON. That is correct, in the District.

Mr. REISINGER. Yes, here in the District, of course. Very possibly in the entirety of the Federal system if it were to adopt—

Dr. CAMERON. There would have to be a change in the law or a judicial change such as occurred here. As I understand it—I am not too certain on this point—there is no law which now allows the Federal Bureau of Prisons to accept a man who is found not guilty by reason of insanity. If that is the case, I think in most instances when this occurs in other jurisdictions the patient is not sent to the Federal Bureau of Prisons, even to its medical center at Springfield, but rather returned to the home State from which the patient came and would be cared for at the State hospital.

Mr. REISINGER. That is precisely the problem I was trying to highlight. Under existing legislation, you become the only place where a District of Columbia prisoner or defendant may be housed after a finding of not guilty by reason of insanity.

Mr. CAMERON. Yes, sir; but not as a result of the *Durham* decision, but rather as a result of a law passed by Congress immediately after the handing down of the *Durham* decision, a law which required any patients found not guilty solely by reason of insanity shall be sent to the hospital.

Mr. REISINGER. That is my whole point, so that necessarily the lesser disorders, sociopathic personalities, as you mention, do come to you and they create a greater escape potential.

Dr. CAMERON. I would not call them lesser disorders. They are rather troublesome. They do come to us, you are quite right about that.

Mr. DANIELS. How is such a prisoner finally released from your institution?

Dr. CAMERON. If he makes a satisfactory adjustment in the hospital and judged on the basis of his progress in therapy, when individual therapy can be offered him, or on the basis of his behavior in the institution, the way he works, the way he conducts himself, we would eventually make a recommendation to the court that he be given conditional release. Then we would specify what conditions we think ought to be imposed by the court in granting such release, if it is granted.

Those conditions usually involve permitting the patients to go into town to look for work. He is ready for this next step in his rehabilitation: to get a job, to make some money, to see if he can get along satisfactorily in society, just as a person paroled from a prison would be sent out for the same purpose.

However, there would be the requirement that he return to the hospital for examination and, if necessary, continue treatment at such intervals as we think indicated. We usually have them come back—I am getting ahead of my story slightly.

If the conditional release is granted, the usual pattern would be to allow the man to go into town and get a job but come back to the hospital every night so we can see him daily.

Mr. DANIELS. Is a conditional release a court order with certain conditions attached?

Dr. CAMERON. That is correct.

Mr. DANIELS. Of the 147 escapes which have occurred this year, how many of those prisoners committed a crime while they were at large and before returning to the institution?

Dr. CAMERON. I cannot answer that question. Mr. Weinstein, can we get at those data and submit them for the record? We can do it insofar as an alleged act has been reported to us relative to these persons.

I might tell you that the alleged acts are not always—the person is not always found guilty of the act as alleged while on conditional release. Such a case came to my attention yesterday.

We had a patient who came to us, I believe, in March of 1960, not guilty by reason of insanity. We recommended to the court in July of 1961 that he be granted a conditional release, and the court concurred. Between July of 1961 and December of that year, he lived in the hospital but got a job in town and was making an income.

He handled that satisfactorily, and we then allowed him, in accordance with the conditions of the release, to live in town. In November of 1962, after he had been living in town a year, we were notified he was charged with three counts of robbery.

We discussed the matter with the U.S. attorney and since the man was in custody and since it had not yet been demonstrated that he did commit the act alleged, we decided not to ask that the conditional release be revoked pending the outcome of the trial.

In February 1963, he was sent back to our hospital for an opinion as to whether or not he was competent to plead, to which we said our opinion was yes, and whether or not if the acts were committed by him, were they, under the *Durham* rule, the product of his illness? We said to the court, in our opinion, that he was in remission as far as his mental illness was concerned and if he committed the acts, he was responsible. He was tried, and the jury found him not guilty. I do not mean not guilty by reason of insanity, I mean plain not guilty.

Since he was still on conditional release from the hospital, the court returned him to us. We promptly returned him to the community because it had been shown by court action that he did not commit this act. We returned him to living in town.

I was notified yesterday that he is now charged with another count of robbery. But now, you see, this is November of 1963, and he has been living outside of the hospital since December of 1961.

Mr. DANIELS. My question is directed to escapees. Some of these voluntarily return to the institution, say, in a matter of hours or a couple of days but at the present time 29 are still at large?

Dr. CAMERON. Yes, sir.

Mr. DANIELS. Do you keep a separate file on these escapees?

Dr. CAMERON. We keep a master record on each man, and it will be relatively simple to go back and pull the record on each of these 147 men and see if there has been a report to us of such act during the time he was out. I am sure some of them have been involved.

I missed the thrust of your question a moment ago. I was coming to the point that some of the escapees are persons who have "escaped" while on conditional release, living in town, escaped in the sense that they failed to come back to keep one of their appointments.

Mr. DANIELS. In your testimony you made reference to the fact that you have about 20 or 30 children at the institution.

Dr. CAMERON. Yes, sir.

Mr. DANIELS. Are these children commingled with all the other patients?

Dr. CAMERON. Not with all of them. They are commingled with adults. They are rarely kept on wards where "prisoner" patients are kept.

We had one child in John Howard at one time, interestingly enough, a voluntary patient. This child gave us no end of trouble because he ran off with monotonous regularity and stole a car every time he left. We got sick of that. Even though he was a volunteer patient, we put him in maximum security, with the consent of his parents, so we could keep track of him.

Mr. DANIELS. How old are the children?

Dr. CAMERON. That boy was 14. The children, about 30 of them, are in age range from around 10 or 11 on the lower end up to 16. Then there are an additional approximately 60 in the age range of 17 to 20, if you call those children.

Mr. DANIELS. We will call them minors. Anyone under 21 we will classify as a minor.

Are these minors permitted to associate with the other patients confined at the hospital?

Dr. CAMERON. Not only permitted; there is no other way to do it since we have no facilities specially for children.

Mr. DANIELS. Are these children then exposed to patients who have been charged with criminal offenses?

Dr. CAMERON. Not very often because the patients charged with criminal offenses are, for the most part, located in three or four locations in the hospital, and we do not keep children there as a general rule.

Mr. DANIELS. They would have the opportunity, though, of mixing with them?

Dr. CAMERON. On the campus; yes, but not on the wards. But again the campus is of fair size, as was earlier brought out. While the children are out on the grounds, surely they can come in contact with prisoner patients, no question about it, but they do not often.

Mr. DANIELS. How would you protect the welfare of a child in mixing with these other patients?

Dr. CAMERON. Mr. Chairman, I do not like the current situation. I have recommended for several years funds for the construction of a special facility for children with a separate campus. So far we have not been able to make it.

In order to do what we could within our existing resources and because the number of patients with tuberculosis is, fortunately, substantially fewer than it was in previous years, I took some space formerly devoted to tuberculous patients and, with our own hospital labor and materials, converted it into what might be called a day treatment center for the children. It will not accommodate all of them. It accommodates about 30.

We send to that facility during the day about 30 of the children who are most amenable to treatment; where the District of Columbia public school system supplies two teachers; where we have teachers of our own and some other staff, and do the best we can for those 30 youngsters during the day hours, if you will. They return to the wards with adults at night because there is no place else to house them.

Mr. DANIELS. Have you found any evidence of the use of narcotics on the part of any of your patients?

Dr. CAMERON. Yes, we get persons occasionally who are sent to us as "not guilty by reason of insanity" on narcotic charges. I cannot tell you the exact number, but I would guess that there are somewhere around 25 known narcotic addicts among the prisoner population. These people are often under a compulsion to continue the use of drugs if they have an opportunity so to do and they figure in the number of escapes.

I might tell you that we keep our narcotic addict patients in maximum security longer on the average than the U.S. Public Health Service Hospital at Lexington, which is designed especially for the treatment of narcotic addicts. In other words, because we are in town, whereas, Lexington is in the country, and because the patients we get as "not guilty by reason of insanity" on these charges are somewhat difficult, we are rather conservative about how rapidly we give them an opportunity to assume increasing responsibility for their own actions. But we do eventually, for most of them, try to give them this opportunity. We have some disappointments, as you well know. These people ordinarily do not commit crimes of violence.

Mr. DANIELS. I yield to Mr. Goodell.

Mr. GOODELL. Dr. Cameron, harking back for a minute to the problem of the *Durham* rule and of distinguishing those with mental illness, I am intrigued by your description of those who have character disorders.

Dr. CAMERON. In my testimony?

Mr. GOODELL. Yes.

Dr. CAMERON. Yes, sir.

Mr. GOODELL. I quote, in part:

They have difficulty in learning from experience, are unable to put off present pleasure for future gain * * * and their behavior appears to be little regulated by their intellect. Such patients are often quite bright, affable, pleasant persons with whom to talk.

I think that description applies to quite a few people I know in Government and in the Congress. Obviously, your line of distinction becomes rather fuzzy here between those mentally ill and those who are not.

Dr. CAMERON. I should not think it is particularly fuzzy, although there is no hard-and-fast line between normality and abnormality. But, believe me, the types of persons that we have would put to shame with the description you just read, most of your acquaintances about whom you speak.

Mr. GOODELL. I am interested in your graph or your chart here on appropriations, No. 14.

Dr. CAMERON. Attachment No. 14.

Mr. GOODELL. I note that for the 1964 fiscal year you show a total estimated direct appropriation and budget of \$27,916,000.

Dr. CAMERON. Yes, sir.

Mr. GOODELL. I take it the difference between the next column, "Estimate to Congress," and the first column is that you define "Payments From the District of Columbia" as part of a direct appropriation.

Dr. CAMERON. Yes, between the \$27.4 million and \$9.7 million.

Mr. GOODELL. Yes, this is part of the new budgetary setup you have where we appropriate the money and the District pays it back.

Dr. CAMERON. Yes, sir; we asked in 1963 for a budget of \$24.3 million and direct appropriation of that amount, but that year this new mechanism was not established, so the appropriation was, as you see at the end of the column, \$25.4 million gross, but with the \$6.3 million coming directly from the Federal Congress.

However, in 1964—it is not apparent from this particular table—a new mechanism was established whereby the \$27.4 million appropriated or total budget is the amount now fixed which we can spend. This is the first year we have known at the beginning of the year how much we would have to spend.

The Federal Congress will appropriate the difference, estimated at \$7.3 million, between the \$27.4 million and the amount we collect from the District and others who reimburse us.

Mr. GOODELL. Can you explain to me why there is the \$2 million difference between the estimate to Congress and the appropriated sum while your total budget has remained the same at \$27.4 million?

Dr. CAMERON. May I ask Mr. Madden, our executive officer, if he could answer that?

Mr. MADDEN. The difference arises, I believe, because the Congress determined that the District of Columbia should undertake to pay for the cost of prisoner patients, whereas, as a matter of policy before, this had not been done. Therefore, the difference is approximately that amount.

Dr. CAMERON. In other words, our estimate to Congress from the Department contemplated that the Federal Government would pay out of its direct appropriations for all prisoner patients, whereas, the Congress determined that this would not be so but rather that the District would pay for prisoner patients originating in the District as well as other patients originating in the District. Hence it was unnecessary to make as large a direct Federal appropriation.

Mr. GOODELL. This was a new determination last year?

Dr. CAMERON. Yes.

Mr. GOODELL. The \$2 million was in effect added to the District of Columbia's burden?

Dr. CAMERON. Yes, sir, as compared with our recommendation. The District has never paid for prisoner patients.

Mr. GOODELL. But they are going to this year?

Dr. CAMERON. If that remains in the appropriation for the District, which has not yet been enacted.

Mr. GOODELL. Somebody has to pay for it. If it does not remain there—

Dr. CAMERON. It will have to come out of direct Federal appropriations.

Mr. GOODELL. For fiscal year 1963 I note the direct appropriation actually allowed was greater than the estimate to Congress.

Dr. CAMERON. Yes, sir.

Mr. GOODELL. What is the reason for that? Is this just that your estimate was off?

Dr. CAMERON. You may notice that the estimate of the Department for new personnel was 400. The allowance of the Bureau of the Budget was 34. The congressional allowance was 350. I can only assume that the Congress found our estimate more realistic.

Mr. GOODELL. In other words, Congress boosted the amount here and went along with you?

Dr. CAMERON. Not quite, but closer to ours than what the Bureau of the Budget recommended.

Mr. GOODELL. In years prior to fiscal year 1963 your direct appropriation figure was in the order of \$3 and \$5 million, and in fiscal 1963 suddenly it became \$25 million in your estimate for the Bureau of the Budget. Why is that?

Dr. CAMERON. You will notice that in the first column, the estimate to the Bureau of the Budget, the total budget has run, beginning in 1959, from \$16, \$18, \$19, \$23, \$25, to \$27 million. That was at the time when this was the amount that Congress, in effect, said we could spend if we could collect it, but Congress then appropriated in those years \$3.1 million, \$3.7 million, \$4.1 million, et cetera, as the direct appropriation.

The District and other reimbursing agencies reimbursed our appropriation for services we provided them. If we did not provide as much service as had been anticipated, we did not collect that much money, and we did not have it to spend. That is why we never knew how much we were going to have for the total year. It meant really pretty awkward financial management.

Mr. GOODELL. I understand. The question is, is fiscal 1963 the first year you estimated on the basis of this new budget?

Dr. CAMERON. Fiscal 1963 is the first year in which the Department approved our asking for a direct appropriation of the whole amount from Congress.

Mr. GOODELL. Next year Congress approved this?

Dr. CAMERON. That is right. This year it approved it. I am sorry I took too long to answer your direct point.

Mr. GOODELL. I just wanted to clarify that. It gets pretty complicated.

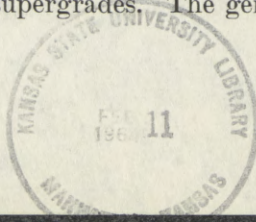
You have mentioned, as one recommendation, that we increase salaries. You have some problems competing for personnel. Does this apply right down the line from the psychiatrists all the way through or is it primarily at your doctor level you are having the problems?

Dr. CAMERON. It is most troublesome at the higher civil service levels. I should say the difficulty decreases as you go down the scale paywise. There are some exceptions to that, of course, but I believe that is correct. Would you agree, Mr. Madden? He does.

Mr. GOODELL. What is the range of your pay for a psychiatrist?

Dr. CAMERON. The Superintendent's position, I happen not to be on civil service, but when it was in the civil service, the Superintendent's position was supergrade 17. The Assistant Superintendent, and First Assistant-physician, and one training position are at grade 17.

There are four or five grade 16 supergrades. The general run of



the physicians at the hospital are in grade range from grade 12, a few at 11, up through 15, the top before you go into the supergrades. I do not happen to have the pay scale with me, but I am sure by ready reference to it you can have a reference to our pay scale for physicians.

Mr. DANIELS. The proposed Pay Act of 1963 would be helpful?

Dr. CAMERON. Indeed it will. We do not expect ever to be competitive with private practice, and I should like to add a word about this pay business. I will speak now primarily of the physicians, but certain other professional personnel as well. For most of these people pay is about the fourth most important item when it comes to recruiting.

Most good professional people wish to work in a place where they can provide reasonably good service to the patients they are to serve. Second, they would like to do some research. Third, they would like to do some teaching. If these things can be satisfied, they would like to work in a place where they do not have to take a pay cut to do it. But if you offered them \$50,000 a year, good people will not come to you unless these first three criteria can be satisfied.

The fact that we have been able to recruit some very good people is evidence of the fact that our research and training activities are reasonably good at the hospital, though they certainly could be vastly expanded and should be, and research and training in a service hospital such as ours is important to the service function. Without training and research, you ordinarily do not provide good service to your patients, and that is our ultimate goal.

Mr. GOODELL. Doctor, you said that prisoner patients require more environmental control, which I suppose is obvious. You have this statement on page 5, and I quote:

It is difficult to provide the necessary type of environmental controls for prisoner patients in a setting which is designed primarily to treat patients who do not require such controls and for whom such controls are detrimental to their rehabilitation.

Dr. CAMERON. Yes, sir.

Mr. GOODELL. You also, as part of your recommendations, cite the need for a security hospital with a completely separate subcampus.

Dr. CAMERON. Yes, sir.

Mr. GOODELL. I take it you feel that ideally your prisoner patients should be kept separate from your civilian patients or nonprisoner patients.

Dr. CAMERON. As a general rule of thumb, but that is not quite accurate, if I could elaborate on this a little bit, Mr. Goodell. The patients who have character disorders need more environmental control and a different kind of program than a grossly psychotic, schizophrenic patient. If there is a grossly psychotic patient of this or some other nature, for example, if there happened to be a woman who killed her child while going through a postpartum depression, that is murder. But her type of problem is such that she can be well treated in the hospital, as we have known it in the past, which dealt primarily with psychotic patients. Even if she were a prisoner patient, I should not want to put her into this program with the increased peripheral security.

On the other hand, as I said, the sociopaths require a different kind of program; not all sociopaths, as I tried to indicate, are involved in

criminal activity. We have some sociopaths occasionally who come in voluntarily or by civil commitment. I would place those persons in the security hospital because there we can provide the kind of program that is needed.

In other words, the decision as to where a patient would be treated would not be so much as to how he came, civil or criminal, but what kind of program he needs.

Mr. GOODELL. I would take it that this ties in with your recommendation that the same physicians stay with a patient throughout and you attach intermediate and minimum security facilities for your John Howard Pavilion.

Dr. CAMERON. Not attach it. It is already too big. I would subdivide it.

Mr. GOODELL. In the same area you call subcampus?

Dr. CAMERON. Yes.

Mr. GOODELL. I think the subcommittee would like to have an idea of your priorities here. You indicated need for physical facilities. You said you want 400 additional beds for medium and minimum security; you want a security hospital with completely separate subcampus, additional buildings for research training; an employee cafeteria; 75 beds for treatment of children and adolescents.

Those are your major recommendations, as I see it, in terms of physical facilities.

Have you any priorities?

Dr. CAMERON. It is difficult to assign priorities because these items are so different in their character, but to me clearly and first the children. Why? Because we have no facilities for the treatment of children and we have children, so let us get on with getting facilities for them, besides which 75 beds is a lot less expensive than 400.

Mr. GOODELL. Have you any idea how much it would cost to provide the 75 beds?

Dr. CAMERON. As a very rough guess I would suggest somewhere on the order of \$18,000 to \$20,000 a bed, perhaps more. We have not really done a definitive study. This is on the basis of some prior experience elsewhere in other parts of the country and contracting is not always the same.

Mr. GOODELL. Would this be entirely separate from the campus?

Dr. CAMERON. Yes.

Mr. GOODELL. Somewhere else in the city?

Dr. CAMERON. No. I think the city needs more than 75 beds for children. I should think it would be highly desirable that the city somehow provide for itself a facility perhaps in conjunction with Children's Hospital to deal with a large number of these persons, but it would be my hope that at some future time, in connection with this joint enterprise you were talking about with Mr. Jones, that St. Elizabeths Hospital would serve for all purposes a segment of the city in which it is located for all types of service.

If so, then it certainly will need a facility for children, and until the District does provide a facility for children it has to be done somewhere.

I think 75 beds is short of what the city as a whole needs but I think this would take care of a portion of them and certainly that area of the city in which the hospital is located.

We have a subcampus where it could be built without the necessity of new powerplant facilities. It could be a separate campus so there would be an interchange between the staff of that facility and the rest of the hospital for teaching and research, but completely separate as far as the children are concerned.

Mr. GOODELL. Have you made this recommendation to the Bureau of the Budget?

Dr. CAMERON. My recommendations go to the Department, sir.

Mr. GOODELL. Has that recommendation reached the Bureau of the Budget to your knowledge?

Dr. CAMERON. Let me check it. I think it has.

I shall check that.

Mr. GOODELL. How long have you been making this recommendation?

Dr. CAMERON. I have been at the hospital only 3 years.

Mr. GOODELL. How long has the hospital been making this recommendation and what is the history in terms of the Department, the Bureau of the Budget, and the Congress.

I also would like to know if that recommendation has reached Congress from the Bureau of the Budget.

Dr. CAMERON. It has not. I can tell you that.

Mr. GOODELL. It has been eliminated in each case?

Dr. CAMERON. Before it got to you.

Mr. GOODELL. This is your first priority for physical facilities?

Dr. CAMERON. Yes, sir. It was not always so listed, even to the Department, as our first priority.

Mr. REISINGER. Your budgetary considerations go directly to the Appropriations Committee?

Dr. CAMERON. No. Our recommendations go to the Department first and then the Department sends them to the Bureau of the Budget and the Bureau of the Budget sends them to you in the President's message.

Mr. REISINGER. I mean from budget.

Dr. CAMERON. From budget? It is part of the overall appropriation of HEW. I testify before Congress if that is what you are getting at.

Mr. REISINGER. Before which committee?

Dr. CAMERON. In the House, Mr. Fogarty's subcommittee and in the Senate, Mr. Hill.

Mr. GOODELL. You do not testify before any legislative committee with reference to an authorization. You have an open authorization here?

Dr. CAMERON. Unless we needed new substantive legislation there would be no point in our so doing. There are some substantive legislative needs which were brought out in the earlier discussion with Mr. Jones and which I clearly indicated in my testimony.

Mr. GOODELL. I disagree with your conclusions from an internal viewpoint in the Congress.

What in effect is happening is that there is no legislative committee which has a continuing oversight over St. Elizabeths Hospital year by year to determine which needs should be met that year and should be authorized for appropriations.

Apparently there is no authorization cycle whatsoever operative here.

Dr. CAMERON. I should imagine Mr. Fogarty and Mr. Hill's subcommittees thought they were doing just that as far as priorities are concerned as presented to them.

Mr. GOODELL. Correct. This is not the rule of Congress. The legislative committees are presumably to consider these authorizations first.

I do not mean they are violating our rules. We feel that in an open-end authorizations we have abdicated our annual review responsibility. We have left it to the Appropriations Committees alone. This is not a normal situation in terms of authorization and appropriation.

Dr. CAMERON. You are now discussing a subject on which you are much better informed than I. It is awkward for me to try to tell you what Congress should be doing.

Mr. GOODELL. You have a second priority among these physical facilities which stands above the others particularly?

Dr. CAMERON. Here we get into trouble. One I did not list is the need for the replacement for the medical and surgical facility. Since we have a medical and surgical facility it would not be high on my priority list, certainly not as high as the children where there is no facility.

I would have difficulty in deciding. I think I should put No. 2 coequally research and training facility and the security facilities.

Then No. 3 would be medicine and surgery, which I did not list in my testimony; and fourth would be the increased facilities for employees.

I will just highlight one of the difficulties in making such a priority arrangement. Nursing schools are increasing in size, and we certainly need more nurses at St. Elizabeths and elsewhere.

We provide training for certain undergraduate nurses on affiliation from 12 different schools. As their classes increase in size we shall not be able to accommodate all their students, and we need an increase, therefore, in the size of our nurses home.

Mr. GOODELL. Doctor, I think the subcommittee accepts the caveat that all of these things are very necessary and important. Nevertheless, we have to rely on experts to set up a priority list for us, assuming all of them will not be done today or tomorrow.

Dr. CAMERON. If you will let me put children first, and research and the facilities for prisoner patients coequally, I think I then would be content.

Mr. GOODELL. Some of the other recommendations you have made are beyond the purview of this subcommittee, as you know, and beyond the jurisdiction of our full committee. You refer to the upgrading of Government salaries. That is one recommendation beyond this committee.

There is the welfare rate in the District and a possible subsidy for nonprofit nursing homes, and an increase in the number of chronic disease hospitals. Most of this is beyond our particular jurisdiction right now, not that it is not relevant. Perhaps we can help serve your purposes in trying to promote them.

The hospital's legal authority to pay foster home costs and nursing home costs I presume would require a change in our basic statute.

Dr. CAMERON. Yes, sir. Such legislation has been drafted. It is ready. At such time as clearances are obtained at appropriate levels, we shall send it along.

You say it is beyond your purview to do anything about the welfare rates. It is certainly beyond ours. They sure have an effect on us. I would invite you to try to find a nursing home for \$100 a month.

Mr. GOODELL. I didn't mean it should not be done. I agree with your point completely. I am saying this is not in the jurisdiction of the Education and Labor Committee to perform.

Dr. CAMERON. It should be said in fairness that the District Welfare Department has requested funds from the Congress for an increase in these rates for the fiscal year 1964, and anything that can be done in that regard will be helpful.

Mr. GOODELL. The reason I point this out is that I wanted your affirmation. To be effective in many fields this subcommittee will have to attempt to get into a liaison relationship with some other subcommittees, at least give them our own findings and strong recommendations.

I, myself, would prefer to set up a liaison arrangement with some of the committees involved so at least we are sure that the Congressmen who bear this direct responsibility in other committees have before them the facts you have brought to our attention.

You mentioned as a recommendation that more definitive studies should be made as to what is needed. This involves population trends, anticipated burdens on your hospital, and so on. Is such a study involved in any way in the HEW study or the District of Columbia study pending?

Dr. CAMERON. To do this one would ordinarily request a fund under the building program for the development of a program statement, and we have so recommended to the Department—that in the fiscal year 1965 there be appropriated a fund for this purpose and from the reception that suggestion has had at the Department I anticipate it will go forward to the Bureau of the Budget.

Mr. GOODELL. It is not part of the two present studies?

Dr. CAMERON. No, it could be a separate and quite definitive study. It would look forward to a billing. Sure, some of the basic data would be the same—in terms of population growth—as that required for the other studies. That is incidental.

The next question would be, What can we anticipate from the courts in the way of not guilty by reason of insanity findings?

Mr. GOODELL. If you can predict that, you are better than most.

Dr. CAMERON. There may be some data coming out of the study being conducted by the Judicial Conference that may be useful on this point.

Then having tried as best one can to estimate the population load for security facilities, then comes the problem of trying to make a program statement as to what kind of facilities are necessary. This leads eventually to the development of blueprints. That is why it is a separate issue.

Mr. GOODELL. You mentioned 25 minutes per patient on the average.

Dr. CAMERON. Yes.

Mr. GOODELL. The average time given by doctors?

Dr. CAMERON. Yes, sir, that is available.

Mr. GOODELL. This figure is a total average for all types of patients in the hospital divided by the number of doctors you have?

Dr. CAMERON. Yes, sir.

Mr. GOODELL. Do you have a figure that is more precise? I notice the chart breaks it down some, but can you give it more precisely as to the time doctors give psychiatric patients as distinguished from nonpsychiatric?

Dr. CAMERON. They are all psychiatric. Some have physical infirmities that are severe.

Mr. GOODELL. I don't mean to get into a quarrel over semantics. You said many of these patients should be outside the hospital and treated outside the hospital. Figures as to time doctors spent with them are a little irrelevant.

Dr. CAMERON. If you turn to attachment 16, it is the reason I included the geriatric services. It has on the average 3 minutes of physician time per day, or 19 per week for its patients.

Within the geriatric service there are a very substantial number of patients who could go to nursing homes were they available. That is one reason for including this.

In detached service, where it is 1 minute per day and 9 minutes per week, a substantial number of patients are there who could be in foster homes.

I included West Side Service because that is where the prisoner patients, male, not in John Howard Pavilion, are located primarily. There are about 175 prisoner patients in that group, and that is indicated there.

I have shown you John Howard because it is essentially all prisoner patients.

I have shown you medicine and surgery because that is a different kind of program. This is where one goes because of pneumonia or a broken leg.

I have shown one, Dix, which is almost entirely as admission service, purely psychiatric admissions and patients.

Mr. GOODELL. Do you have physicians on your staff who are not psychiatrists?

Dr. CAMERON. Yes, sir.

Mr. GOODELL. What number do you have?

Dr. CAMERON. Forty-nine.

Mr. GOODELL. Out of a total of 94?

Dr. CAMERON. If you would permit me to get this statement first. We have 54 psychiatrists, 48 other physicians and dentists, and 37 physicians in training, for a total of 139.

Mr. GOODELL. Does that include any in-training?

Dr. CAMERON. Yes, 30 to 40 in training in such areas as psychiatry, surgery, physical medicine, pathology, radiology, and the like. Total physicians for whom the hospital pays is 139.

There are an additional 19 physicians assigned to the hospital either by the National Institute of Mental Health or by other universities for training; 9 of those are psychiatrists, 9 are physicians in training, and

1 is an "other" physician. The total working at the hospital is 158, and the hospital pays for 139.

Mr. GOODELL. The chart 15—

Dr. CAMERON. My chart was based on the 139 we pay for.

Mr. GOODELL. I don't quite understand the chart 15, then, where you have the pie-shaped sections for each type of personnel. You show 94 M.D.'s.

Dr. CAMERON. That does not include the trainees. Where it shows 94 M.D.'s, you will recall I said psychiatrists and other physicians and dentists, on the figures I have just given you, would add up to 102. Well, there are at least four or five dentists and this number fluctuates from day to day as employees come in and out.

On the day we developed this chart there were 94. As of today there are about 96 or 98.

Mr. GOODELL. Finally, Doctor, and I have other questions but you have been very patient and the hour is late, you have cited the fact that at the time of the study a year and a half ago approximately 50 percent of the patients then hospitalized really required hospitalization in mental institutions.

Dr. CAMERON. Yes, sir.

Mr. GOODELL. In your opinion is that approximately the situation today?

Dr. CAMERON. Yes, sir.

Mr. GOODELL. About half of your patients really do not require hospitalization today in a mental institution?

Dr. CAMERON. There should be some slight qualification to that statement.

If you turn to attachment 9, there it is shown in percentage figures, the 50 percent we think require mental hospitalization.

There are 6 percent, approximately 400 patients, who could be in chronic disease hospitals, I believe that is a firm figure.

The nursing home with strong physical care, that is a reasonably firm figure. While these patients have mental difficulties, they are secondary in importance to physical problems.

When you come to the 20 percent listed as nursing home with strong psychiatric care, you could with considerable conscience argue that these people should remain in the mental hospital, that if you were to put them outside you would have to develop nursing homes not only which do not exist numerically now but which do not exist in kind. This, then, would be the last group and it is a substantial one which we would expect to get out of the hospital as community resources are developed.

Foster homes—that is easy. If there were an adequate welfare rate, homes could be found, and no capital expenditure for building is needed.

The others are primarily persons who are in the process of almost being ready to go out at the time this study was made and will be going to their own homes or other facilities, able to pay for themselves, and so on.

To look at it in an extreme way, yes, 50 percent should be out, or, to look at it in a less extreme way, 30 percent should be out.

Mr. GOODELL. With adequate rates for nursing homes and foster care you would eliminate some 1,500 patients very quickly?

Dr. CAMERON. Yes, and through time many of these we have listed as nursing homes, strong psychiatric care, will either be moved to such homes or they will decrease in number through time as we progress because these are, for the most part, older patients.

We are not adding to this backlog of chronic patients as rapidly now as was the case 20 or 25 years ago because of new techniques of treatment. Therefore some of these will disappear by death and not be replaced, I hope, as a result of improved treatment.

Mr. GOODELL. Thank you, Mr. Chairman, and thank you, Dr. Cameron.

Mr. DANIELS. We are wondering if you can return here tomorrow morning at 10 o'clock. There may be other questions we would like to take up with you.

Dr. CAMERON. I would be happy to.

Mr. DANIELS. We shall resume at 10 o'clock tomorrow morning.

ADMINISTRATION AND OPERATION OF ST. ELIZABETHS HOSPITAL

WEDNESDAY, NOVEMBER 13, 1963

HOUSE OF REPRESENTATIVES,
AD HOC SUBCOMMITTEE ON ST. ELIZABETHS HOSPITAL
OF THE COMMITTEE ON EDUCATION AND LABOR,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to recess, in room 429, Cannon House Office Building, Hon. Dominick V. Daniels presiding.
Present: Representatives Daniels and Goodell.

Also present: Dr. Deborah Wolfe, education chief, and Mr. Reisinger, counsel.

Mr. DANIELS. The committee will come to order.

TESTIMONY OF DR. DALE C. CAMERON, SUPERINTENDENT, ST. ELIZABETHS HOSPITAL

Mr. DANIELS. At the conclusion of yesterday's hearing, Doctor, you stated that you would bring forward certain information in response to questions asked by the committee yesterday. Do you have that material available at the present time?

Dr. CAMERON. Yes, Mr. Daniels. I should like to submit for the record, and have already given to the stenotypist a copy of material relative to our request for a residential treatment center for adolescents.

(The information follows:)

RESIDENTIAL TREATMENT CENTER FOR ADOLESCENTS

The following tables set forth the history of hospital requests for funds for the construction of a residential treatment center for children and adolescent patients at St. Elizabeths Hospital.

Fiscal year	Preliminary estimate to Department	Request to Budget Bureau	Request to Congress
Fiscal year 1964.....	¹ \$40,000	² \$150,000	0
Fiscal year 1965.....	³ 160,000	0	-----

¹ For development of a comprehensive program statement.

² For development of a program statement, plans, and specifications.

³ For development of a program statement, plans, and specifications based on Public Buildings Service estimates of cost.

This material shows that we requested, for the fiscal year 1964, \$40,000 to prepare a program statement and for fiscal year 1965, \$150,000 to prepare the plans and specifications. This was not approved. We have again requested in the 1965 budget an amount to prepare both the program statement and plans and specifications.

You also asked about the number of placements.

Mr. DANIELS. To whom was the request submitted?

Dr. CAMERON. From the hospital to the Department.

Mr. DANIELS. HEW?

Dr. CAMERON. Yes, sir.

You also asked about the number of foster home placements. In fiscal year 1962 these were 80 and in fiscal year 1963 these were 87, and since January of 1963 through October of 1963, 103 have been placed in foster homes.

You also asked about nursing home placements. In the time period January through October 1963, 14 were placed but almost all of these were in homes where the patient or his family paid for the nursing home care. In other words, there were few if any welfare cases. In fiscal year 1963 there 18 and in fiscal year 1962 there were 15.

Mr. DANIELS. On the question of nursing and foster homes, is there any authority vested in you as the Superintendent of St. Elizabeths or anyone in charge of St. Elizabeths to place the patient in a foster or nursing home?

Dr. CAMERON. No, sir. We can recommend it and of course if the patient or his family can afford it they can pay for it directly and this is handled quite expeditiously.

If, on the other hand, the person is medically indigent, then the payment for these services would, if they are District of Columbia welfare patients, be by the District of Columbia Welfare Department, or if they are beneficiaries of other Federal agencies who pay for their care in the hospital, they could make comparable arrangements but seldom do. But for the patients who are not the financial responsibility of any political jurisdiction or any agency of Government, we have no authority to place them out or to use our funds and I believe that legislation enabling us to do so would be in order.

You also asked that of the 147 so-called prisoner patients who went on unauthorized leave since January, how many were still out and we said 29.

You asked how many of these elopements resulted in any criminal charges. There were 29. There were 29 new criminal charges among the 147 persons who eloped during that period.

Mr. DANIELS. How serious were those?

Dr. CAMERON. They cover quite a range.

One of them was murder. One was for rape. One was not charged because he died, Mr. Smallwood. We assume he would probably have been charged with assault with intent to kill had he survived.

Four were charged with robbery and 22 were charged with other types of crimes such as assault, larceny, leaving the scene of an accident, auto theft, housebreaking, peeping Tom, traffic violation, forgery, drunk, and unauthorized use of a vehicle.

I believe, sir, those are the questions that you posed yesterday which we did not answer at that time.

Mr. DANIELS. Counsel would like to ask you questions with respect to these prisoner elopements.

Mr. REISINGER. The information received from the Metropolitan Police Department indicates there were a total of 62 prisoner patients who were reported to the Department as escapees during 1963, of whom 44 are still at large.

Can you reconcile those two figures?

Dr. CAMERON. Did the Police Department give you the data on a fiscal year basis or calendar year basis as you asked for it yesterday?

Mr. REISINGER. It would appear to be calendar years, since the first of this year, first of 1963 through, I believe, the last day of October.

Dr. CAMERON. I am unable to reconcile those figures, Mr. Reisinger. The 147 we reported was from an actual tally from our records and if you wish, we can check to see how many of those were called to the attention of the Police Department. It is our policy to call the elopements of prisoner patients to the attention of the Police Department.

Mr. REISINGER. As I understand it, a letter is forwarded to the U.S. attorney in the case of an eloped patient; is that not so?

Dr. CAMERON. The first thing that happens is a telephone call to No. 11 precinct and that is followed up within the next day or so with a letter, as you suggest.

Now, if the person were returned to us voluntarily or if he were returned by the Police Department and therefore we knew that the Police Department knew that he had been returned, the confirming letter might not be written.

Mr. REISINGER. This completes my questioning.

Mr. DANIELS. You may proceed.

Dr. CAMERON. Well, I believe I answered the questions that were carried over from the preceding day.

Mr. DANIELS. Is it true, Doctor, that maintaining security facilities for prisoner patients causes a reduction in the amount of personnel available for the care of your other patients?

Dr. CAMERON. Well, it is quite clear that if we did not have prisoner patients and still had the same number of personnel we now have, additional employees could be devoted to the civil patients.

The staffing on the wards of John Howard Pavilion is somewhat better than the staffing in some of the other parts of the hospital, as indicated in my testimony yesterday.

Mr. DANIELS. Do you use the same ratio you recommended yesterday, one to one at the John Howard Pavilion?

Dr. CAMERON. We used 1 to 1 as a recommendation for the hospital as a whole. That doesn't mean that each place in the hospital would have exactly that ratio. Some would be higher and some would be lower.

John Howard would be one of the services that would approximate that or perhaps be a little higher.

Mr. DANIELS. And it is dependent on the nature of the patient confined in that pavilion?

Dr. CAMERON. That is correct.

Mr. DANIELS. Now, you gave testimony yesterday with respect to the use of St. Elizabeths Hospital as a training facility.

Dr. CAMERON. Yes, sir.

Mr. DANIELS. Is a training program being developed at St. Elizabeths at the present time?

Dr. CAMERON. It is being developed. Training activities have long been a part of the function of the hospital. At the present time there are somewhat over 200 full-time professional trainees on the campus at any given time. I can't give you the exact numbers but they break down somewhat as follows:

There are approximately 30 to 35 residents in psychiatry. There are seven, I believe, trainees in psychodrama. There are 24 in social work and 10 or 11 in psychology and 90 undergraduate student nurses, and anywhere from 3 to 40 graduate nurses in training in psychiatric nursing, nursing administration, or nursing education.

There are usually about six or eight students in occupational therapy. There are three surgical residents, two residents in radiology, one in physical medicine, and we do not have at the moment a resident in pathology, although the hospital is approved for such training.

We have six rotating interns and four dental interns.

I may have overlooked one or two categories since I am telling you from memory.

This comes to roughly 200 trainees.

In addition to this, we have inservice training programs for our nursing assistants and for our registered nurses who come to work with us.

In connection with the nursing assistants, these people, for the most part, have a high school education but no experience in a hospital at all. They go into a program which involves over 200 hours of classwork during the first year plus supervised experience on the wards, at the end of which time, if they successfully pass the examination, they are promoted and become regular staff members at the hospital.

During the course of the year, because not all trainees are there for a full year, we have over 600 different students in the professional category and among the nursing assistants 300 or 400 at least. I may be wrong on that. It is probably low. Dr. Harris, do you happen to recall how many nursing assistants pass through our training program?

Dr. HARRIS. About 400.

Mr. DANIELS. What authorization is there in the law for the conduct and operation of this training program as you have just described?

Dr. CAMERON. The basic organic act, which establishes the hospital, says that it shall provide, "The most humane care and enlightened curative treatment" of the mental ill for whom the hospital is responsible.

It has been our belief and that of my predecessors that training is an essential part of providing this type of service for, without training in a hospital, ordinarily you do not have the most humane care and enlightened curative treatment. Therefore, since its inception, the hospital has been a training center.

Mr. DANIELS. Now, in the operation of this training course, are any fees charged of the applicants?

Dr. CAMERON. No, sir. This training is primarily to serve the needs of the hospital, although there are in some instances a number of persons trained in a particular discipline beyond the needs of the hospital. And that reminds me I did overlook one important category as I was naming them, "Chaplains." We have six Catholic priests, ordained priests receiving training relative to the ministry for the mentally ill and 10 or 12 Protestant ministers in the same type of training. This is obviously beyond our immediate needs.

So we have also, for some years, been endeavoring to train personnel not only for our needs, but to assist with the manpower resources of the country since we are a Federal institution.

Mr. DANIELS. Is there any other Federal facility similar to St. Elizabeths in the United States which conducts a training course such as you operate at St. Elizabeths?

Dr. CAMERON. The literal answer to your question is "No," but this must be qualified. I say "No," because there is no other Federal hospital like St. Elizabeths that provides services to all classes of patients. There are indeed other Federal hospitals which provide training. The Veterans' Administration provides training services in its hospitals, but those hospitals provide service only to, for the most part, male patients eligible because of their veteran status.

The U.S. Public Health Service operates two hospitals for psychiatric patients, one at Fort Worth and one at Lexington. Lexington is almost exclusively for narcotics addicts so again it does not have the broad range of patients available for training programs which we have at St. Elizabeths and the same is true at Fort Worth.

Mr. DANIELS. It would appear that because of the possibilities at St. Elizabeths, this training program would be most practical and desirable. Is this correct?

Dr. CAMERON. It is and without it we would have difficulty in recruiting staff members to take care of our patients because, as I said yesterday, most well-qualified professional people wish to teach at the same time they are providing services to patients and unless they have this opportunity, they won't work in a place where service is the only endeavor.

Mr. DANIELS. I just have one or two more questions.

Do you have an advisory or permanent committee to work with you in connection with the operation of the hospital?

Dr. CAMERON. Not in the sense I think you may mean it, Mr. Chairman. There is no board of advisers. There was at one time. There is no formalized professional advisory group. However, I should tell you that we have about 15 psychiatrists on the consultant staff of the hospital, not on the permanent staff, who come to the hospital and assist with the teaching and service programs and some 60 other physicians who give general service in the general medical and surgical areas of the hospital.

In addition to this I have ready access to such persons as Dr. Felix, the Director of the National Institute of Mental Health; Dr. Walter Barton, the medical director of the American Psychiatric Association; Dr. Jack Ewalt, the president of the American Psychiatric Association; Dr. Paul Hoch, the commissioner of mental health in New York; and other outstanding persons of this kind throughout the country who are personal acquaintances of mine. Whenever I have a question on which I think they can be of assistance I do not hesitate to call.

Mr. DANIELS. But would it not be more desirable and advisable to have a permanent committee to work with you?

Dr. CAMERON. It would depend, I think, sir, on what you consider the purpose of the committee to be. For certain types of consultation the ad hoc consultation from selected persons is, I think, more useful than a standing committee.

If you had a standing committee this type of ad hoc consultation would perhaps not be quite as easy as it now is.

On the other hand, in terms of the long-range policies, things of this sort, I think that an advisory group might be useful and should con-

tain, if established for that purpose, not only professionals but certain public leaders as well.

Mr. DANIELS. Have you had an opportunity to look at the bill which I introduced recently, H.R. 9072, which would provide for the establishment of a Presidential Commission to advise about the organization, operation, and improvement of St. Elizabeths Hospital?

Dr. CAMERON. I have.

Mr. DANIELS. Now, that bill provides for the appointment of a five-member commission. Can you give us your opinion about the advisability of the enactment of this bill?

Dr. CAMERON. I interpret this bill to intend to establish a committee somewhat different than the one I understood you to be talking about just before. I understood your earlier question to have to do with an ongoing, continuing, body through time, whereas the bill provides for a time-limited study or committee, as I understand it.

But, commenting on the membership of this committee, I should suggest that consideration might be given to additional psychiatrists beyond the one designated and that the psychiatric social worker might be replaced by a person with a degree in sociology, who perhaps came to sociology through the social work field. What is needed here is a broader sociological approach than the social worker per se might be expected to give. I would assume that the hospital administrator need not necessarily be a person limited to that precise field, but rather might well be a hospital administrator who is also a psychiatrist or something of that sort.

Otherwise, I think the composition of the proposed Commission is quite satisfactory. Speaking now only for myself and not for the Department, I must say I like section 1 which starts out with the assumption of declared policy that the hospital will provide an example to other institutions throughout the Nation who are engaged in the treatment of the mentally ill.

In your discussions yesterday with Mr. Jones, it was apparent that another committee has been established by the Secretary to look into many of these questions and Mr. Jones, as I heard him, was not ready to prejudge the recommendations of that committee relative to the policy issue which you have enunciated in section 1 of your proposal.

Otherwise, I have one further point. The need for a Commission as proposed in the bill would, in my opinion, be dependent somewhat on the results of the study now being conducted by the Secretary's Committee. As Mr. Jones indicated, it will look only to the major policy issues. If it is felt necessary to look beyond the recommendations of that Committee, then H.R. 9072 would certainly provide the mechanism to do it and perhaps the mechanism to look into the questions of implementation in greater depth than I imagine the Secretary's Committee will be able to do.

Mr. DANIELS. Do you think the Commission should be temporary?

Dr. CAMERON. That is the way I read the bill, the intent.

Mr. DANIELS. What is your view on that point?

Dr. CAMERON. I would be perfectly willing to see it a temporary committee and let it consider among other things whether or not there should be a permanent ongoing body. I should say that one of the questions addressed to the ad hoc committee proposed here might be the need for a continuing ongoing advisory body.

Mr. DANIELS. One final question. What is your view as to the best utilization of St. Elizabeths Hospital within the framework and guidelines laid down in the President's letter to Commissioner Tobriner dated February 15, 1963?

Dr. CAMERON. Well, I have some very definite thoughts on that point.

First of all, the President has asked the Commissioners to develop a program in the District of Columbia as a model for the Nation. The major responsibility for so doing will fall on Dr. Grant of the Health Department who operates the program for the District.

I think it would be quite unfortunate if the long tradition and the enormous resources of St. Elizabeths Hospital were not included in an overall plan for providing service to the District of Columbia.

My own view of how it might fit into an overall program for the District would be as follows:

That the District be divided into 2 or 4 geographic areas, each with a population of approximately 100,000 to 250,000 persons, that each of these geographic areas be served by a community health center which provides complete and comprehensive services. By that I mean inpatient services, outpatient services, home visiting and the like—day hospital and night hospital.

I believe that it would be useful to utilize the existing resources of the District in developing these centers, for example, the existing psychiatric services in the general hospitals. Further, St. Elizabeths Hospital might well be utilized to serve one segment of the city—to provide complete services to the segment of the city in which it is located.

It is unlikely, if such a plan is developed, that the other segments of the city will, within the foreseeable future, develop the hospital bed resources to take care of the intermediate and long-term patients who come from those areas. St. Elizabeths could, of course, take care of intermediate and long-term patients from its section of the city and I would assume it would continue to receive intermediate and long-term patients from the other sections of the city, but in those other sections the comprehensive mental health center would provide short-term hospital care and all other kinds of services.

I think it would be useful to utilize St. Elizabeths in this way: (a) since it exists and is a resource and (b) because the Federal Government, in trying to further the overall plan recently enacted by the Congress, will need to have, in my judgment, a place where it can demonstrate the ways in which larger hospitals may be subdivided into smaller units, may be reduced in total size, and form close liaison with the community they serve when those large hospitals are proximate to the community to be served, as is St. Elizabeths.

I think, too, that the Federal Government, through the National Institute of Mental Health, provides a quite complete program with one major exception. It has, for example, a research program which is prosecuted through extramural grants, to universities and through an intramural program in which it endeavors to study those problems which other centers are not studying or which appear to the staff to be particularly crucial. Because of that, and because some types of problems require large numbers of patients in order to study them, there has been established, by the NIMH at St. Elizabeths,

the clinical neuropharmacology research center designed primarily to study the effects of medications on substantial numbers of patients. The NIMH does not have enough patients in the clinical center to carry on study of this sort.

The research program of the Institute is quite complete, but in the training field it is far from complete. The NIMH does provide extramural grants to training centers but it has no real training program of its own worthy of the name. I believe the Federal Government should have such a training program primarily for the purpose of trying out new teaching techniques which might be made available to other teaching centers.

Now, you can't have a training program unless you have patients. St. Elizabeths has patients in ample variety and therefore I believe the training program at St. Elizabeths should be further developed to augment the national effort in this particular field and should eventually become a locus for advanced training in many different disciplines which have a bearing on the problems of mental illness.

I have given you a rather long answer to a very short question but the point is, in summary, St. Elizabeths can play a crucial role in the development of services to the District of Columbia and should.

Mr. DANIELS. Just one final question. Is it your opinion that we have an acute nationwide shortage of adequately trained personnel to take care of our mentally ill?

Dr. CAMERON. There is no question of the truth of that statement. There is a marked shortage.

Mr. DANIELS. Does this shortage exist in any particular area?

Dr. CAMERON. In psychiatry there is a marked shortage. The shortage is not quite as acute in the field of clinical psychology. The NIMH extramural grant program has made a very substantial impact on that particular field as it has in psychiatry and the others.

As for social workers, this is an extremely critical area, particularly when it comes to the outplacement of patients from hospitals, a problem not unique to St. Elizabeths, and I should say the most critical shortages are in the field of psychiatry, social work, psychiatric nursing, and clinical psychology in that order as far as the four major disciplines are concerned.

Mr. DANIELS. Do you have any questions?

Mr. GOODELL. No questions.

Mr. DANIELS. I think counsel has a few questions to ask.

Mr. Reisinger.

Mr. REISINGER. Doctor, I am sure I agree with much you say but the entire area of training techniques and advances in mental health is still in a very formative state, is this correct?

Dr. CAMERON. Yes, sir. This is another reason why research is so crucial. For example, schizophrenia, the illness which accounts for roughly one-fourth of all admissions in mental hospitals in the United States and one-half of all patients currently hospitalized is a disease the cause of which is currently not known. You can't expect us to be sharp in treatment if we don't know the cause of the disease. It doesn't mean there aren't things we can do because we can, but it highlights the need for research. There are other major deficiencies in our knowledge as well which point to the need for research and training.

Mr. REISINGER. Secondly, I suppose the reason or one of the major reasons for inadequacy of trained personnel in the field is there simply are not a sufficient number of training institutions in being to provide the requisite professional population?

Dr. CAMERON. An increasing number of medical schools is being established and, of course, this is the basic group from which the psychiatrists would come. Medical schools are, in general, increasing the size of their classes but have not been able, so far, even to keep up with the growth of the population of the United States. There have been enormous increases in the number of professionals working in the mental health field but there has also been an enormous population growth at the same time.

Mr. REISINGER. Now, is it not also true that psychiatric training is somewhat more specialized than the other areas of medical training and requires psychiatric patients to work with?

Dr. CAMERON. To train persons in psychiatry there must be patients with whom to work. To say this is a more specialized field of medicine than the other fields of medicine I think would not be quite an accurate statement. I believe the surgeons, internists, or radiologists might say to you their fields are just as specialized as ours and I would not agree with them.

Mr. REISINGER. There are, however, a larger number of hospitals available which offer the opportunities for surgical residency than psychiatric, is that true?

Dr. CAMERON. I assume it to be true but I don't have the exact data before me. I would say, since one-half of all the patients in the United States hospitalized on a given day are psychiatric patients, the problem is a very substantial one.

Mr. REISINGER. Now, Doctor, yesterday, in your testimony you made reference, I believe, to a convalescent patient who had been charged with a crime the day before.

Dr. CAMERON. Yes, sir.

Mr. REISINGER. Would that be the William H. Williams who was reported in the press?

Dr. CAMERON. Yes, sir.

Mr. REISINGER. The general area of security provision in the hospital is, I think you indicated, at three intermediate levels: one, maximum, which is John Howard Pavilion, and for female patients, Dix Service. How many female patients are there at Dix in maximum security?

Dr. CAMERON. About 30, plus or minus 2 or 3 and there are about 60 female so-called prisoner patients in the hospital in its entirety.

Mr. REISINGER. Now, I judge, from your testimony yesterday, you are satisfied that the maximum security facilities at least at John Howard Pavilion are, as the chairman put it, A-1 on a comparative basis with the other institutions?

Dr. CAMERON. I think that is a fair statement. The unit is somewhat larger than I would like to see but from the physical facilities point of view, there is no question it is one of the best in the country.

Mr. REISINGER. Now, with respect to John Howard, what method of identification of employee personnel is utilized.

Dr. CAMERON. You mean how are visitors and others identified coming into the hospital?

Mr. REISINGER. Yes, sir.

Dr. CAMERON. Well, as you know from your visit there, there is a sallyport and each person who comes into the building is supposed to sign his name on a little book kept by the guard before he comes in in order that we may know who has come into the building. You know further that there are no patients on the first floor, that is, housed on the first floor of the building, so that once you go through a sallyport you are essentially in an office area. If a person is coming in to see one of the staff, he would go directly to the office and never go into the patient area. If it is a visitor, he would be conducted by an employee to the visitor's room and the visit supervised. If it is another employee from the hospital, such as myself, or one of the staff, we don't always sign in when we go in and we are not always conducted throughout the building.

Mr. REISINGER. Obviously, you are pretty well known to the staff, but there are presumably a good many staff personnel who are not known to the hospital guards. Is it a guard on the sallyport?

Dr. CAMERON. Yes, it is. And any person not known personally to the guard at the sallyport would be required to sign in and report to the nurse supervisory's office before he goes anywhere.

Mr. REISINGER. Would he be required to show any form of identification?

Dr. CAMERON. Not necessarily.

Mr. REISINGER. How about usually or the normal practice?

Dr. CAMERON. No.

Mr. REISINGER. Now, the nursing supervisor who he reports to—is it the nursing supervisor to whom a visitor reports?

Dr. CAMERON. Yes, sir.

Mr. REISINGER. Is that office immediately adjacent to the sallyport?

Dr. CAMERON. Yes, sir.

Mr. REISINGER. And the guard can see into the supervisor's office?

Dr. CAMERON. Yes, sir.

Mr. REISINGER. And then from that point the identification, if it is necessary, the identification procedure would take place there with the nursing supervisor?

Dr. CAMERON. Well, there is usually not any request to present a driver's license or that kind of identification. The person would state his name and business and be taken to see the person whom he wants to see on the staff. The staff members would usually be able to identify the person. But if someone comes saying, for example, that he is the attorney for a patient, we usually take the attorney's word for it, although if we had a question we could verify this with the court, if he were a court-appointed attorney.

Mr. REISINGER. I see. Do the employees carry some character of identification card indicating they are St. Elizabeth Hospital employees?

Dr. CAMERON. No, sir.

Mr. REISINGER. Of course, there is no badge or anything of that character that they wear?

Dr. CAMERON. No, not routinely, although the nursing department has instituted a system of name badges, which give the name and the position of the employee. The physicians, the administrative personnel, and so on do not wear such badges. All of the nursing assist-

ants wear clothing furnished by the hospital which is clearly marked "St. Elizabeths."

Mr. REISINGER. So there is nothing of the character of a badge with typical identifying characteristics, anything of that type utilized by the personnel?

Dr. CAMERON. No, sir; they have pictures of patients, not of personnel.

Mr. REISINGER. But those pictures are in a file someplace, is that not so?

Dr. CAMERON. Of the patients?

Mr. REISINGER. Yes.

Dr. CAMERON. Yes; they are in the file.

Mr. REISINGER. Now, with respect to the guard system as such, what is the total number of guards employed at the hospital?

Dr. CAMERON. I can't give you an exact number but 30, plus or minus 4 or 5.

Mr. REISINGER. And this would include, I assume, since you have three shifts, probably at least five of an administrative character?

Dr. CAMERON. There is a captain and two or three lieutenants. The guard force mans the sallyport at John Howard Pavilion; the gates coming into the hospital (not as a policing function as to who may enter or not, but as a courtesy to the public to give directions to visitors as to the location of buildings); and it mans the patrol cars which move around the grounds constantly trying to be sure that that proper decorum is kept on the grounds not only by the patients but some of the visitors.

Mr. REISINGER. What are the minimum age requirements for the guard appointees?

Dr. CAMERON. I can't answer. It would be the requirement as established by civil service. In general, people under 18 years of age are not employed. To my knowledge, there are no guards that young.

Mr. REISINGER. So your thinking is that it is at least 21?

Dr. CAMERON. Yes, sir.

Mr. REISINGER. Now, on this gate duty, first of all, how many gates are there?

Dr. CAMERON. Four. One of them is kept closed to vehicular traffic at all times and three are manned.

Mr. REISINGER. And the guard duty at the gate then does not include stopping people leaving the premises or campus for identification?

Dr. CAMERON. It does in this sense, Mr. Reisinger, the guards at the first gate, the main gate, have a picture of all of the so-called prisoner patients in the hospital so that if a person were to come through that gate and they recognized him from the picture which they have on file, they would certainly check with him.

We keep the guard force informed regularly as to the status of the prisoner patients; that is, whether or not they are permitted to be on the grounds or whether they are supposed to be confined to their ward. Also, the patients who have the privileges of the grounds carry a pass which, if they go out, they are expected to present to the guard to show whether or not they are to be permitted to go into town. I will readily admit that patients may sometimes trade passes.

Mr. REISINGER. The population, I believe, prisoner patient population is roughly 700 at the present time, is that correct?

Dr. CAMERON. There are 738, I believe, in the house at the present time, and there are about 50 additional ones on conditional release and approximately 50 on elopement so there are 830 to 850 prisoner patients for whom we have responsibility.

Mr. REISINGER. Subtracting the John Howard and Dix population, which would be, in round terms, 425, that would mean that there are approximately 300 to 325 who are in lesser security status?

Dr. CAMERON. Yes. Now, it should be understood that some of the patients who are not in John Howard and Dix may have no privileges of the ground even accompanied. As a matter of fact, if we take the 738 in the house, there were on June 30, 152 of those who had the opportunity to walk about on the grounds unaccompanied.

Mr. REISINGER. May I interrupt? Would this constitute the number of photographs that are maintained? Is this No. 1 gate only, or are they maintained at all gates?

Dr. CAMERON. No. 1.

Mr. REISINGER. Would that constitute the number of photographs maintained at the gate?

Dr. CAMERON. That is what we started with, but we have been trying to increase so they would have pictures of all the patients who are in prisoner status.

Mr. REISINGER. So, then, the only means the guard has of identifying an individual who comes out of the hospital grounds is a recollection of 150 photographs?

Dr. CAMERON. Something of that sort, but I should tell you, also, that most of the guards worked at one time or another on the patrol cars as well, and most of our prisoner patients have been there for some time, and most of them are known by sight by every member of the guard force.

Mr. REISINGER. The pass that is required of the patient who has leave privileges, whatever they may be, does this have any specialized form?

Dr. CAMERON. Well, it is a small form that has been devised in the hospital.

Mr. REISINGER. What is it, a lightweight, mimeographed paper?

Dr. CAMERON. Yes.

Mr. REISINGER. It is not a card as such?

Dr. CAMERON. It is not a very substantial card, no.

Mr. REISINGER. Is there any particular reason why, Doctor, identification passes, carrying a picture such as now used as driver identification in the District, would not be practical?

Dr. CAMERON. I think it is unnecessary for the bulk of the patients. We have certainly considered it in connection with the prisoner patients and it would not be a major job to provide them for those persons who have the opportunity to be on the grounds.

Those are the only ones who really need it to show they had a right to be there. If they didn't have one they should not be on the grounds. We have had some problem about this in terms of our photographic laboratory and its capacity to handle the added load.

Mr. REISINGER. What is the photographic laboratory used for, therapeutic purposes only?

Dr. CAMERON. Both. It takes all the identification pictures of all patients when they come to the hospital and it also does certain photographic work in connection with our medical activities.

Mr. REISINGER. Well, for every patient who comes to the hospital, then there is a photograph of the patient in being after the admission?

Dr. CAMERON. Yes, sir.

Mr. REISINGER. And that presumably is in the files some place?

Dr. CAMERON. There is one in the photographic laboratory and one in the patient's record and one in the ward.

Mr. REISINGER. Now, with respect to employees, they have no identifying card that carries their picture?

Dr. CAMERON. We have no pictures of our employees. This has been a bit of a problem. I wish we did. Actually, the reason I understand it hasn't been done is because of the volume of work involved in doing it. Then there has been some question about doing it because of the interdiction of the Civil Service Commission that we endeavor not to identify people by race.

Mr. REISINGER. With respect to the patient population, Doctor, it is the case, is it not, that you try to have them dress as they normally would if they were living outside the hospital?

Dr. CAMERON. Yes, sir; within limits, we certainly try to do that. We try to encourage the patients to wear their own clothes. We furnish clothing if they do not have it. You might be interested, parenthetically, in the fact we employed a person not too long ago to help with shopping for patients who have money and before that person was employed the patients were spending from their funds under \$1,000 a year to buy clothing and last year they spent over \$50,000 to buy clothing from their own funds and gladly when they had some help in getting clothing.

Mr. REISINGER. Are all of the patients on city privileges or leave privileges of any character required to go through the No. 1 gate?

Dr. CAMERON. They would be able to go out any of the gates. That is, if they have city privileges, and patients with city privileges carry their city privilege pass.

Mr. REISINGER. Are they required to log in or sign in and sign out at the gate?

Dr. CAMERON. No, they are not, not at the gate. The logging in and out would be at the ward level.

Mr. REISINGER. At the ward level.

There are how many medium security wards or services?

Dr. CAMERON. For the male patients, the great proportion of these patients are in so-called west side service. There are about 50 patients in the so-called detached service and there may be a half a dozen patients sprinkled throughout the rest of the population for particular reasons. For example, it may well be that we want to house a particular patient in an area where he does not have the opportunity frequently to come in contact with other prisoner patients.

Mr. REISINGER. Are these services—and let's limit this to west side and detached, and I assume there is some comparable medium security facility for women?

Dr. CAMERON. Yes.

Mr. REISINGER. Limiting the inquiry then to those three services or wards, is medium security characterized by a locked ward?

Dr. CAMERON. Yes, it would be a locked ward and in west side there are two wards which have special locks and detention screens, one of which you saw during your visit. The patient may be moved from that ward in due course to another so-called locked ward but which does not have detention screens and which does not have a special lock.

Patients in these latter wards are not all required to remain in those wards and may have privileges to go out on the grounds and the employees know which ones and will let them in and out. Still, other areas in those two services have unlocked wards on which some of the prisoner patients live and that would not be medium security at all. These are the patients who have the opportunity to move onto the grounds.

Mr. REISINGER. Now, then, I think we have used the term "minimum security" from time to time. Would that apply to all other services that we have not mentioned here?

Dr. CAMERON. You mean where prisoner patients are housed?

Mr. REISINGER. Well, any patients, prisoner or otherwise.

Dr. CAMERON. No; some of the patients are on locked wards and some are on open wards and the same ward may be locked today and open tomorrow. It depends on the behavior of the patients and who has recently been admitted to that ward, so it is not at all unusual to go to a particular area and find it open today and tomorrow closed and fluctuating in that way.

Mr. REISINGER. Now, "detached service," as I recall in our visit, is a group of buildings which have a wire fence intervening between the buildings where there is no other enclosure. That is what, an 8-foot fence?

Dr. CAMERON. Something of that kind. It is not intended to be a security fence in the sense of preventing prisoner patients from escaping. Rather, it is a fence which would remind someone who is quite confused that he may be getting too far away from home base.

Mr. REISINGER. I see. Now, on west side, my recollection doesn't serve me, but that is a self-contained building, or does it have a fenced yard?

Dr. CAMERON. There is no fenced yard although we are planning to build one in the spring primarily to give the patients who are housed there, who have come to us as a result of criminal proceedings, an opportunity, before they receive the opportunity to go on the grounds, a chance to go out in an area and get some exercise outdoors.

Mr. REISINGER. Now, directing your attention to a memorandum over Dr. Overholzer's signature which sets forth classes A, B, and C prisoner-patient's status, is that still in effect?

Dr. CAMERON. Yes, sir; that is standard procedure No. 36 dated May 1, 1959.

Mr. REISINGER. Yes; May 1, 1959, I don't see the standard procedure number—Division of Medical Services, Revision No. 2.

Dr. CAMERON. That is right.

Mr. REISINGER. I would like, if there is no objection from the chairman and Mr. Goodell, to offer this.

Mr. GOODELL. No objection.

Mr. DANIELS. Without objection it is so received.

(The information follows:)

[Standard Procedure No. 36—Division of Medical Services (Revision No. 2, May 1, 1959)]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
ST. ELIZABETHS HOSPITAL,
Washington, D.C., May 1, 1959.

To: Division and branch heads and others concerned.

Subject: Classification of prisoner patients.

All patients who are committed as prisoners (whether under criminal charges, under sentence, as sexual psychopaths, or acquitted of charges by "reason of insanity") will be categorized into one of three classes as follows. These classes relate to the degree of custodial security in the care of the patients and, in turn, are based upon clinical evaluations of the patients. It is to be noted that in the cases of prisoner patients the hospital has an additional responsibility to the community, to the courts, or to other Government agencies. Therefore, the hospital must exercise every reasonable precaution in safeguarding these patients, in addition to the application of sound medical care.

CLASS A

All prisoner patients are automatically placed in this class on admission. This class of patients will be cared for in those buildings and wards in which maximum security can be provided by the physical structure of the wards and a suitable number of available personnel. Employees on such maximum security wards should be carefully selected and appropriately instructed.

Such patients will not be permitted to leave the building in which they reside except to provide medical, laboratory, or similar services which cannot readily be performed in the building. When it is necessary for such a patient to leave the building in which he resides, two ward employees should accompany the patient (using wristlet restraints if necessary). If more than one prisoner patient are to be sent out of the building together, three ward employees may, at the discretion of the physician in charge of the Service, be assigned to escort two patients; four ward employees for three patients, etc. In all such instances, one of the employees should be designated as in charge of the group; and each patient should be assigned as the responsibility of a designated employee.

Patients will not leave the ward to which they are assigned for occupational therapy, hydrotherapy, or similar programs unless such facilities are available in the same building. The physician in charge of the Service must approve such attendance.

Class A patients will remain in this category until a change is formally made. Under ordinary circumstances, no change will be effected until the patient has been adequately studied and evaluated at a diagnostic conference. Time alone is not the principal factor in retaining a patient in this class. The main consideration is the patient's clinical condition as determined by thorough study. However, due consideration must be given to security factors in patients under sentence or for whom there are detainer warrants. Either at the admission conference, or subsequently, the patient may be transferred to class B on the recommendation of the physician in charge of the Service and with the approval of the clinical director. Patients may be transferred out of the maximum security building (to class B) only with the approval of the Superintendent (through usual channels).

CLASS B

Prisoner patients in this category are in an intermediate level of security (comparable to other patients without special privileges). Such patients may reside in any closed wards compatible with the patient's clinical status. These patients may attend or participate in activities within their ward building and outside the building under appropriate supervision and with the approval of the physician in charge of the Service. They may be permitted on the hospital grounds in the company of a responsible relative or other visitor if, in the opinion of the physician in charge, the privilege is warranted by the patient's condition. Patients in this class, however, may not have unaccompanied ground privileges or privileges for visiting outside the hospital.

Transfer from classes B to C may be made on the recommendation of the physician-in-charge of the Service with the approval of the Superintendent. Such a recommendation will be submitted as a note in the clinical record through the usual channels.

CLASS C

Patients in this group may have unaccompanied ground privileges. Any further extension of privileges requires specific approval of the Superintendent on recommendation by the physician in charge of the Service submitted through the usual channels.

With the approval of the Superintendent, patients committed as sexual psychopaths (Miller Act cases) may be granted permission to leave the hospital grounds for day or more extended visits.

Patients committed after acquittal by "reason of insanity" may be granted brief visits from the hospital during the day provided the patient is accompanied by a hospital nurse and/or attendant. Permission for unaccompanied visits, or visits in the care of someone other than hospital personnel, cannot be granted without the prior approval of the committing court in the form of a conditional release order. The patient may not be discharged from the hospital without an unconditional release order from the committing court. Such court orders are obtained by certification by the Superintendent to the committing court, with a copy of certification to the U.S. attorney, or the Corporation Counsel, depending upon which office is handling the case.

WINFRED OVERHOLSER, M.D.,
Superintendent.

Prisoner patients under examination remain class A.

Prisoner patients incompetent for trial or serving sentence remain class A or B unless unusual treatment circumstances indicate class C.

If any prisoner patient leaves hospital unauthorized and returns he automatically returns to class A and may be returned to JHP.

Mr. REISINGER. Now, I note here, Doctor, certain provisions relative to this situation. There are class A, or maximum security, patients. Are they housed in John Howard Pavilion exclusively?

Dr. CAMERON. No, sir. There are some class A patients in West Side.

Mr. REISINGER. So there is a maximum security ward of some character in West Side?

Dr. CAMERON. No; it is a medium security ward as you saw, but a class A patient may live there but not be permitted to leave the ward.

Mr. REISINGER. Are there the same medical laboratories and like facilities available within West Side as there are at John Howard?

Dr. CAMERON. No; and if a patient had to go to a clinic, he would be accompanied if he had class A ordinary, by two employees.

Mr. REISINGER. And sometimes they move in groups of two or more, the ratio of employee attendants to patients increases, is that correct?

Dr. CAMERON. That would be true, but not for class A. For patients on so-called class B accompanied they may go in larger groups.

Mr. REISINGER. Directing your attention to the directive, it suggests the basis for my question in the last sentence on the first page.

Dr. CAMERON. Yes, sir; you are correct.

Mr. REISINGER. Is that practice followed?

Dr. CAMERON. Yes, sir.

Mr. REISINGER. Now, with respect to patients who are in the class A category and for the most part in John Howard, am I correct that it is the administrative direction that in these recreational situations such as dances involved in the Smallwood matter, no persons outside the service, that is, outside John Howard, no male patients at least would be brought in?

Dr. CAMERON. Not to participate in the dance per se, although occasional patients may be brought in from other services to round out the orchestra or provide some special service of that sort during the dance.

Mr. REISINGER. There is a gymnasium in John Howard?

Dr. CAMERON. Yes.

Mr. REISINGER. Is this ever utilized by other than John Howard patients?

Dr. CAMERON. Yes.

Mr. REISINGER. In what category would these people fall who come into John Howard?

Dr. CAMERON. There is an intramural basketball team in John Howard and elsewhere in the hospital. Some basketball teams from elsewhere in the hospital would come to John Howard to play and John Howard also plays some teams from the community, incidentally, always on their home court.

Mr. REISINGER. I understand the FBI is among them?

Dr. CAMERON. Yes, sir.

Mr. REISINGER. Medium security patients are in class B; is that right?

Dr. CAMERON. Yes, sir; it makes a good contest, incidentally.

Mr. REISINGER. If my recollection serves me correctly, there has been one elopement where there was a bolt-and-run situation in this year.

Dr. CAMERON. Yes, sir.

Mr. REISINGER. And what provision is made in terms of accompaniment for class B prisoners?

Dr. CAMERON. Class B prisoners may ordinarily be accompanied on a one-to-one basis or sometimes there may be one employee with several patients at the same time.

Mr. REISINGER. Also, with a responsible visitor or relative, I note here in the statement.

Dr. CAMERON. That is correct. That is allowed on the order of the physician when he has reason to believe that the visitor is trustworthy.

Incidentally, we lost a patient or two when our judgment of the trustworthiness of the visitor seemed to be somewhat less than accurate.

Mr. REISINGER. Now, to get to the class C category. I judge, from reading the statement to which I refer, these are patients who fall into any category up to the conditional release situation?

Dr. CAMERON. Yes.

Mr. REISINGER. And they may have unaccompanied privileges throughout the grounds?

Dr. CAMERON. Yes; but for particular patients there are some restrictions even within this group. For example, a so-called prisoner patient might be put on class C, but allowed only to move from the ward to his place of work and return by a certain hour and remain in the ward the rest of the time, whereas other class C patients might not only do that, but have the opportunity to go off the ward in the evening and out into the yard, as I explained yesterday, for some free leisure time.

Mr. REISINGER. Now, with respect to class A and class B prisoners, assuming that the procedures that you, as Superintendent, lay down and try to enforce, assuming these are followed, there would be almost an immediate knowledge of an escapee or elopee, is that correct?

Dr. CAMERON. With the exception of class C.

Mr. REISINGER. I say, of course, two categories, A and B.

Dr. CAMERON. With the first two we should know rather promptly.

Mr. REISINGER. It is the class C, then, that gives you some measure of trouble in the immediacy of detection of their elopement?

Dr. CAMERON. Yes, sir.

Mr. REISINGER. How are you first advised on an elopement?

Dr. CAMERON. A nursing attendant or some other employee with whom the patient was supposed to be working makes a report.

Mr. REISINGER. I see. At that point, procedurally what happens?

Dr. CAMERON. The nurse supervisor on the ward from which the patient came is immediately notified. The nurse supervisor ordinarily notifies the physician in charge and before doing so they start looking on the grounds to see if by chance this person simply forgot to come in at the appointed hour or something of that sort.

If, for example, the person is out with a relative in class B, and he didn't come in, they would start looking on the grounds to see if they were having a picnic and simply failed to come in on time.

Mr. REISINGER. Assuming they did not then find the particular patient on the grounds, they would then notify the nursing supervisor?

Dr. CAMERON. No; the nursing supervisor should be notified immediately and the search is started at that juncture. The physician is notified at that juncture. If they have not found the person within 15 or 20 minutes ordinarily, the clinical director and myself would be notified and a determination made relative to notification of the police.

Mr. REISINGER. Now, the clinical director—that is one individual, is that correct?

Dr. CAMERON. Well, there are several clinical directors on duty during the day. At night, there is one who takes the duty for the whole hospital.

Mr. REISINGER. I see. He would then be notified in the evening?

Dr. CAMERON. Yes.

Mr. REISINGER. Incidentally, is your greatest occurrence of elopements during the day or the night hours?

Dr. CAMERON. It is difficult to tell because the greatest number occur among the class C patients and among those for the most part who have 9 p.m. report in time. So when you look at our records you will see that the bulk of them are reported around 9 p.m., but a person could have been gone from class C status all day.

Mr. REISINGER. Well, for our purposes then the greater number would take place prior to 9 p.m.?

Dr. CAMERON. Yes, sir.

Mr. REISINGER. Now, presumably Saturday and Sunday there is some limitation of staff simply by virtue of the 40-hour week, is that the case?

Dr. CAMERON. There is limitation in medical and other professional staff. The wards, as far as nursing assistants and nursing, are manned essentially the same 7 days a week.

Mr. REISINGER. So that basically the administrative staff is reduced Saturday and Sunday?

Dr. CAMERON. Yes.

Mr. REISINGER. Is there a greater incidence of escape during the weekend or during the week, or do you know?

Dr. CAMERON. I can't answer that question. We have looked at the hour-of-the-day situation, but we frankly haven't looked at it by day of week.

Mr. REISINGER. Then, taking, or going back in our discussion at the point in time where the clinical director is notified, what occurs then?

Dr. CAMERON. He would check to see that appropriate persons have been notified, that a proper search has been undertaken, and if he thinks additional search procedures should be taken, he would undertake them, and he notifies me at the same time.

For example, the other day we had this situation.

Mr. REISINGER. May I ask one question, sir? When you say "appropriate people who should be notified," is that solely within the hospital?

Dr. CAMERON. No, sir.

Mr. REISINGER. We will get back to that. You wanted to give us an example.

Dr. CAMERON. I was going to give an example in a "nonprisoner" category where a man was missing—a civil patient. He was feeble, reasonably feeble, and it was a cold night and I was quite worried about him because I was afraid he would not be able to fend for himself. When I learned of his absence, I asked several of the wards to strip themselves to the minimum of personnel so that we could send people out onto the grounds to hunt for him. We have many ravines on the grounds, places where a person could stumble and fall and not be able to make it back to the hospital building.

Several people were assigned to search the ravines that night. He was later found off the grounds.

Mr. REISINGER. Now, with respect to notification of personnel or agencies outside of the hospital, what procedures exist there?

Dr. CAMERON. If it is a patient—speaking now of those coming to us by virtue of criminal procedures, or civil for that matter, if the man has been involved in any threat activity or things of that sort—we would notify the family routinely either by telephone locally or by telegraph or sometimes by letter if it is at a great distance. If it is a White House case, that is, someone who has come to the attention of the Secret Service because of their activities at the White House, we notify the Secret Service.

Mr. REISINGER. By telephone?

Dr. CAMERON. Yes. If it is a Federal prisoner we notify the FBI.

Mr. REISINGER. Again by telephone?

Dr. CAMERON. Yes, by phone, and we notify No. 11 precinct by phone.

Mr. REISINGER. The 11th precinct is the one which has jurisdiction of the hospital area, is that correct?

Dr. CAMERON. Yes, our hospital is in its area.

Mr. REISINGER. With respect to notification to the Bureau and the Secret Service, this is presumably direct to the officer in charge of the local office?

Dr. CAMERON. Yes, sir.

Mr. REISINGER. With respect to the Police Department, are you familiar yourself with what occurs in the routine procedure of handling these cases after notification is given to No. 11?

Dr. CAMERON. No, sir.

Mr. REISINGER. You do know, however, that the result is that a squad car responds and officers take the details of the escape?

Dr. CAMERON. They usually send a squad car to the hospital quite promptly, primarily to look at the picture and to get the identifying data. We furnish identifying data by telephone but identifying data is certainly not as precise as a picture, so they like to come and get a picture as well, or see the picture, at least.

Mr. REISINGER. Is there any practical reason, Doctor, why the responsible official, the clinical director at the hospital, could not immediately contact, say the lieutenant in charge of the communications department at police headquarters in the case of an escapee?

Dr. CAMERON. If the Police Department would like us to make that change, we would certainly have no objection. We are following a procedure which was worked out previously with the Police Department, since so many of the patients are found promptly within the 11th precinct. It was apparently felt wise to notify No. 11 and let them notify the central communications. There would be another problem, too. There seems to be a tendency for the police and the press to consider anyone who goes on unauthorized leave, though it may not be an escape, it may be an elopement, a walkout, as being a dangerous person. Many of these persons are not. Some are. I think it inappropriate to alarm unduly the public relative to these matters. I think the public should be informed, of course, if the person is really dangerous but I think whatever system is worked out should take account of this important feature.

Mr. REISINGER. Am I correct that the comprehensive record relative to a patient is at the immediate disposal of the clinical director?

Dr. CAMERON. There are two locations where a complete clinical record is kept, one in the administration building, where my office is, and another on the ward where the patient is located. I didn't tell you, but there is also on duty in addition to the clinical director at night a physician who makes calls all over the entire hospital. He then has access to the records at either location as would the clinical director.

Mr. REISINGER. Well, now, from these files it would be entirely practical to determine, at least in terms of the reason for commitment, whether the individual has a proclivity toward shoplifting or rape?

Dr. CAMERON. Quite so.

Mr. REISINGER. Would it then not be practical to make this determination and communicate that fact to the Police Department so that you have a responsible official determining whether a special effort should be made to apprehend the escaped person?

Dr. CAMERON. We ordinarily tell the police when we call him with what the person had been charged when he came in.

Mr. REISINGER. I see. So there would be, then, no objection that you see beyond the necessity of avoiding undue alarm in the making of a direct report to communications?

Dr. CAMERON. No. That, as I see it, is largely an internal matter within the Police Department and if they want to reexamine these

procedures we would be happy to consult with them about any change in procedure they might wish to make, so we could examine what the effect would be on us.

Mr. REISINGER. You would agree to the general proposition that it would be highly desirable to have the most responsible police official in immediate contact with the case where the more dangerous criminal is involved?

Dr. CAMERON. You are asking me to judge within the Police Department who is the most responsible official and I think I will pass on it, if you don't mind.

Mr. REISINGER. View it in this sense, Doctor. By virtue of his position I think we can assume the Deputy Chief is a more responsible official than a sergeant as you are a more responsible official than a nursing assistant. This is what I had in mind. With respect to the notification procedure, this would also be of assistance to you, for example, in the case of the feeble gentleman who escaped recently?

Dr. CAMERON. We notified the police that night and the police did find him but we made it quite clear to them in our telephone call we thought this man was not dangerous but we really solicited their earnest help because we were afraid for the life of this man on a cold night.

Mr. REISINGER. So there is also an humane consideration in making available forces to assist you in a search as well as the protection of the public in this particular matter?

Dr. CAMERON. Surely.

Mr. DANIELS. Mr. Goodell.

Mr. GOODELL. Dr. Cameron, when we were at the hospital I think the reaction of the members was that your so-called intermediate or medium security facilities left something to be desired. We looked at the screens you had, the windows, and we saw the place where several of them climbed out and escaped. Are they still at large?

Dr. CAMERON. The six? They are all back, I think, with the exception of one, possibly.

Mr. GOODELL. Do you see, under present circumstances, a conflict between the interests of public safety and optimum treatment for your patients?

Dr. CAMERON. Not philosophically. If a patient is likely to commit an act of violence, it is no service to him or the public to let him commit it, therefore, philosophically, there is no conflict. However, as a practical matter, as I tried to indicate yesterday, it is difficult to provide the environmental controls for these patients in the rehabilitation setting.

Mr. GOODELL. Let me reemphasize the phrase in my question. Under the present circumstances I am not interested in the philosophical as much as I am the practical here. Under present circumstances at the hospital, do you find yourself often facing a decision wherein optimum treatment of a patient does come in conflict with the interests of public safety?

Dr. CAMERON. Yes; surely. This comes up in terms of the number of employees that will be assigned to various wards, those housing so-called prisoner-patients versus other patients, but we have to make these unfortunate decisions day in and day out as long as the staff is short because you also have the rather troublesome question as to

which patients will receive the time and attention, particularly of the professional staff, that you have to devote.

Mr. GOODELL. I am not concerned at this stage with that point. You have maximum security facilities that prevent most escapes and the public is protected.

Dr. CAMERON. Yes, sir.

Mr. GOODELL. You reach a stage with many of these patients where they, in terms of optimum treatment methods, should be moved from maximum security into intermediate security, and at that stage the public is endangered more than it should be because of your inadequate facilities. Is this a true or false statement?

Dr. CAMERON. True if you will add "and also an inadequate staff."

Mr. GOODELL. All right. I recognize that you have other things that could help minimize this danger.

Dr. CAMERON. Yes.

Mr. GOODELL. But I am anxious to get it straightened out here in terms of buildings and facilities. I know you emphasize staff a great deal and this is very important but assuming inadequacy of staff for whatever reasons—salary scale and so forth. I think the Congress would like to provide sufficient facilities to minimize escapes out there in this medium security range.

Dr. CAMERON. I think I understand the thrust of your question and if you are asking me if I think improved physical facilities would help protect the public the answer is "Yes."

Mr. GOODELL. Now, can you be specific?

Dr. CAMERON. I will be repeating somewhat what I said before, but to have an ideal situation—

Mr. GOODELL. Priority for physical facilities was for children?

Dr. CAMERON. Yes, sir.

Mr. GOODELL. As I go down the list you place second priority on the need for 400 extra beds?

Dr. CAMERON. For security purposes.

Mr. GOODELL. For medium and minimum.

Dr. CAMERON. Yes, sir.

Mr. GOODELL. All right, elaborate a little more on that.

Dr. CAMERON. Yes. Ideally one would have for the number of male prisoners we have, at least three different services, one at Howard and two others, into which a patient could be admitted and retained in that service under the supervision of the same nursing and professional staff throughout the entire period of his hospitalization. This would save staff time in that it would be unnecessary for a new professional staff person to get acquainted with the person if he were transferred, as is now the case, but to keep him with the same professional staff throughout that period as he moves from maximum, medium, to minimum security. I honestly believe that the current staff does not try to pass the buck, if you will, to another service when they transfer a patient to that other service, but if the same staff were responsible for the treatment of the patient regardless of his placement in maximum, medium, or minimum security, this would tend to erase any unconscious, if it exists, motive for moving a patient to another place. It would also have the advantage that I previously mentioned of providing for continuity of treatment.

These three units could be housed within a separate subcampus which had some peripheral security. By "peripheral security," I do not mean a 35-foot prison wall. I mean a fence of reasonable substance, far enough away from the buildings so that if a patient were working or was close to the fence you would have some reason to wonder why he was there and start your inquiry as to what he is up to before he tries to leave the security area.

Mr. GOODELL. You are talking about a fence that would surround all three?

Dr. CAMERON. All three; that is correct.

Mr. GOODELL. This would presumably apply primarily to your minimum security people, the fence?

Dr. CAMERON. No; you would have your maximum and medium facilities within this peripheral security and if anyone left the maximum security area, there would be the additional fence.

Mr. GOODELL. I see; all right. What do you have around your medium security?

Dr. CAMERON. The same fence. The medium and maximum would be provided primarily in the building and the minimum would be provided by the peripheral fence.

Mr. GOODELL. All right. Now, how many buildings are you talking about?

Dr. CAMERON. I am talking about three.

Mr. GOODELL. You want a maximum building, a medium building and a minimum building?

Dr. CAMERON. No, sir; I do not. I want three buildings each of which has maximum, medium, and minimum within it, so the patient can stay with same staff throughout the entire period of his treatment. This would mean we would have to modify the structural arrangements in John Howard to accommodate this concept.

Mr. DANIELS. How many beds would that entail?

Dr. CAMERON. About 800 beds; with approximately 400 in John Howard and 400 new beds.

Mr. DANIELS. You would require two additional buildings?

Dr. CAMERON. Of approximately 200 beds each.

Mr. DANIELS. Of 200 beds each?

Dr. CAMERON. Yes.

Mr. DANIELS. And do you have any idea of what the cost per bed would be?

Dr. CAMERON. Yes; this would be a very rough estimate, but it would come out to be about \$18,000 to \$20,000 a bed.

Mr. DANIELS. Is the area where the John Howard Pavilion is located presently practical for these two buildings and the wall?

Dr. CAMERON. It would not be a wall; a fence. It would be a pretty tight thing, Mr. Daniels, because there is not a great deal of additional area on that part of the campus. Some of the more obsolete buildings on the west side of the campus can, I hope, eventually be torn down and if they were torn down that would be the preferable site but I am afraid they can't be torn down in time to provide, within the next very few years, the space that would be needed for the subcampus about which we are talking.

We have not had the architects look at this section of the campus with us to determine the feasibility of adding two buildings of that size in that area, that is in the area adjacent to John Howard, but it is pretty tight.

You may recall that John Howard is on the edge of a ravine and if the ravine were filled it would be fine. That would result in a much higher building cost, to fill the ravine and put in the necessary piling that would be required in that kind of a new fill.

Mr. GOODELL. Ideally, Doctor, what is the difference between a maximum security and medium security service, as far as security aspects are concerned?

Dr. CAMERON. Maximum is John Howard and medium is primarily the issue of class B status, about which Mr. Reisinger was asking me awhile ago.

Mr. GOODELL. What kind of facilities are we talking about here?

Dr. CAMERON. This would be a facility which, when you locked it up at night, you would be reasonably sure that no one was going to leave, but the major security for class B patients is provided by personnel rather than physical facilities, but the physical facilities do contribute very substantially, as you know from looking at the inadequate facilities on the west side service. The physical facilities would prevent the people leaving by pushing out a screen, would prevent the people crowding past someone by pushing out the door, because you could have a double door system but it would not prevent someone from running off from a person who was accompanied elsewhere on the grounds, except if you had this whole thing within the peripheral security that I mentioned, and if he ran off within that he has one more barrier before he leaves.

Mr. GOODELL. Screens and doors do not, offhand, seem to be very expensive item in terms of protecting the public. If you have inadequate screens and doors cannot these be installed within your present medium security buildings?

Dr. CAMERON. We do have, in the two wards on the west side, so-called detention screens which are quite satisfactory for most purposes in a psychiatric hospital. They are obviously not satisfactory in connection with some of these patients because those screens can be penetrated.

Now, if you are going to try to provide security so that nobody can get out the window, this means the kind of thing we have in John Howard, windows with tool steel.

Mr. GOODELL. You have said, I think, that with better doors and with better screens you could prevent them from breaking out and that this should be done and would be done in the optimum facility.

Dr. CAMERON. That is right.

Mr. GOODELL. Now, this does not seem to me to be a very expensive item of installation, is it?

Dr. CAMERON. Well, I think it could be rather expensive.

Mr. GOODELL. Have you recommended such changes be made in your medium security buildings?

Dr. CAMERON. No, sir; in those buildings I hope to put very little expense into them because some day in the not too distant future, they should come down.

Mr. GOODELL. Are you talking, as you did when we were out there, of using such buildings for a period of 15 or 20 years while we continue to have escapes from such buildings?

Dr. CAMERON. I would much prefer rather than to have those buildings have thousands of dollars poured into them for this security feature to have new features built because even if you put in the security features in the old buildings, Mr. Goodell, you would still have an eminently unsatisfactory facility. It really boils down to the question of an architectural study of cost to determine the preferable solution—new versus refurbishing of existing construction.

It would be my judgment, and I am not an architect, that the cost of really making those good functional wards and at the same time providing the security features needed that the cost would probably approximate that of building new facilities. I repeat I am not an architect but this is a dollar-and-cent question which I am, as a physician, not well qualified to answer.

Mr. GOODELL. You are talking about much more extensive revisions than we mentioned, but when you are talking about some of the obvious things such as screens and doors it just does not make much sense to me not to do this immediately.

I would not think there would be such a substantial amount of money involved in such expenditures that it would not be worthwhile for any building that you expect to use for 10 to 15 years. When we were out there, most of the buildings you referred to, you anticipated 10 or 15 more years of use for them?

Dr. CAMERON. This is true. Your point is well taken and we will be glad to look into the relative costs of this if you like, Mr. Goodell.

Mr. GOODELL. I think there ought to be a gradation. There may be an ideal building. It might cost a great deal of money to change your present building into an ideal building, but maybe there are some steps that could be taken that would increase the safety factor here and would be minimal in expense.

Dr. CAMERON. I think this is probably true. Whether it would be minimal is something we would have to study to find out. We will check on that. But the point I am trying to make, Mr. Goodell, is that while I agree with you that improved physical facilities will certainly help with this problem, I invite your attention to the fact that the bulk of the escapes or elopements are by patients on the grounds and this is more a people issue than a building issue. I would not wish the Congress to provide the funds to refurbish one of the existing buildings along the lines you are suggesting with the expectation that it would solve the major problem of escapes at our hospital.

Mr. GOODELL. I understand that but the average dumb layman such as myself thinks you ought to have adequate facilities to protect the public first and foremost. We understand you need personnel and, in the process of medium security, you need people watching them. We want to provide you with what is sufficient for public safety. Ideally, obviously, we want to provide you with all the personnel you need to get the people back into home environment and into society. We want to provide them all but most of us feel the first and foremost thing is to provide you with the obvious physical facilities necessary to protect the public to the extent physical facilities can protect the public.

Dr. CAMERON. I agree with you on the point and I am not trying to argue the point with you, but if we speak of protection it can be done with people a lot faster than it can be done with buildings.

Mr. GOODELL. You worry me because you always bring up people and staff in connection with this, as though that is an alternative. It doesn't seem to me to be an alternative to physical facilities or even relevant. There are certain physical facilities, it seems to me, you ought to have out there to provide protection for the public. Now, you will have no argument from this subcommittee or, as far as I know, from anybody, that you need more personnel, too.

Dr. CAMERON. I agree with you.

Mr. GOODELL. Doctor, you interested me when you talked about the ideal facility containing maximum, medium, and minimum services. Why was John Howard designed as maximum alone then?

Dr. CAMERON. Since I didn't design it, I can't answer from personal knowledge, but my guess would be that the most urgent need at that time was felt to be for maximum security and I would suspect that was probably true. Old John Howard Hall was only 186 beds. It was too small and the new one is considerably larger and a much better physical facility.

Another thing that has happened since that building began to be designed. There is an increasing recognition of the importance of continuity of treatment for patients by the same staff throughout their entire period of hospitalization and this is, in essence, a new factor that has been added to our thinking now, which may not have been in the thinking of those who designed that particular building.

Then there is also the question of how much money the then existing staff was able to obtain for what it thought was needed. I am sure you are well aware that as buildings are constructed, or anything else is done, for that matter, compromises are inevitable around the issue of funds.

Mr. GOODELL. Well, I think we are talking about, we agree we are talking about an ideal type of facility and we want to eventually have that type of facility. We might do better concentrating our funds to build it right originally than to do it haphazardly and then try to add on as we go along. It seems obvious now that to convert John Howard into this ideal type of facility including medium and minimum, there is going to be considerable more expense than to have built a structure originally in that form?

Dr. CAMERON. Yes.

Mr. GODDELL. That is all.

Mr. DANIELS. Dr. Cameron, you testified earlier you have 30 guards plus or minus 4 or 5 which would envision a total of about 26 to a maximum of 35. These guards are used on three shifts?

Dr. CAMERON. Yes, sir.

Mr. DANIELS. How many guards are used on the day shift?

Dr. CAMERON. I can answer that question in this manner, only one gate is open—

Mr. DANIELS. In the hours stated you have three different shifts. Can you give me the number of hours and the number of guards?

Mr. MADDEN. I couldn't give it now but I could give it for the record.

Dr. CAMERON. Could we give it for the record? As Mr. Madden says, one gate is open 24 hours a day, two gates are open two shifts a day and three gates are open one shift a day and of course at John Howard that is manned around the clock and this is one person in the sally port. That takes 4.8 people to man that one position in John Howard Pavilion.

The thrust of your question, if I understand it correctly, is, What do we need in the way of guards to prevent escapes? It is not guards, it is nursing assistants, because the only place the guards really have any control at all over escapes is at the sally ports in John Howard Pavilion.

Mr. DANIELS. Of course, there is a procedure to be followed.

Dr. CAMERON. Yes.

Mr. GOODELL. There is no need for anybody to go over the fence when they can go out the gate; is that not correct?

Dr. CAMERON. They can go out the gate or go through the openings in the fence. There are a lot of places on the grounds that are not fenced.

Mr. DANIELS. Well, is it your opinion that the present staff of guards is sufficient to take care of the entire population of the hospital including both the civilian as well as the prisoner patients there?

Dr. CAMERON. As far as the guards are concerned, if we need additional ones it can be measured in terms of 5 or 10.

Mr. DANIELS. But the point of my question is, Do you have an adequacy of guards presently employed at the hospital?

Dr. CAMERON. With as few as 5 or 10 additional it would be ample for the kind of functions that the guards perform. To accompany patients to and from their wards is not the function of the guards, but of nurse assistants, personnel who must go through a rather substantial training program relative to the mentally ill, which the guards do not necessarily have.

Mr. DANIELS. How many nurse assistants do you have?

Dr. CAMERON. There are in the order of 1,500 to 1,800. I will give you a more precise figure in a moment. The nursing department has 2,100 employees, of which slightly over 300 are registered nurses. There are probably 50 or 60 others in there. It is about 1,700 or 1,800 nursing assistants, Mr. Chairman.

Mr. DANIELS. Do you feel that group is sufficient to do this?

Dr. CAMERON. No, sir.

Mr. DANIELS. How many do you feel would be necessary to fully augment your staff?

Dr. CAMERON. Approximately double.

Mr. DANIELS. Mr. Reisinger.

Mr. REISINGER. Doctor, is there any utilization made of the licensed practical nurse at the hospital?

Dr. CAMERON. Yes, sir, we do employ some and we try to get them when we can find them. These people, when they come to the hospital, are not required to go through the full basic training program made available to other nursing assistants trainees.

Mr. REISINGER. I see. They would be what?

Dr. CAMERON. They are relatively few in number within the hospital.

Mr. REISINGER. They would be utilized as nursing assistants?

Dr. CAMERON. Yes, sir.

Mr. REISINGER. That is a job category you officially have, nursing assistant?

Dr. CAMERON. Yes, sir. Nursing assistant performs essentially the functions in a psychiatric hospital that you would think of for a practical nurse in a general hospital and our nursing assistants are taught not only procedures relative to the mentally ill but the procedures for caring for the physically ill as well.

Mr. REISINGER. Would the end result of your training program develop personnel capable of qualifying as licensed practical nurses in the nursing system training program?

Dr. CAMERON. No, sir; that has not been an objective. Our training program is a little less than the practical nurse would get relative to some of the physical problems and substantially more, very substantially more than a licensed practical nurse would get in the psychiatric field and it is that part we have to give the licensed practical nurse training in when she comes on duty.

Mr. DANIELS. This will conclude our hearing today and I want to thank you on behalf of the committee for coming here and testifying and giving us your views. You have been most helpful. I am sorry that we have not been able, and time does not permit us to get to the other two witnesses and I am wondering if Dr. Barton and Dr. Billett are here and whether or not they can return tomorrow morning?

Dr. BARTON. I could, with readjustment of my schedule with the Navy.

Mr. DANIELS. You will let Mr. Reisinger know whether or not you can be here tomorrow morning.

How about Dr. Billett?

Dr. BILLETT. I will be able to be here.

Mr. DANIELS. Thank you.

The committee will now recess until 10 o'clock tomorrow morning.

(Whereupon, at 12:15 p.m. the hearing recessed to reconvene at 10 a.m. Thursday, November 14, 1963.)

ADMINISTRATION AND OPERATION OF ST. ELIZABETHS HOSPITAL

THURSDAY, NOVEMBER 14, 1963

HOUSE OF REPRESENTATIVES,
AD HOC SUBCOMMITTEE ON ST. ELIZABETHS HOSPITAL
OF THE COMMITTEE ON EDUCATION AND LABOR,
Washington, D.C.

The ad hoc subcommittee met, pursuant to notice, at 10:25 a.m., in room 429, Cannon House Office Building, Hon. Dominick V. Daniels presiding.

Present: Representatives Daniels and Goodell.

Also present: Emory W. Reisinger II, counsel for the subcommittee; Dr. Deborah P. Wolfe, education chief, and Gail Smith, subcommittee clerk.

Mr. DANIELS. The committee will come to order.

Our first witness this morning is Dr. Walter Barton, medical director of the American Psychiatric Association.

Dr. Barton, will you step forward to the witness chair?

STATEMENT OF DR. WALTER E. BARTON, MEDICAL DIRECTOR, AMERICAN PSYCHIATRIC ASSOCIATION

Mr. DANIELS. Dr. Barton, as you know, my colleagues and I are attempting to evaluate the role of the full committee in assessing the future of St. Elizabeths, the organization and operation of which is the legislative responsibility of the Committee on Education and Labor.

We have asked you to be with us today with the thought that your broad knowledge of the entire field of mental health would enable you to suggest to us areas of inquiry which might be valuable in determining how we might best exercise the responsibility invested in the committee.

Dr. Barton, you may proceed. Do you have a prepared statement?

Dr. BARTON. I do.

Mr. DANIELS. You may proceed, sir.

Dr. BARTON. Mr. Chairman and members of the committee, the American Psychiatric Association appreciates the expressed interest of your committee in the mentally ill offender. There is little precise, recorded knowledge on the problem. The field needs exhaustive study and there are few guidelines on which to begin an investigation.

The APA heartily endorses the declaration of purpose contained in H.R. 9072—

that a program should be undertaken for the improvement of St. Elizabeths Hospital in the Nation's Capital so that such institution will provide an example to other institutions throughout the Nation which are engaged in the treatment of the mentally ill.

The concern of your committee focuses on security measures at St. Elizabeths Hospital for the protection of the public. The American Psychiatric Association desires to help understand the special problems of the mentally ill offender. Too often, acts of violence by mental patients enhance latent fears, perpetuated by folklore that all mental patients are potentially dangerous. This statement is untrue. Most mental patients are not a hazard to the public. This has been amply demonstrated by the fact that most mental patients can be cared for in general hospitals as voluntary admissions in open wards. They also may be treated as outpatients in day hospitals and in community centers with safety both to patients and the public.

Admissions: Should a person indicted for a crime, found guilty of a crime, or imprisoned for a crime be admitted to a mental hospital for observation? Should the initial examination be made in jail? Should the individual be observed and examined in a prison reception center? When should exceptions be made so the examination is conducted in a mental hospital ward?

The public has acknowledged the diminished responsibility of children, of the retarded, and of the mentally ill. In the latter instance, in the District of Columbia—

the person is not responsible for criminal conduct if, at the time of such conduct as a result of mental disease or defect, he lacks the substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of law.

If observation of the indicted or of the convicted criminal is to be in a mental hospital, what degree of security should be provided? Will this security differ in any way from the management provided the non-criminal patient? Will all offenders be treated identically without exception? I raise this point because some all-open hospitals refuse the admission of the criminal offender unless the judge assumes the responsibility of directing that the patient shall be accepted. Under the circumstances of lack of security sometimes in those instances in some States a police guard is assigned by the court to be with the patient at all times and provides that measure of security.

If exceptions are made, on what criteria will they be based? Should criteria be based on the nature of the crime or upon the degree or type of mental illness that is responsible for the patient's behavior? Is it proper, one might ask, from the public's viewpoint, that a Government worker be sent to St. Elizabeths Hospital for treatment of a depression when that hospital also admits the criminal with a long history of arrests culminating in some major offense which on this occasion is excused by reason of mental illness? If both types of individuals should be admitted, should they be cared for, at any time in their period of treatment in the same ward? Should there be a separate facility for District of Columbia mentally ill offenders apart from St. Elizabeths Hospital? Should St. Elizabeths Hospital admit only Federal prisoners?

Security needs: Experts disagree as to the degree of security needed to manage mentally ill patients. Some would admit all new patients to locked wards. Some experts contend that even the most disturbed and aggressive patients may be safely managed in the open wards and on voluntary status. This is possible when modern therapeutic measures are promptly applied. It also requires the presence of an ade-

quate number of qualified personnel. It has been demonstrated that within hours, even suicidal or extremely hostile and aggressive patients may be managed under this routine.

It is also acknowledged that basic character traits and antisocial conduct may persist after the successful treatment of mental symptoms. The inadequate "sow's ear" is still inadequate and does not become a "silk purse." The retarded patient is no brighter or better able to make decisions that will keep him out of trouble after successful treatment for a superimposed mental upset. The shiftless and lazy remain unproductive. The individual with poor control of his impulses may fly off into rages after his illness has cleared. Those with a history of antisocial acts such as stealing or assault may continue to show these traits after the symptoms of their mental illness are removed.

Treatment needs: No useful purpose will be served to elaborate, at any length, upon therapeutic measures employed in the public mental hospital for the mentally ill offender. It may be said that usually the patient is admitted into a treatment setting where the attitudes of staff and employees create a supportive milieu. Routines are structured at first and an effort is made to reeducate the patient to adopt acceptable social values and to adopt conforming behavior. Social and vocational rehabilitation is undertaken to attempt to overcome residual handicaps of his disease. Under this regimen, most mentally ill patients respond. Those who do, show a progressive capacity for assuming responsibility for their own management and demonstrate inner controls. This diminishes the need for external controls provided by the personnel and facilities. There is a push forward to return to healthy living with a progressive loosening of all restrictions and restraints.

Group therapy, dietary and physical treatment, drugs, patient government and training in self-management, patient social activity committees, work assignments, and work with families are all a part of the therapeutic management. Many patients arrive at a point where they may be safely managed in an open ward. There are two elements in the decisionmaking process essential in the move from a closely observed and structured routine, often in security surroundings, to locked ward management or to open ward management. The two elements are (1) professional judgment, and (2) observation by trained personnel.

Professional judgment views the patient's attitude toward authority, his intellectual capacity, his attention and concentration, his attitude toward himself, the concept he has of himself as a worker and conforming citizen, and his attitude toward others as demonstrated by his ability to relate to the group.

Observation by personnel examines the patient's behavior in everyday situations. It is geared to detect changes in behavior or unusual responses to stressful situations. For example, a "Dear John letter" may undo weeks of therapy in an hour's time.

The risk of escape increases with the movement toward greater reliance upon self. Practice in living requires that the individual take responsibility for his own management. These steps are incompatible with security. The judgments that are made to loosen restric-

tions are highly personal. Sometimes they are correct; occasionally, they err.

The extent of the crime is not a suitable criteria for movement. It is interesting to note in passing, that a woman who murdered her husband worked in my own home for many months while my own children were growing up. I had confidence in my own professional judgment and in that of my colleagues. A psychiatrist can usually also identify some individuals as not deterable from acts of violence. Persons in this category often occupy the maximum security prisons that are built to contain them. When their sentence expires, they often return to a criminal career.

Between the extremes of patients in whom we have a high degree of confidence that he will not repeat his crime and those individuals whom we believe will resume their criminal careers is a group of individuals about whom we are uncertain. It is this intermediate group in which the risk of escape is considerable. There is every desire to protect the public from harm and yet at the same time, do no injury to the patient. The public releases a Leopold even though in his youth he committed a most dastardly crime. The sentence given a mental patient must not be more severe than that of a nonpsychotic criminal. The public is equally indignant when persons are "wrongfully confined in the mental hospitals." The goal then, is the reduction of escapes of persons who are potentially dangerous.

How best to classify the mentally ill offender: There are several factors of importance. First we may look at the facility. Maximum security wards have built into them all safeguards that a structure can provide to limit the possibility of escape. The John Howard section of St. Elizabeths Hospital is a good maximum security unit. It compares favorably with any in the country. It probably could also be said that its few escapes compare favorably with escapes from prisons where greater security features are presumably offered.

The locked ward is an intermediate step in management. Strong peripheral security is desirable. There is reliance on detention screens in windows and secure, locked doors. More importantly, there must be alert qualified personnel on hand in sufficient numbers.

At some stage, the mentally ill offenders will be ready for open ward care. This corresponds with the trusty in jail who is given his freedom on demonstrated cooperation.

Principles in therapy: Continuity of care has been demonstrated as more effective in promoting recovery from mental illness than the transfer of patients from ward to ward and from one group of personnel to another. There is a tendency, even among qualified personnel, to sidestep trouble and transfer a patient who is troublesome. If this route is open, it is sometimes used to the disadvantage of the patient. Therefore our most modern psychiatric facilities are being constructed to allow the same psychiatrist, nurse, and team to follow the patient through his progressive stages of improvement.

Because of the role of therapy and of judgment, highly qualified professionals are essential. They are most difficult to obtain in sufficient numbers to be maximally effective.

In different parts of the country different patterns of care are favored. For example, a security ward may be a unit in a mental hospital as in Fulton State Hospital in Missouri. The facility for of-

fenders may be a section or a building not unlike other patient buildings except that it may have strong peripheral security provided by a fence or wall and guards. This is true at Augusta State Hospital in Augusta, Maine. St. Elizabeths and Trenton State Hospitals in New Jersey are examples of well-run maximum security buildings, that provide the facilities of a modern prison, in a mental hospital.

Some States provide separate institutions for the management of the criminal offender. Examples are Patuxent in Maryland, Dannemora State Hospital in New York for mentally ill felons, Mattewan State Hospital in Beacon, N.Y., for the mentally ill offender charged with petty crimes, Albion State Training School in New York for female defective delinquents, Napanoch State Training School in New York for male defective delinquents.

When there are separate facilities, it is possible to provide strong peripheral security. Within this security perimeter, a maximum security unit, locked wards, and open wards are available together with facilities for work, recreation and for treatment. One of the disadvantages of such an institution is the great difficulty in obtaining staff. Psychiatrists and other mental health workers, who are in short supply, choose not to work with the criminal patient. The professionals much prefer to treat acute mental illness in community general hospitals. As a record level of choice, mental health professionals elect to work in mental hospitals near their place of residence. It is difficult to staff any chronic disease hospital. It is particularly difficult to find qualified persons who will dedicate themselves to the criminal offender, most rejected of all among the mentally ill. However, a separate facility does solve many of the problems that beset an institution such as St. Elizabeths. When a maximum security unit is on the grounds of the mental hospital, the public's alarm over escapes is always greater. The crime committed by the recidivist is translated into the fear of all mental patients as potentially dangerous. This attitude defeats the objectives of early entry into treatment causing delay in getting to the hospital.

Some summary statements about important aspects of the problem of the mentally ill offender:

1. Criminal acts committed by patients released from mental hospitals. A 1962 New York study surveyed 10,247 male patients released from State mental hospitals. These patients were followed for 6 years after release. It was found that the arrest rate for ex-patients was far lower than that for the general population—122 per 10,000 for ex-patients; 491 per 10,000 for the general population.

The released mental patient is less likely to be arrested than is the so-called normal individual in the general population. Some of the other findings of this survey are equally interesting. Patients who had been in a mental hospital who had a prior record of arrests have a rate of rearrests that compares favorably with figures available for persons in the general population who have an arrest record. This would tend to show that mental patients behave like the sector of the population from which they come. If they have been mentally ill and have had previous arrest records, their records after release are no worse than those who have not been mentally ill. Another finding was—

the more obvious the evidence of mental illness during hospitalization, the lower the rate of of arrest after release.

This highlights the fact that the sicker patients from the standpoint of mental illness have an even lower rate for arrests than do "normal people."

2. A Baltimore group, Rapoport, Lassen and Gruenwald, in June of 1962, studied patients who had had court sanity hearings. It was not possible from their findings to select in advance of release that group of offenders who could not adjust in the community. In their series none of the patients, regardless of how released, committed any so-called serious crimes such as murder, rape, arson, or aggravated assault. This finding confirmed a similar study made by Dr. D. Hastings of Minnesota in 1958. It was true, however, that only 30 percent in the group were doing well and 70 percent of the hospitalized offender group after release made an unsatisfactory adjustment. Many were involved in minor assaults, auto accidents, thefts, and burglaries.

3. Addison Duval, formerly of St. Elizabeths Hospital, now the Director of the Department of Mental Health in the State of Georgia, has drawn attention to the deplorable conditions under which the insane offenders are cared for in some mental hospitals and has recommended that acceptable standards for care be set up.

I might say that the State from which I come, Massachusetts, has one of the deplorable institutions referred to by Duval.

4. Boslow and Kohlmeyer, studying the Maryland defective delinquency law, followed patients released for 8 years. Up to that time 81 had been paroled in all, about 15 each year. Of those studied, 51 percent violated their parole. However, of those who did violate, only 28 of 41 committed a new offense. The national anticipated recidivism rate for criminals is somewhere between 65 and 70 percent.

5. There is little recorded information in standard works of psychiatry about the mentally ill offender. For example, in the most comprehensive "American Handbook of Psychiatry" (S. Arieti, editor, Basic Books, New York, 1959) there is no mention of the management of the criminal mentally ill patient. There is no mention in the APA standards for hospitals and clinics of any standards for the criminally insane except to indirectly suggest possible classification according to behavior. There is no reference made to this problem in the standards of the Joint Commission on Accreditation of Hospitals by which all U.S. hospitals are evaluated and approved. Most standard textbooks of forensic psychiatry such as Davidson's "Forensic Psychiatry" (Ronald Press, 1952) concern themselves with the legal aspects of the problem, not the management of the criminal offender after he is hospitalized.

All of this highlights the need for special study of an area that has for too long been neglected.

Recommendations:

1. That a comparative study be made of the effectiveness of the different forms of management of the mentally ill offender with a view to development in Washington, D.C., of a model program that could serve as a demonstration for the various States. They are all struggling with the problem. They would like to find an answer.

2. There is need to study the problem of the mentally ill offender himself:

(a) The diagnosis: For example, at St. Elizabeths Hospital, while the number of patients with schizophrenia is about the same as the

number in civil patients, psychoneurosis, personality disorders, character defects, and mentally deficient occur in greater numbers in the criminal offenders than among the civil patients.

(b) There is need to understand the types of individuals who comprise the criminal group as a guide to management. For example, at St. Elizabeths, when the criminal group is compared to the civil population, the criminal patients number more males, more colored, more single, more in the lower educational levels, more unskilled, and more with a history of antisocial acts. Social factors have been inadequately studied.

3. There is a need for the development of standards of excellence against which the performance of any particular hospital facility for the mentally ill offender may be judged. These measures of therapy, of rehabilitation, of the number of patients released and effectively restored to productive living and measures of incidents that endangered the public.

4. There is need to study the future role of St. Elizabeths Hospital in relationship to the mental health program of the District of Columbia. Such a study is currently underway in the Department of Health, Education, and Welfare, and in the Health Department of the District of Columbia.

5. There is need to study the management of such problems as alcoholism, drug addiction, and the criminal offender in the general population as well as its relationship to the mentally ill offender and addict confined in St. Elizabeths Hospital as part of the total health problem and not a separate fragment, just the mentally ill.

6. It is essential to determine what proper staffing standards may be for such categories of personnel as guards, nurses, rehabilitation experts, and professional mental health experts in the sections for care of criminal patients.

7. Study should be directed at the size of St. Elizabeths Hospital, both present and future. Already, St. Elizabeths Hospital has over 6,000 patients. The Joint Commission on Mental Illness and Health, reporting to Congress, held that not a single bed should be added to a mental hospital that already had 1,000 beds. It suggested that, in the transition period, larger hospitals might be subdivided into independent administrative units. When applied to St. Elizabeths Hospital, one might ask such questions as the following:

Should St. Elizabeths Hospital comprise only that section of the whole that cares for the mentally ill?

Should Howard Hospital be exclusively for the mentally ill offender and be a complete and self-contained unit within a peripheral wall or fence—an institution within an institution?

Should there be a portion of St. Elizabeths Hospital that serves Northeast Washington as its Community Mental Health Center?

Should there be a children's division for the mentally ill and emotionally disturbed child?

As an alternate to such development, should these four subdivisions (among other possible subdivisions) actually constitute separate institutions, located in different parts of the District? For example, should the hospital for the mentally ill offenders be entirely separate from St. Elizabeths Hospital and, instead of building or remodeling facilities on the grounds of St. Elizabeths, be erected as a new institution in a new location?

Mr. DANIELS. As to the last question you propounded, what do you recommend?

Dr. BARTON. These are questions being raised for study. I would think that it would be premature to give any recommendations until there had been a thorough opportunity to study both the projected plan for St. Elizabeths future and the District of Columbia health plan for its future. When one has the data in, one can arrive at the answers to such fundamental questions.

Mr. DANIELS. Dr. Barton, I take it from your testimony that there is insufficient knowledge and study on this question of mental illness as it affects not only criminal patients but civil patients as well; that it requires a very, very extensive survey and study.

Dr. BARTON. That is true, Mr. Chairman. The lack of knowledge is evident at almost every point and I raised far more questions than I could answer.

Mr. DANIELS. Yesterday, Dr. Cameron appeared here and I believe you were present in the room while he was testifying and a question arose as to whether or not John Howard Pavilion ought not to be divided into three separate security sections, (1) a maximum security, (2) intermediate security, and (3) medium security; all housed in one building. He felt that the needs of the District, as well as the Federal Government, might necessitate the construction of two additional buildings of the same type requiring an additional 200 beds in each or a total of 400 additional beds. What is your thought on that question?

Dr. BARTON. You will note the agreement in my statement of the desirability of continuity of care by the same team through multiple facilities. You will also note that I made the comment that it was not to have three levels of facilities, just as Dr. Cameron indicated—maximum security, an intermediate locked ward facility and an open-ward management at the other end.

I also suggested that this combination of facilities is easier to provide with greater safety to the public when there is stronger peripheral security, a fence or a wall around the perimeter that limits motion of the patient beyond that while loosening the bonds of freedom. This has been accomplished with great success in some locations.

However, when you do this and construct such a separate institution, you increase the difficulty in getting the staff to work it.

Mr. DANIELS. I noted that in your testimony today. So there would be a recruiting problem because of the limited number and type of patients, and the lack of interested trained personnel to staff such a hospital.

Dr. BARTON. I would hesitate to extrapolate that quite so sharply as you have for the reason that we are talking about a unique situation: the District of Columbia is a compact area. Even if a separate institution were created the distance from the population center would be very slight in comparison with the kinds of problems faced by other States so that it would still merit serious thought as to whether or not the institution should be within the institution of St. Elizabeths or a separate institution somewhere else. I am not prepared to say which is the better choice of alternates without further study.

Mr. DANIELS. Do you believe that the participation of the public or lay personnel in an institution of this type would broaden the understanding of the public in this matter?

Dr. BARTON. I am most enthusiastic for that point of view. Having run a mental hospital for many years, I found that the volunteer contributed enormously not only to the actual service brought to the patients but to the public understanding which I felt was much more important in the long run. People work in the hospital; after all they are experts and they know what goes on there and they translate it into vernacular of the public so it is understandable.

Mr. DANIELS. In what capacity could the volunteer participate most effectively?

Dr. BARTON. Almost all levels. Let me begin by giving you just a few examples of the range and most importantly from the medical standpoint are medical volunteers, physicians of all specialties who donate their services so that patients, the public domain, get better quality of service, medical and psychiatric. This was enormously helpful to me in Boston when I ran the Boston State Hospital. I had help from the entire medical society and during the critical period of building a staff I couldn't have gotten to the level I got without their help.

Second, one uses the help of opinion formers, the molders of opinion, the true leaders of the community, to get an enterprise underway. When you wanted to extend the hospital services into emergency home treatment and into the community itself, into the neighborhood house, providing psychiatric service there, I found that the professionals that one ordinarily turns to didn't really have the power to build community opinion.

The leader of the neighborhood is a dedicated fellow and likewise the judge on the bench and the policeman at the station, but what you really need to find is who are the people in the community that help form opinion. Some of the strangest people develop as leaders of the community. The head of a big grocery store and a barber in another area turned out to be key people in building community support for a new service and those individuals, like the good ladies from Concord, Mass., who came in and redecorated wards, actually helped patients in the fundamental development of milieu therapy, so at all levels, in other words, and in this kind of hospital as well.

Mr. DANIELS. What is your opinion about the commingling of criminal patients with civil patients; and of children and narcotic addicts in the same hospital?

Dr. BARTON. Here I get into some of my own personal biases. I am strongly in favor of the separation of the criminal offender with multiple arrests from the general population. Now I must qualify. We psychiatrists never can seem to say yes or no. Let me give you an example. If a woman becomes depressed and during her depression she injures her child and that child dies, she is guilty of murder in the eyes of the law. In the eyes of the psychiatrist she is very likely not going to repeat her act and she would be treated like any other depressed patient. In my view she would go to the mental hospital section. This requires very careful screening to make decisions. But if you allow for such exceptions, and there would be many, then I would favor a separation of a certain type of repeater in crime from the general patient. I would also separate the emotionally disturbed children below the level of adolescence from the adult person who is mentally ill.

Mr. DANIELS. Mr. Goodell.

Mr. GOODELL. Not the adolescent?

Dr. BARTON. Here we get into one of those disagreements among psychiatrists. There are those who favor separate units for the adolescents, with good argument. The major concern of most adolescents is going to school and learning an occupation, but not the same type of rehabilitative efforts are presumed as the adult needs who had already had an occupation.

There are others who contend, however, that it is far easier to manage a few adolescents on an adult ward than when you put them all together. When you get five or six, you can have a rat pack that will upset a hospital.

Mr. GOODELL. Is this your criteria in the management of the patient?

Dr. BARTON. No; it is actually what you can do for the patient in changing his way of looking at life. What you have to do is change his attitude toward authority and change his values system and make them identify more closely with your own values system.

Mr. GOODELL. I assume the application of your answer was ease of management, as the primary criterion?

Dr. BARTON. No; I am implying the therapeutic ease of management as well.

Mr. GOODELL. Well, you certainly would agree, I presume, that in certain types of patient selectivity, maybe adolescents would not be wanted?

Dr. BARTON. You see, this kind of patient who gets into the hospital is a social misfit of high order. Usually, he had serious difficulties if he falls into the criminal offender group of adolescent.

Mr. GOODELL. Frequently, in certain types of mental patients, the fact that he got into criminal difficulty, the only distinction between him and the man who didn't get into criminal difficulty, in many instances, the accident that he got caught or was in a channel which resulted in behavior where he was picked up is the only distinction, is it not?

Dr. BARTON. Well, I am presuming that he developed a mental illness. Here, I can't categorize all patients. Maybe we are saying the same thing, I am not sure. I can't categorize all mental illness under one heading.

Mr. GOODELL. I agree with that. I am trying to be selective, also.

Dr. BARTON. Here are the schizophrenics who form a very real kind of separate entity.

Mr. GOODELL. But there are certain categories of criminal mental patients that you would find it very difficult to distinguish from the noncriminal mental patients for psychiatric purposes?

Dr. BARTON. They would have identical symptoms mentally; yes.

Mr. DANIELS. I noted your remark that John Howard Pavilion at St. Elizabeths Hospital is a good maximum security unit and compares favorably with other institutions of our country, especially that of Trenton State Hospital. I was glad to hear you mention that because Trenton is the capital of the State from which I come. Are there any other outstanding institutions in the country that you have knowledge of?

Dr. BARTON. I put down those which are the better ones. One hesitates to widen the list without firsthand knowledge. I prefer to let it stand as it is.

There are undoubtedly others I have not mentioned but I don't know how they rate.

Mr. DANIELS. Mr. Goodell.

Mr. GOODELL. What, in your personal professional view, is the role of punishment in terms of crime?

Dr. BARTON. Well, I believe human behavior is shaped by rewards, by praise, and that one also inhibits certain undesirable traits by disapproval and by punishment so that I feel that it is a counterpart in the shaping of human behavior and conduct.

Mr. GOODELL. Not all determining but a very essential factor?

Dr. BARTON. Essential factor.

Mr. GOODELL. You suggested a comparative study of the effectiveness of physical plant design in a mental institution as correlated with the different forms of management of the mentally ill offender. Have there been no such studies made? I would think this would be a continuing endeavor in the psychiatric field among the professors and among the doctors.

Dr. BARTON. I am afraid the criminal offender has had a low priority in the many pressures that are on psychiatrists so that the studies actually have not been made or let us say only a very few studies have been made.

Mr. GOODELL. If your reference is primarily to the criminal patients, then would you say that there is need for this study?

Dr. BARTON. Yes, certainly.

Mr. GOODELL. I wonder if you can't today pretty well predict, in a given group appointed to make recommendations, what their conclusions will be by the identity of the group?

Dr. BARTON. Well, it is possible, I would say, to pick a committee so that they all have a point of view, but you can also pick a committee that you know will run head-on. For example, the District of Columbia's own idea as to how St. Elizabeths might feature in a program as compared with how, for instance, the Federal Government might figure St. Elizabeths future might run, has been interesting to me coming from the outside. They are exactly opposite points of view. How they are resolved will be interesting.

Mr. GOODELL. The District of Columbia Committee?

Dr. BARTON. I am talking about the welfare accumulation of experts looking at the future of St. Elizabeths. They have very divergent backgrounds.

Mr. REISINGER. I don't believe the record shows that Dr. Barton is a member of the Secretary's Advisory Group, Secretary of Education and Welfare Advisory Group on St. Elizabeths Hospital.

Mr. GOODELL. I take it from what you have said here, that there does come a stage where the public must bear a certain risk if the patient is to have a degree of freedom necessary for his advancement in treatment.

Dr. BARTON. That is true, sir.

Mr. GOODELL. Can you elaborate a little bit more on the transition stage from maximum security, where there is no real problem in protecting the public, to minimum security and release?

Dr. BARTON. I doubt if my answer will be precise enough to answer your question.

Mr. GOODELL. Keeping in mind protection of the public here as a very high element.

Dr. BARTON. Let me give you an example. Before this hearing convened today, I was talking with someone in the audience about a hospital we both knew. There were no escapes from the wards of that hospital because everybody was spread-eagled out in a bed tied hand and foot—arms tied to the side of the bed and the feet tied to the foot of the bed. This was done to persons who are depressed also. That is a number of years ago. But also no one ever recovered. They had the lowest recovery rate you could imagine.

Now, today to handle a depressed patient, applying treatment from the moment the person steps into the hospital, he might be cared for on an open ward from the very moment he came into the hospital even though he were suicidal. You would alert the nurse so he would not be left alone but he would be cared for in an open ward and the figures thus far have shown there have been no increase in the suicidal rate even though there is never a locked door around the person that is depressed.

What is more important is that over 90 percent of the patients so treated leave the hospital very promptly in a matter of days, 2 weeks to 30 days, a fair running average for the general hospitals' management of such types of patients today. The difference between these two extremes is what I would now allude to in the other situation. In order to arrive at the point where you increase the recovery potential, you have to build into the treatment the responsibility in the patient for his own self-management. He has to assume you have confidence in him and he has to be willing to change his behavior to please you. If he so does, then you take certain risks to let him demonstrate successfully all the freedom he can manage and as you do that each time you increase the risk potentially to the public because he might walk off or he might even do something to himself but nevertheless in the long run the end product, evaluated by what measures you have to measure progress, will give you a better statistic and a better individual patient result.

Mr. DANIELS. Well, in that situation, it is not a matter of exercise of judgment in evaluating the progress that has been made by the patient?

Dr. BARTON. Yes. You will note in my comment I tried, Mr. Chairman, to indicate two levels on which that judgment was based—the professional level, those who have a deeper knowledge of behavior in the interview situation, actual examinations of the individual, and the opinion that comes from the qualified person who lives with the problem every day. This is the nurse on the ward who is trained to detect changes in behavior.

Mr. DANIELS. Mr. Goodell.

Mr. GOODSELL. Doctor, on page 13 you posed a number of questions to be answered by the study. Can you give us your own answer to any of these questions?

Dr. BARTON. No, I wish I knew the answers. These require serious study and they have not been studied. They have not even been the subject of conferences between experts just to discuss the dimensions of the problem.

Mr. GOODSELL. Well, some of them, it appears to me, that someone of your experience and capability would have a view on it if you were a member of a group to study this. We are going to have to, in this

subcommittee, make determinations of an immediate nature. Do you have any immediate recommendations for this committee?

Dr. BARTON. Let me give you an example of how this might work. When we talk about proper staffing standards I heard Dr. Cameron say yesterday that his goal approached a one-employee to one-patient ratio. If I were to answer this kind of question from my own experience, I would have to know several things. You see, this is why you can't give quick answers. I would need to know what are you going to do on this ward, are you going to provide security but in an atmosphere of inactivity? I can quickly calculate for you the number of people it would require to cover that ward around the clock if you are not going to do anything but just watch people as long as you tell me the number of patients that are going to be confined there. But just as soon as you say you are going to conduct group therapy, you are going to have an active recreation program and you are going to conduct other kinds of therapeutic regimes, then I need to know the extent of your program because it is going to add hours of personnel time and the complexities here defy easy answers.

One needs to sit down and thoroughly study out objectives of each step that you take and they have not been actually studied.

Mr. GOODELL. I understand that. However, quoting from your statement with reference to a study directed at St. Elizabeths, you say:

The Joint Commission on Mental Illness and Health, reporting to Congress, held that not a single bed should be added to a mental hospital that already had 1,000 beds.

Do you agree with that?

Dr. BARTON. Yes, sir; I was a party to the Joint Commission, a member of it and the Joint Board of Directors.

Mr. GOODELL. In other words, you think St. Elizabeths is about six times bigger than it should be?

Dr. BARTON. Far too large.

The United States is saying it believes in larger hospitals than the rest of the world. The world's recommendation is 250 beds but the Joint Commission carefully studying it agreed that a thousand is about the maximum size of such institution.

Mr. GOODELL. If a thousand-bed hospital is the maximum desirable size what is its character?

Dr. BARTON. We are talking primarily about mental hospitals, of course, not just the criminal offender.

Mr. GOODELL. You eliminate all of those we have been talking about who are arbitrarily put in the nonpsychiatric category?

Dr. BARTON. No, I am just saying that the Joint Commission, when it arrived at the thousand figure, was talking about psychiatric patients not criminal.

Mr. GOODELL. I understand but how will you start cutting down St. Elizabeths size? Would you eliminate one section of it or another section of it?

Dr. BARTON. No, I am sure that Dr. Cameron has already given much thought to this. There are several ways in which the problem is attacked. I would begin by looking at admissions. How do you get in? If you want to determine how a hospital is growing you want to first look at the admissions.

I would construct or "develop" is a better word, in the District of Columbia a series of resources that could serve as alternate facilities. Already these changes are taking place admitting those individuals who need to be hospitalized to the general hospital. But I would do more than that because in front of the general hospital comes a whole host of extramural resources that have demonstrated their effectiveness. For example, if you were to apply in the District of Columbia area the home treatment service we developed in Boston you would find that half of the cases that are hospital destined never need to go to the hospital in the first place. So you keep out 50 percent before you begin. I would, in other words, cut down on the admissions. Secondly, I would try to cut down on the patients who are already there. I believe Dr. Cameron has said that there are in his hospital numbers of patients who by his own definition do not belong there, who could be cared for elsewhere. I read in the papers the suggestion that nursing homes, financial arrangements, and so on, be changed so it would be possible to place patients out. Many States have done this and reduced their census considerably. I would increase the activity of rehabilitative activity at all levels in aftercare support, because, as we have become more proficient in shortening hospital stay time, we increase the readmission rate. We have to make certain the patient continues in treatment so he needs an extension of St. Elizabeths into the community to provide aftercare.

My fourth suggestion is contained in the suggestion that in the transition period perhaps it ought to be subdivided into relatively independent units that are of small and manageable size.

Mr. GOODELL. Well, you have come to the point where maybe I am a little arbitrary in interpreting your answer, but I had the impression, listening to you and reading your recommendations that you had an answer in mind for each question you raise, and it seems to me you have pretty much answered those questions.

Now, do you have in mind breaking St. Elizabeths Hospital down into various units? You wouldn't be arbitrary about what the units would be?

Dr. BARTON. No; many different arrangements would be possible. These were just suggested as possible ones.

Mr. DANIELS. Dr. Barton, I believe you have not answered the question that was put before you by Representative Goodell and that is what would you deem an adequate staff for a hospital of 1,000 mental patients as you have recommended in item No. 7?

Dr. BARTON. I can't answer your question, sir.

Mr. DANIELS. Why not?

Dr. BARTON. The whole question of staffing standards within the APA is under study. It has been shown that the new objectives set for mental hospitals no longer permit our old scales to apply. We have not reissued our staffing standards since 1958 as a consequence. We have employed Dr. Francis Gerley, the former commissioner of the State of Illinois and professor of psychiatry at the University of Illinois, to devise a long-range study to get at the proper answers. It is a very complex problem. We know that the preexisting standards no longer will do the job we are requiring of the mental hospital today and we don't know what personnel will be required.

Mr. DANIELS. Do you agree with the opinion of Dr. Cameron that the ratio should be one staff member to one patient?

Dr. BARTON. I would agree that is a good minimal figure but he may be 100 percent off if the objectives reach the same level that some of the general hospital sections are where the staffing ratio already is two employees for one patient.

Mr. DANIELS. Just one further question.

I have introduced a bill, H.R. 9072, which would provide for the establishment of a Presidential Commission to study St. Elizabeths Hospital. The Commission would consist of five members appointed by the President. One would be a representative in the field of psychiatric medicine and another one a psychiatric social worker and third, a hospital administrator and fourth, a psychiatric nursing representative, and finally a person representative of the public. Have you had an opportunity to examine that bill and to come to any conclusions as to its approval or disapproval?

Dr. BARTON. I have had an opportunity to read it and I am heartily in accord with its objectives. If such a committee had access to consultants among the two groups of persons who are not mentioned there, those who have made a special study in the field of law and psychiatry and those who have actually managed the criminal offender, then I think this study could contribute a great deal to your knowledge, which I have indicated is very deficient in almost every area in the field.

Mr. DANIELS. Mr. Goodell.

Mr. GOODELL. Doctor, would you say the bulk of those individuals who engage in criminal activities have some kind of a mental problem, mental disorder—would you call it a personality disorder, a character defect or a psychoneurosis or all the way up to a schizophrenia or something this serious?

Dr. BARTON. I would not agree with such a "wholistic" view. I believe there is such a category in people who are relatively normal. I am sure we all have our quirks and eccentricities but I would not magnify those to say that everybody has a neurosis or everybody has a personality disorder. I think there are plenty of people who can cope with ordinary life stresses.

Mr. GOODELL. Doctor, I was very careful not to say "all," and you converted my question into "all," and I said "the vast bulk." Do you disagree "most of them?"

Dr. BARTON. I would disagree. I would still say most of them are not mentally ill. They may be a product of stressful environment which causes certain ways of behavior but this does not, in my view, and we are talking about my personal view, constitute mental illness.

Mr. GOODELL. We have to get into a definition of what mental illness is. I don't think it is worthwhile to do it here. I appreciate your testimony.

Mr. DANIELS. Dr. Barton, thanks very much for your testimony.

STATEMENT OF DR. SANFORD BILLET, CHIEF, BUREAU OF MENTAL HEALTH, DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH

Mr. DANIELS. Our next witness is Dr. Billet, Chief of the Bureau of Mental Health of the District of Columbia.

Dr. Billet, do you have a prepared statement?

Dr. BILLET. No; I do not.

Mr. DANIELS. All right, sir, you may proceed to testify.

Dr. BILLET. Mr. Reisinger indicated he would have several questions he would want to put to me.

Mr. DANIELS. Well, do you intend to make any statement for our record as to your views on this subject or do you prefer that questioning be presented to you?

Dr. BILLET. I would prefer that questions be asked.

Mr. DANIELS. All right.

Mr. Reisinger.

Mr. REISINGER. Doctor, what is your capacity in the District of Columbia Government?

Dr. BILLET. I am the Chief of the Bureau of Mental Health in the District of Columbia Department of Public Health.

Mr. REISINGER. And what general areas of supervision do you have in the field of mental health at the present time?

Dr. BILLET. The Bureau of Mental Health is primarily an outpatient clinic operation. We have six outpatient clinics. In addition, I have a major responsibility in advising the Director of Public Health in the District of Columbia concerning matters of the care and treatment of the mentally ill and in program planning for the mentally ill.

Mr. REISINGER. Your jurisdiction includes then the categories that we know or we have referred to earlier here as foster homes?

Dr. BILLET. We do have a home finding section in the Bureau of Mental Health. This home finding section does find foster homes. I think it would be appropriate to define foster home. There are several categories of placement available and I think that on occasion there may be some different statistics that are based on different definitions.

A foster home, according to the Department of Public Health and according to the Department of Public Welfare in the District of Columbia is necessarily a home that is found by our home finding section so that any placement made through other channels would not be considered a foster home.

If I may read to you, and this is a definition as of August 4, 1960:

The Bureau of Mental Health Home Finding Division is developing a foster home program for patients who do not have homes with families or relatives able to provide the type of care which will make it possible for them to leave St. Elizabeths Hospital. Social service at St. Elizabeths will continue to utilize regular public assistance programs already established for indigent patients who are eligible and able to use such programs to return into community life. The home finding division is establishing a type of care known as psychiatric foster care whereby home sponsors offer, under the general direction of the Bureau of Mental Health, homes where (1) good health habits in relation to proper amounts of sleep, nutrition, and encouragement in matters of the patient's personal hygiene and maintenance of medical regime are fostered. (2) The therapeutic effort of the hospital is extended into the patient's life in the community. This will include planning with and motivating the patient to expand his sphere of activity or to make community substitutions for facilities offered the patient during hospitalization. There also will be included recreational, religious activities and general opportunities for socialization on an individualized basis geared to the needs and capacities of patients. Home sponsors will be responsible for cooperating with vocational planning including programs under the direction of the District of Columbia's Department of Vocational Rehabilitation and for stimulating occupational or avocational interests on the part of the patients which might lead to a more formal vocational program.

In instances of long-term hospitalized patients without recent community contacts, home sponsors will help acquaint patients with routines of life outside an institution and with changes in the community.

(3) Observation and reports of significant changes in patient's condition are expected. The home finders division will assume responsibility for orientation and education of sponsors in home care of mental patients, will provide assistance to home sponsors in relation to problems encountered with patients behavior or general care, and will maintain a close and coordinated working relationship with the St. Elizabeths social service staff with defined areas of responsibility.

The kind of care provided by home sponsors for mental patients is much more extensive than that provided by the usual boarding home keeper and is entirely different from specialized nursing care. The time, effort, and personal investment required of the sponsors makes it impossible to secure such services at the usual boarding home rates. The home sponsor in the psychiatric foster care are not asked to accept patients who are confined to bed or chair, nor do they offer physical assistance and individual feeding and sleeping rooms—

And there are several other exclusions here.

I read this to point out to the committee that the foster home, according to our definition, is quite different from nursing home, from personal care home, or from room and board arrangements.

M. REISINGER. Would it be a fair statement, in short, that you seek to find a home atmosphere which would offer an optimum family-type relationship for the patient?

Dr. BILLET. More than that. We provide continuing supervision of the home so that, for example, a patient might go into a foster home while still a patient at St. Elizabeths Hospital and then upon discharge from St. Elizabeths Hospital the patient would, say, be followed in an outpatient clinic in the Bureau of Mental Health. Our home finding social worker would offer continuing consultation to the foster home sponsor and would keep an on-going contact with the patient, whereas in a room-and-board arrangement or some other arrangement, I think more often than not, once the patient left the hospital there would be no further contact with the sponsor in the kind of care that was provided, whether it be room and board or some other type.

Mr. REISINGER. What monetary allowance on a monthly basis is available for procuring such homes?

Dr. BILLET. The sponsor receives \$100 and I believe the patient receives a small amount of money, around \$10. Yes, that is the right figure, \$100 to sponsor and the patient gets \$10 for spending money.

Mr. REISINGER. Now, I have two questions. First, at that level, is that adequate to find a substantial number of homes?

Dr. BILLET. It is adequate to find a substantial number of homes. I believe it is not adequate to find the number of homes that might be required if all of the patients at St. Elizabeths who have been earmarked as suitable for leaving the hospital in this kind of setting were indeed to leave the hospital but since the inception of our program in February 1960, we have always had placements available for patients at St. Elizabeths. At no time have we been without available placements and the rate of patients referred for placement has never been up to the level of placements available.

Now this, of course, has influenced our efforts to find additional placements.

If we were to find a foster home and evaluate the home and make arrangements, and frequently this requires a considerable amount of work on the part of our social worker, and then we don't get a placement to put into this home, this becomes quite discouraging for the prospective sponsor and many of them withdraw.

So we have learned not to seek more homes than we realize we are going to need.

Mr. REISINGER. In short, there are presently available homes which you have no patient for?

Dr. BILLET. At this moment, we have 39 vacancies.

Mr. REISINGER. Beg pardon?

Dr. BILLET. We have 39 open vacancies at this moment.

Mr. REISINGER. So there are, at present, presumably 39 patients at St. Elizabeths who could be placed in these homes today?

Dr. BILLET. Yes, sir.

Mr. REISINGER. Is there a breakdown in communication of some character here that results in this situation?

Dr. BILLET. Well, I don't think so. I think that our social worker, Mr. Hicks, is in close contact with the social workers at St. Elizabeths who are involved in the foster care program and that they are very much aware that these vacancies exist. For example, when we find a home that we feel is suitable and investigate the home, a report is sent to St. Elizabeths Hospital so they will be aware of this.

Mr. REISINGER. Of course you heard Dr. Cameron testify yesterday indicating that an increased number of these homes would materially reduce his caseload.

Dr. BILLET. I think Dr. Cameron quite correctly indicated that there are a great many patients who could be placed in homes.

Mr. REISINGER. I see. And at the moment there are 39 such vacancies?

Dr. BILLET. There are.

Mr. REISINGER. Doctor, assuming that some intensive program were instituted to remove patients from St. Elizabeths into foster homes, would you find, or do you think you would find, the present rate adequate to provide as many as 1,500?

Dr. BILLET. I don't think so. I think, as it is, people who participate in this foster home care program are hardly breaking even and I doubt if that many homes could be found.

We tried to estimate how many homes we could find if we suddenly had all of our available vacancies filled. We felt this was a very difficult matter for us to try to estimate.

If we had full utilization of the vacancies, then in an on-going way we could be trying to develop new vacancies, but in fact in the past couple of years we have curtailed our program. Whereas two social workers were authorized in the original authorization subsequently we requested that one of these positions not be filled since there was not sufficient work to be done in view of the small number of referrals.

We have been in operation since February of 1960. In that entire time, a period of almost 4 full years, we have placed only 97 patients in foster homes through our home-finding program—26 of these patients have been placed in the last 6 months. That means in the first approximately 3 years of operation, only about 70 patients were placed through this program.

I might add that we have placed every case that has been referred to us unless St. Elizabeths withdrew the referral.

Mr. REISINGER. Now, I believe the figure of \$175 a month was mentioned in testimony yesterday as a desired minimal allowance for such home placement. Would you feel that with that figure you could perhaps run as high as 1,500 homes?

Dr. BILLET. I think that we could do very well. We might still have some problems. At the current rate, for example, we find that we have difficulty in obtaining homes for white patients if we use a policy of placing white patients in white homes. I think if we raised the amount of money available we could find more homes both for Negro and white patients.

Mr. REISINGER. The authorization to increase the allowance would come from whom?

Dr. BILLET. This would have to be approved so that the Welfare Department would be permitted to provide this larger sum of money.

Mr. REISINGER. Approved by whom, sir?

Dr. BILLET. I presume by the Congress.

Mr. REISINGER. The District of Columbia Committee presumably?

Dr. BILLET. Yes.

Mr. REISINGER. Now, then, would you recommend that this be done?

Dr. BILLET. I would. I think it would be very helpful if the foster care program could provide enough money so that sponsors could at least break even.

Mr. GOODELL. Have you recommended it?

Dr. BILLET. I have not specifically recommended this, but I know that we have for some time let the Director of Public Health know that we are dealing with a marginal fee.

Mr. DANIELS. The District of Columbia pays \$340 for each patient housed in the St. Elizabeths Hospital, is that not true?

Dr. BILLET. That is not exactly true.

Mr. DANIELS. Your recommendation that this fee be increased from \$110 to \$175 would result in a net savings to the District of Columbia of \$165 per patient?

Dr. BILLET. Perhaps under the present method of determining per diem that might be so. That certainly was not so in the past. In the past the per diems were determined by dividing certain costs at St. Elizabeths by the number of patients receiving certain services and if you lowered the number of patients you raised the per diem.

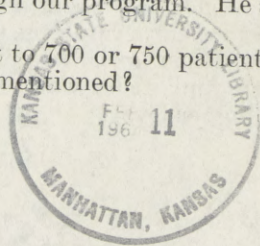
Mr. DANIELS. Under the present arrangement, would it not be advisable to place some of these patients at St. Elizabeths in foster homes?

Dr. BILLET. Under present arrangements and previous arrangements I think we are all in agreement it would be highly desirable to provide patients with the care they need and to provide them with what would be best for them and certainly, according to Dr. Cameron's own statistics, 12 percent, I believe, of these patients would be highly suitable for foster care placement. If we have 5,000 patients who are District of Columbia residents this would be a figure of at least 500 patients who are District of Columbia residents at St. Elizabeths who would be suitable for foster care placement. I think it would be highly desirable to so place them.

Mr. DANIELS. Dr. Cameron stated here he felt that about 50 percent of the population of St. Elizabeths Hospital could be moved out of the hospital. Why is there a difference?

Dr. BILLET. Sir, I believe 12 percent was the figure for foster, or for the kind of home we are providing through our program. He also included nursing homes and personal care.

Mr. DANIELS. That would amount at least to 700 or 750 patients if we take the figure of 12 percent you have just mentioned?



Dr. BILLET. Yes, sir.

Mr. DANIELS. Then I do not understand why only 97 patients have been placed in the past 4 years and 27 in the past year.

Dr. BILLET. I don't understand that either.

Mr. DANIELS. What is the reason; is there a breakdown in communication between St. Elizabeths Hospital and the District of Columbia?

Dr. BILLET. I feel I am repeating myself, but I feel our social worker, who is in our home finding program, has a very excellent relationship with the social workers who are assigned to this program at St. Elizabeths Hospital. Why the patients are not referred is a matter that has been quite distressing to us. We have, in fact, recommended that our program be discontinued for lack of utilization. I have a letter, or a memorandum, that I might refer to.

In November of 1960, the then Director of Public Health wrote a memorandum to the District of Columbia budget officer indicating that there was not proper utilization of the program. This was when the program was about 9 months old. I might point out to you that there has been an average of only about two patients per month referred even though this program was developed because we were led to believe that many hundreds of patients were immediately available for placement.

Mr. DANIELS. What is the date of that letter and to whom was it directed; from whom, to whom, and the date of the letter?

Dr. BILLET. This is a memorandum dated November 15, 1960, addressed to Mr. David P. Herman, budget officer, District of Columbia, from Daniel Leo Finucane, the Director of Public Health. The subject is "Foster Health Program Instituted by the Department of Public Health To Facilitate Discharge of Patients from St. Elizabeths Hospital."

Mr. REISINGER. Doctor, you have taken all the steps that you feel that you can to call this to the attention of Dr. Grant, who I believe is your supervisor, is that correct?

Dr. BILLET. Yes, sir.

Mr. REISINGER. And what steps, if any, have you taken to communicate this condition to the hospital; that is, St. Elizabeths Hospital?

Dr. BILLET. Well, a number of steps have been taken. I have met with Dr. Harris concerning this in the last month or 2 months at his own request and I was recently informed of a meeting that took place between Dr. Cameron, Dr. Grant, and Mr. Brewer concerning this same matter—

Mr. REISINGER. Was this last Friday?

Dr. BILLET. It may have been.

Mr. REISINGER. And prior to that time—by the way, how long have you been in the position you have currently?

Dr. BILLET. Since July of 1962.

Mr. REISINGER. And you made attempts to communicate this condition previous to a month or so back?

Dr. BILLET. Well, I must emphasize that in an on-going way we have, since the inception of this program, kept St. Elizabeths fully informed concerning the number of vacancies available.

Mr. REISINGER. Now, in this sense you mean through contact between your social worker and the social workers at St. Elizabeths or at a higher level?

Dr. BILLET. Well, I have just referred to a memorandum in which it was indicated that the program was not being utilized. I am certain that this has been communicated.

Mr. REISINGER. I see. So that it has gone forward from the budget officer to St. Elizabeths or as far as you know?

Dr. BILLET. I am not able to say that is so. I do know that we have, on occasion, and this was prior to assuming my present position, that it has been recommended that perhaps the program should be dropped for lack of utilization. St. Elizabeths may be providing this through their own organization. Dr. Cameron's figures would indicate to me that they have placed a number of patients through their own organization since only a total of 97 patients have been placed through our program since February of 1960.

Mr. GOODELL. May I clarify this. I don't quite understand. As I understood St. Elizabeths did not have a placement service?

Dr. BILLET. Sir, I tried to clarify this matter of definition. What I mean by foster care program is a program that we have and I believe that the Welfare Department uses the same definition that we use. However, the term "foster care" may have broader definition and I think that Dr. Cameron, when he speaks of foster home care, may be including patients who have their own funds who have been placed in private situations or he may, and I am not certain of this, be including some patients I would consider to be patients that are on room and board and not part of a foster care program.

Mr. DANIELS. He has no authority, if I understand it correctly, to place a patient who is charged to the District of Columbia in a foster home where the District of Columbia is going to be making payment for their support?

Dr. BILLET. It depends on what you mean by foster home. I think he does indeed have authorization to have patients go into a room and board situation. This is as long as the patient meets the welfare requirements for \$67 that are paid, then the patient can receive this. But this differs from our foster care program in that there is no provision for an on-going supervision by a trained worker.

Mr. REISINGER. You are saying he can place them directly as a \$67 public assistance category but they cannot place it in the \$100 foster home category?

Dr. BILLET. That is correct. The foster home category is through our own program. We set this program up because we understood that St. Elizabeths felt not adequately staffed or prepared to do all that was necessary. We offered our assistance and set this program up with their approval. At the beginning of this program or perhaps just before its actual inception, we developed a questionnaire and tried to survey the entire population at St. Elizabeths Hospital to determine which patients specifically might fit into this program. This survey was not completed but we did receive forms on very nearly 500 patients and out of a total of 489 patients on whom we received completed forms, according to St. Elizabeths own estimates, there were 251 patients out of these 489 who might have been considered suitable for the foster care program, yet we received only two referrals a month on the average during the first 3 years of this program.

Mr. REISINGER. Now, in May of this year, or let us put it another way, to your knowledge, Dr. Billet, did you confer with Dr. Grant about this fact or this situation? Have you?

Dr. BILLET. Yes. I tried to go through the various categories with him. I feel it is a very difficult program to understand in that there are these various categories of foster care, nursing home, personal care home, and room and board. I think this can be confusing and frequently someone will be using one term when they should be using another.

Mr. REISINGER. Do you know if Mr. Scuyler Lowe is also aware of this condition?

Dr. BILLET. I am unable to answer that question. I don't know.

Mr. REISINGER. One other question. The funds which are available to you, are they flexible, that is for mental care, are they flexible in this sense? I believe I am correct that the District last year paid approximately \$17 million to the St. Elizabeths Hospital for treatment of District of Columbia patients, is this correct?

Dr. BILLET. I think nearer \$18 million.

Mr. REISINGER. Nearer \$18 million. Now, then, are your funds specifically allocated or would it be possible for funds to be transferred from that \$18 million to your program for implementation of funds?

Dr. BILLET. These funds are allocated.

Mr. REISINGER. They are allocated, so it is a fixed proposition over which you have no control?

Dr. BILLET. That is correct.

Mr. REISINGER. Now, what funds or what budget do you have for foster home purposes?

Dr. BILLET. We have authorized in the regular authorization, I believe, three positions, two social worker positions and a clerical position and in addition the funds that are paid to the sponsors, but these funds are not funds of the Department of Public Health but rather these are Welfare Department funds. But insofar as the Department of Public Health goes, the funds we have are specifically the authorization for these three positions that I have mentioned.

Mr. REISINGER. Well, now, must you then obtain approval of the Department of Public Health, in this?

Mr. DANIELS. Department of Public Welfare.

Mr. REISINGER. I am sorry, Department of Public Welfare, for funds to place an individual in a foster home?

Dr. BILLET. When we approve a home and when we place a patient, the Department of Welfare is notified and they come forward with the funds.

Mr. REISINGER. Do you know what amount of money was available for this purpose in fiscal 1963?

Dr. BILLET. I don't believe—no; I do not know.

Mr. GOODELL. You described something that would seem to me automatic, that you have a home and they make the funds available, is this true, or do they have to approve it?

Dr. BILLET. No; we investigate the patient's eligibility and make sure that the patient in fact is eligible.

Mr. GOODELL. I understand that. You have a patient; you have a home. Now you notify the Welfare Department and do they have to approve it and say, "We have enough funds available to do this," or do they automatically make funds available?

Dr. BILLET. They do approve it. The funds are available.

Mr. GOODELL. I will put it another way. From your viewpoint, do you often have delay or rejection at that stage?

Dr. BILLET. No, sir; in fact we practically have never asked them, we have only placed 97 patients.

Mr. GOODELL. You never faced the problem?

Dr. BILLET. I might add we have placed 26 patients in the last 6 months and we had a couple of months recently where we had 10 patients placed in a month. I think this is a highly satisfactory figure.

Mr. GOODELL. Have you not any explanation as to why they have not been referred to you?

Dr. BILLET. No, sir.

Mr. GOODELL. From anybody?

Dr. BILLET. No, sir.

Mr. GOODELL. Do you have any direct contact with the people in St. Elizabeths?

Dr. BILLET. I discussed this problem with Dr. Harris either this last month or the month before.

Mr. GOODELL. With whom did you say?

Dr. BILLET. Dr. Harris, the physician responsible at St. Elizabeths Hospital.

Mr. GOODELL. You got no explanation?

Dr. BILLET. I don't believe there was an explanation. We were trying to understand it. The meeting I had with him was at his request.

Mr. DANIELS. Mr. Reisinger.

Mr. REISINGER. Was this ever brought to Dr. Cameron's attention, do you know?

Dr. BILLET. I am certain. This program has been in existence since February 1960.

Mr. REISINGER. Now, to leave this area briefly, I want to ask this one question to which you may be able to give us a comprehensive answer. Does the same condition prevail with respect to nursing home care as foster home availability?

Dr. BILLET. I think the condition concerning nursing care and personal care is quite different in that these facilities are extremely limited.

Mr. REISINGER. The nursing home?

Dr. BILLET. Yes; the nursing home facilities are extremely limited and so are personal care facilities. These are being utilized I would say very nearly 100 percent and there is an acute shortage of these facilities.

Mr. REISINGER. Is this because of the simple absence of physical facilities or inadequacy of funds for their use?

Dr. BILLET. I believe the inadequacy of funds is the primary factor. If adequate funds were made available I believe that our private enterprise system would take over and these facilities would be made available but the funds are simply inadequate.

Mr. REISINGER. What per patient allowance per month would be necessary in your judgment to achieve the availability of adequate or additional nursing home facilities?

Dr. BILLET. I think it is impossible to group everything under one category. If I may, I would like to say this.

Mr. REISINGER. We are here to learn; so explain what is necessary.

Dr. BILLET. Well, I feel, in the questions you asked about criminals and patients, you have done this: You have tended to group them as if they were homogeneous, and they are not. I was struck earlier in the meeting that it was almost as if we were losing sight of the fact there are so many patients and they are in fact a part of society and when we protect society we must protect these patients also and insure that the very best thing is done for them. I am sure this is part of the difficulty that the doctors have in making their decisions about when should someone go from maximum security to medium security to minimum security. The patient's welfare must be a primary consideration. I think that is because they are part of society.

I can't give you a specific amount of money that would be necessary, but I suspect it would be different for different kinds of patients, whereas one kind of nursing home facility might be necessary for certain patients still another would be necessary for other patients.

Mr. REISINGER. Can you give us illustrations of the type of category you refer to?

Dr. BILLET. Yes. One patient who suffers, who is at St. Elizabeths, for example, might need only physical care and this would require a certain kind of facility.

Still another patient might need something else.

Mr. REISINGER. Do those facilities exist?

Dr. BILLET. They are being fully utilized. There are no vacancies available.

Mr. REISINGER. Even if you had additional funds there would be no vacancies?

Dr. BILLET. Well, I suppose that would get to the level of funds. There are some facilities in the community; I suspect that they have beds open and that they are being utilized by private patients who can afford the fees being asked.

Mr. REISINGER. Let us say if you had \$300 a month available would you be able to get additional facilities?

Dr. BILLET. I think if there were \$300 a month available, additional facilities would be developed and chances are there are some existing facilities we might be able to utilize.

Mr. REISINGER. You would then save roughly \$40 a month per patient out of District of Columbia funds, assuming they are charged \$340 at St. Elizabeths?

Dr. BILLET. Presumably, according to the new method of figuring the per diem, that might be so.

Mr. GOODELL. I do not understand why that statement is couched in such careful language. Presumably it might be so under the new method of per diem allowances. It is correct, is it not, if you take them out of a home and put them in St. Elizabeths?

Dr. BILLET. I am not sure of how the per diem is being figured and not sure of what is going to happen to it. This is something that is completely out of the control of the government of the District of Columbia. It always has been and I don't know what the situation is at this moment or what it will be next year. But I do know that the

per diem is an average figure and if you go into any large adequate mental hospital or any hospital of high caliber, which I think St. Elizabeths is, some of the patients are receiving care that amounts to perhaps \$40 or \$50 or \$60 a day and some of the patients are receiving care that costs realistically perhaps \$2 or \$3 or \$4 a day. They are not all receiving the same services. They are in very different kinds of buildings. The staffing is quite different.

Mr. GOODELL. All right, but, Doctor, the way they are figuring per diem now is not on the individual patient cost, it is an average, and you don't expect that average cost to go down, do you?

Dr. BILLET. No, sir; I don't.

Mr. GOODELL. All right. So you have a minimum of \$40 savings if you pay \$300 for a person who is removed from that hospital and put in a nursing home?

Dr. BILLET. If you want to make it a matter of my figuring that out mathematically, I would say "Yes."

Mr. REISINGER. May I ask this question very bluntly? Are we asking you questions that might better be asked of Dr. Grant or his immediate superior?

Dr. BILLET. I think he has a much better familiarity with who knows what at a level outside of the District of Columbia Department of Public Health. I don't know how much he has communicated with Mr. Lowe or other individuals.

Mr. DANIELS. I think the record should show that the committee has requested the appearance of Commissioner Duncan as well as Dr. Grant, and that you were sent in place of these two gentlemen.

Mr. GOODELL. I think, Mr. Chairman, the record should show that we feel we should have them here and we should renew our request that they come.

Mr. DANIELS. That will be done.

Mr. GOODELL. If I may make a comment, perhaps we gave an impression in the earlier statement we were losing sight of the patient as a part of society when we were talking about public safety. That certainly was not our intent. I do not understand how the impression got across, but we are talking about the balance of public safety with the interests of the patient in terms of treatment. We want to do everything possible to help the patient return to society and protect him. That is a primary consideration, but another very primary consideration is the protection of the public and during their transition back into society the public must be protected from these patients and from any action of violence that they may commit.

Dr. BILLET. I don't feel there is any disagreement about that at all.

Mr. GOODELL. I do not quite understand the extraneous comment that was made, then.

Dr. BILLET. Well, I feel that part of the difficulty that the physician faces in making some of the decisions that you are most concerned about have to do with the fact that the patient is in fact a part of society and must be protected.

Mr. REISINGER. Doctor, you are cognizant of the fact that in each of the areas we are discussing that the courts of the District of Columbia, both general sessions, local and U.S. district court, retain the power and direction in terms of conditional or total release of the

NGI or "Not guilty by reason of insanity" patients and thus to some extent, at least the decision is taken both out of your hand and our hands?

Dr. BILLET. I am aware of that. My reference was to the difficulties that may be involved, not in releasing a patient from care but on the level of care that is given.

Mr. DANIELS. Dr. Billet, thank you very much. You have been very helpful to the committee.

I would like at this time to call Dr. Cameron back to the witness chair.

**TESTIMONY OF DR. DALE C. CAMERON, SUPERINTENDENT,
ST. ELIZABETHS HOSPITAL**

Mr. DANIELS. Dr. Cameron, will you please explain once again what the policy of St. Elizabeths Hospital is with reference to placement of patients in foster homes?

Dr. CAMERON. Yes, Mr. Chairman.

Mr. DANIELS. Do you or do you not have the authority to do so?

Dr. CAMERON. When we spoke yesterday of the authority to place, I understood we were talking about the authority to pay. We, of course, have, as I indicated, the authority to try to help a patient make arrangements for being in a foster home if it is found. Those patients who do have funds we assist in finding nursing homes or foster homes and the patient, or his estate, pays for this, but we help make the arrangements and will continue, while he is on our rolls, to supervise him while in the foster home.

Mr. DANIELS. As to the indigent patient you do not have authority?

Dr. CAMERON. If he can be placed in a boarding home where the welfare payment is \$67 a month to the home sponsor and \$10 a month to the patient, we would try to help the patient find a home, help him make application for public assistance and if that arrangement is approved by the Department of Welfare, the Department of Welfare would pay the home sponsor for that home.

If we are trying to place a patient in a foster home of the kind described by Dr. Billet, it would be necessary for both the home and the placement of a particular patient in that home to be approved by the Department of Health—acting, if you will, as the agent of the Department of Welfare to approve that particular relationship and to recommend to the Department of Welfare the payment of \$100 to the home sponsor and the \$10 to the patient. We always have the opportunity to try to help place these persons. What I was trying to say the other day is that we have no funds available to the hospital to pay for such persons and there are some patients in the hospital, of course, who are not the responsibility of the District of Columbia in any sense. We believe we should have funds available in our appropriation to pay for the latter persons in foster or nursing homes if such is a suitable arrangement for them rather than to keep them in the hospital.

Mr. DANIELS. Are you aware of the availability, I believe Dr. Billet said of 39 homes presently in the District for patients of St. Elizabeths Hospital?

Dr. CAMERON. Yes.

Mr. DANIELS. Why hasn't St. Elizabeths Hospital taken advantage of this opportunity for the placement of these patients in these foster homes at the rate of \$100 a month?

Dr. CAMERON. We are trying to take advantage of it. The problem is that you can't just put a patient and a home together without regard to what kind of home and what kind of patient. In order for the patient to have a reasonable expectation of remaining in the home their must be a fit, if you will, between the patient and the home so there is compatability between the two.

We, very often, even where the patient is going to pay for the home himself, have to take him to three, or four, or five different homes before we can find a home sponsor who is willing to have that particular patient and with whom that particular patient is willing to live. In other words, you have to have a fit. The Department of Health keeps us advised of all of the homes they have found and we had them posted on the board in our Social Service Department. Our own social workers, working with our patients, can see where the home is, what kind of a home it is, at any given moment they walk into the office and try to match a patient who is ready to leave with the particular home.

It often takes several months of work with the patient to get him to the point where he is willing to leave the hospital and will make an honest effort to stay in the home. We thus have to wait for the propitious time with a patient and then have an appropriate match between the patient and the home.

As to the vacant homes, we do not at the moment have a patient ready for that particular type of home, so we would like to have a larger selection of homes into which we can place patients.

There are obvious problems. For example, many white patients do not want to live in a Negro home and vice versa. So you have the racial problem aside or in addition to the broader issues of the mental condition of the patient.

There have been problems, too, where a patient has been placed in a home, let us say a white home. It happens that Dr. Billet's social worker in his home finder unit is a Negro and three of the four social workers working for us in our foster home unit are also Negro. We try to make no distinction on this basis as to who will provide the professional service, but on occasion we have lost white homes because a Negro is following the patient in that home and they don't like to have the social workers come to their home.

Now, I don't like this any better than I am sure you do, but it happens that more of our social workers are of the Negro race and they are good people. This problem is a reflection of the prejudice that exists in the community. This is only a minor part of the total kind of problem that we face. The important issue is to get the fit. We could use a larger availability of homes.

Now, it is obvious there have been some failures of communication between the Health Department and the hospital in relation to this, from the testimony just given. We have not—and perhaps we should have—referred patients to the home finders unit unless we knew of a reasonably good fit between a patient and a home. What we should have been doing, I think, and what we will do is to refer additional patients to them when we have no idea what home might be available or suitable. Then there would be a larger caseload facing the home

finders unit of the Department of Health and hopefully would stimulate them to a greater effort in finding additional homes.

Mr. GOODELL. You have now, I take it, then, all of these 39 homes under consideration and you have not been able to find a patient to fit into any one of those 39 homes?

Dr. CAMERON. That fits into those particular ones; yes, sir.

As a matter of fact, returning to one of the racial issues and I do not wish to dwell on it unduly, but for some reason it would appear that the Negro community is more responsive to the opening of their homes to patients than is the white community. Whether this is a reflection of social economic pressures or reflection of the attitude toward humanity, I don't know, but the fact is at the rates available it is easier to find a home for a Negro patient than it is a white patient.

Mr. DANIELS. Mr. Reisinger.

Mr. REISINGER. Since, and I think unnecessarily, frankly, the racial issue has been injected in the hearings, what is the approximate hospital population of colored?

Dr. CAMERON. It is approximately 50-50.

Mr. REISINGER. So that you have somewhere in the vicinity of 3,500 colored patients at the hospital at the present time?

Dr. CAMERON. Roughly, yes.

Mr. REISINGER. And assuming the Washington population is approximately the same—well, forgetting that for a moment—what you are saying, in effect, would appear to be that you have placed all of the colored patients that you can in foster homes and you are now confronted with the fact that white foster homes are not available?

Dr. CAMERON. I shouldn't like to leave that impression. We have not placed all of the Negro patients.

Mr. REISINGER. I just wanted to be sure you didn't want to leave that impression.

Dr. CAMERON. No, we have not placed all the Negro patients.

Mr. REISINGER. So that, as a practical matter, perhaps it might make sense for you to, shall we say, select a patient, refer him to Dr. Billet, and say, "Find us a suitable home"?

Dr. CAMERON. Yes, I think that will be very useful and we will start doing that.

Mr. REISINGER. So, in the existing patient population you could find patients who are ready for foster home placement.

Dr. CAMERON. Yes.

Mr. DANIELS. We will have to discontinue the hearing at this point because the bells have rung requiring our presence on the House floor.

This hearing will be continued to next Tuesday and I am sorry we were not able to get to the other witnesses who were notified to be here today. I am wondering if Mr. Layton, Deputy Chief of the Metropolitan Police Department, is present here?

Mr. LAYTON. Yes.

Mr. DANIELS. Would it be convenient for you to return next Tuesday?

Mr. LAYTON. I think so.

Mr. DANIELS. This hearing will recess until next Tuesday morning at 10 a.m.

(Whereupon at 12:25 p.m., the hearing adjourned, to reconvene at 10 a.m. Tuesday, November 19, 1963.)

ADMINISTRATION AND OPERATION OF ST. ELIZABETHS HOSPITAL

WEDNESDAY, NOVEMBER 20, 1963

HOUSE OF REPRESENTATIVES,
AD HOC SUBCOMMITTEE ON ST. ELIZABETHS HOSPITAL
OF THE COMMITTEE ON EDUCATION AND LABOR,
Washington, D.C.

The ad hoc subcommittee met, pursuant to recess, at 10 a.m., in room 304, Cannon House Office Building, Hon. Dominick V. Daniels presiding.

Present: Representatives Powell, Daniels, and Sickles.

Also present: Dr. Deborah P. Wolfe, education chief; Emory W. Reisinger II, subcommittee counsel; Charles Radcliffe, minority counsel for education; and Gail Smith, subcommittee clerk.

Mr. DANIELS. The subcommittee will now come to order.

Our first witness this morning is Dr. Murray Grant, Director of the Department of Public Health, government of the District of Columbia.

Dr. Grant, will you step forward to the witness chair, please? Dr. Grant, the committee has asked you to appear here today in an effort to reach an understanding on the seeming confusion and lack of communication between the District of Columbia and St. Elizabeths Hospital in placing patients from the hospital in foster homes. I hesitate to state a conclusion at this time, but the present state of the record suggests a rather comprehensive failure to coordinate the program of the two governmental agencies involved. I hope that you may be of assistance to the committee in arriving at an accurate picture of existing conditions.

Dr. Grant, will you proceed.

STATEMENT OF DR. MURRAY GRANT, DIRECTOR OF THE DEPARTMENT OF PUBLIC HEALTH, GOVERNMENT OF THE DISTRICT OF COLUMBIA

Dr. GRANT. Mr. Chairman, I am sure you understand that this program was started prior to the time I came to the Health Department, but if I may relate to you that which I understand has transpired during the past 4 years or so—

Mr. DANIELS. When did you become associated with the Department?

Dr. GRANT. A little over a year ago, Mr. Chairman.

Mr. DANIELS. In your present capacity as director?

Dr. GRANT. Yes.

Mr. SICKLES. I might add that prior to that he was in my own Prince Georges County. We were very unhappy when he was stolen by the District of Columbia.

Dr. GRANT. Thank you.

In February 1960, Mr. Chairman, this program started with the employment by the Department of Public Health of two social workers and a secretary whose job it was to find foster homes with the idea that St. Elizabeths Hospital patients suitable for this purpose could be placed in those homes. During the subsequent 5 months, approximately, or 4 months I think it was, Mr. Chairman, only five patients were placed in those homes.

During the past period of almost 4 years the Department of Public Health has always had available at least 40 placement possibilities for these individuals and often as high as 80 available places for these people to go. During these past 4 years or so a total of only 97 patients have actually been placed in homes that we have located and we currently have 38 vacant positions; 31 of these are for colored persons and 7 are for white.

I would like to introduce for the record, Mr. Chairman, two memorandums which were written by my predecessor. They relate entirely to this matter and indicate his feeling concerning the problems involved.

Mr. DANIELS. Without objection they will be received.

(The memorandums referred to follow:)

NOVEMBER 15, 1960.

Memorandum to: Mr. David P. Herman, budget officer, District of Columbia.
Subject: Foster care program instituted by the Department of Public Health to facilitate discharge of patients from St. Elizabeths Hospital.

This program was established and went into official operation in February 1960, at which time we had two social workers and a clerk, whose sole responsibility was recruiting foster homes that would be willing to accept discharges from St. Elizabeths Hospital. This staff worked with the social service department of St. Elizabeths Hospital in an attempt to place these discharges.

Our foster care program has been very successful in locating what we consider to be adequate and fit homes for the reception of such patients. As the program got underway, we were successful in constantly maintaining a registry of from 40 to 50 homes willing to accept patients in this program. From February 1, 1960, to November 1, 1960, a total of five such patients were placed in foster homes. Two of these patients were returned to St. Elizabeths Hospital and as a result of 9 months of operation, we now actually have three such patients placed in foster homes. During the current fiscal year our results have been as follows: July, no placements; August, no placements; September, one placement; and October, no placements.

In view of the above facts, it appears from our point of view that this program has been unsuccessful in the results obtained. We cannot see any reason for finding additional homes since we cannot fill the ones that we have already on record. This has become a very frustrating program for the workers concerned. One of the social workers has already resigned for this reason. We are therefore proposing a change in this program.

We propose that the use of this program be made available to other areas of the Department of Public Health; that is, the various bureaus of the Department and the two hospitals. In particular, there are patients in District of Columbia General Hospital and some in Glenn Dale Hospital that could use these available facilities to very great advantage. We propose that St. Elizabeths Hospital be notified of this change and that they be advised that this program will not be kept for their exclusive use but that the program will continue in existence and will be available to them at any time they wish to refer a patient. We will keep this as a standby facility for St. Elizabeths Hospital. We will accept any referrals that they send us but we will not continue to main-

tain this program for the sole use of St. Elizabeths Hospital since it does not appear to this office to be a valid expenditure of money when one looks at the results that have been obtained—a total of three patients in the homes after 9 months of operation.

We propose, temporarily, not to fill the one existing vacancy for a social worker position until we see how this program progresses in the next few months.

Your approval of this proposal will be appreciated.

DANIEL LEO FINUCANE, M.D.,
Director of Public Health.

DECEMBER 6, 1960.

Memorandum to : Commissioner Mark Sullivan, Jr.

Subject: Foster home program for patients discharged from St. Elizabeths Hospital.

Due to the fact that recently there has appeared in the press references to the foster home program for patients eligible for discharge from St. Elizabeths Hospital, I thought that it might be desirable to present some factual data to you concerning the Department of Public Health's participation in this program.

Well over a year ago, the District government embarked on a program of providing governmental and private facilities in order to move patients out of St. Elizabeths Hospital that had been certified by the staff of St. Elizabeths Hospital as no longer being in need of mental hospital care. These patients were classified by the staff of St. Elizabeths Hospital as being eligible for discharge if certain facilities could be provided for their care in the community, depending upon the social, economic, physical, and mental condition of the individual patient. These facilities were categorized as follows: Private home of the individual or his family; foster home; personal care home; nursing home; home for the aged; or chronic disease hospital.

The primary agencies of the District government involved in trying to make such facilities available were the District of Columbia budget office, the Department of Public Welfare, and the Department of Public Health. No attempt was made by the District government to try to place patients in their own homes or those of their family as this was considered to be 100 percent the responsibility of St. Elizabeths Hospital. However, we did work on such areas as a home for the aged, and patients were placed at District of Columbia Village, and a chronic disease hospital, and beds were made available at Glenn Dale Hospital for some patients in this category.

In the field of nursing homes, so few licensed homes are available that no provisions could be made available for these patients in nursing homes. However, we have worked diligently on providing personal care homes. Regulations were established and promulgated by the Commissioners and it is anticipated that in the immediate future some of these homes will be licensed. We hope this will relieve the situation and provide additional beds, and perhaps also stimulate the development of the nursing home program.

The area of the foster homes has received the principal publicity recently. This has traditionally been a responsibility of St. Elizabeths Hospital. However, the District government offered to cooperate with St. Elizabeths Hospital and to this end authority was granted to establish within the Department of Public Health a foster home finding program. Two social workers and a clerk were appointed for this purpose. This program got underway in February of 1960 and almost continuously from that time to the present, we have been able to maintain a register of about 40 to 50 homes willing to accept patients in this program. The detail of this is set forth in my memorandum of November 15, 1960, addressed to Mr. Herman, Budget Officer, District of Columbia, which is attached for your information.

To date, five patients are actually in such foster homes in the program set up by this Department. A total of seven patients were placed but two had to be returned to St. Elizabeths Hospital on the hospital's recommendation. St. Elizabeths Hospital claims that 29 patients have been moved into this program. However, 26 patients were in the hospital's regular continuing program and were separate and distinct from this particular program of the identified patients by St. Elizabeths Hospital that were eligible for discharge and in the group that the District government was working on.

In a progress report prepared by Mr. Stanley of the Department of Health, Education, and Welfare, on the movement of St. Elizabeths patients, under

date of November 9, 1960, and submitted to the Secretary of the Department of Health, Education, and Welfare on November 14, 1960, the following was stated: "It has proved difficult to locate sufficient foster care homes for white patients, and the Social Service Branch of St. Elizabeths will try to locate suitable homes in Virginia and Maryland." However, it is a fact that over the period of time that this program has been in operation, we have had as high as 17 vacancies in foster homes for white patients. Currently, we have eight such vacancies.

There is no question in our mind that we could have found additional homes for white patients if the available homes that we had on our list had been used. There is no purpose in finding large numbers of homes that are willing to accept such patients if no patients are made available to go into such homes. The people that have registered to receive such patients become impatient at the long delay and finally lose interest and ask that their names be withdrawn from the list. Because of the long delays and the frustration encountered in accomplishing little or nothing, we have lost one of our two social workers and we have made no attempt to fill the position as we do not feel that we could justify the expenditure of money in finding homes that are not being used.

As a byproduct of Dr. Cameron's recent talk before a pastoral group, St. Elizabeths Hospital has received a number of calls from individuals interested in taking patients from St. Elizabeths Hospital and establishing a foster home for such patients. Many of these calls have been redirected to the Department of Public Health. This has resulted in a rather difficult situation since we have no way of placing patients in these homes. In addition, we have had calls from people, whose names are already on our list, wanting to know why they have not had patients referred to them since they understand from reading the papers that additional homes are required.

I must say in all honesty that I do not believe that St. Elizabeths Hospital staff has made the maximum use of the facilities that we have made available in the foster home program.

DANIEL LEO FINUCANE, M.D.,
Director of Public Health.

Mr. DANIELS. Would you briefly describe the contents of those two memoranda?

Dr. GRANT. Basically, Mr. Chairman, my predecessor indicated very much what I have just indicated; namely, that since the program was initiated, the Department of Public Health has been successful in constantly maintaining a registry of from 40 to 50 homes willing to accept patients in the program.

From February 1 to October 31, 1960, a total of five such patients were placed in foster homes. Two of these patients were actually returned to St. Elizabeths Hospital and, as a result, my predecessor says, of 9-months operation only three patients were placed in foster homes.

During the next fiscal year—that is, the 1961 fiscal year—the results have been as follows, he says: In July there were no placements; in August no placements; in September one placement, and in October no placements.

I quote now, Mr. Chairman:

In view of the above facts, it appears from our point of view that this program has been unsuccessful in the results obtained. We cannot see any reason for finding additional homes since we cannot fill the ones that we have already on record. This has become a very frustrating program for the workers concerned. One of the social workers has already resigned for this reason.

I may say, Mr. Chairman, that subsequent to that employee's resignation the Department did not replace that individual because it was felt that there would be no point in replacing him based upon the fact that homes were already available which were not being used, and in fact, we have at the present time only one psychiatric social

worker in this particular capacity and for this reason we have not filled the position.

Mr. DANIELS. How many people did you have working there at the initiation of this program?

Dr. GRANT. There were two psychiatric social workers and a secretary. There is now one psychiatric social worker.

Mr. DANIELS. Is there any date on that memorandum that you read from?

Dr. GRANT. This memorandum that I just read from, Mr. Chairman, is dated November 15, 1960. The other memorandum is dated December 6, 1960.

Mr. DANIELS. What is the substance of the second one?

Dr. GRANT. Perhaps the substance of the second memorandum is reflected in one of the paragraphs which I will read, if I may, Mr. Chairman. It says here:

There is no question in our mind that we could have found additional homes for white patients if the available homes that we had on our list had been used. There is no purpose in finding large numbers of homes that are willing to accept such patients if no patients are made available to go into such homes. The people that have registered to receive such patients become impatient at the long delay and finally lose interest and ask that their names be withdrawn from the list. Because of the long delays and the frustration encountered in accomplishing little or nothing, we have lost one of our two social workers and we have made no attempt to fill the position as we do not feel that we could justify the expenditures of money in finding homes that are not being used.

And the last statement in this memorandum I quote:

I must say in all honesty that I do not believe that St. Elizabeths Hospital staff has made the maximum use of the facilities that we have made available in the foster home program.

Both of these are signed by Dr. Finucane, who was the Director of Public Health.

Mr. SICKLES. Would the chairman yield for one question at that point?

Mr. DANIELS. Yes.

Mr. SICKLES. Are the facts that the personnel at St. Elizabeths did not review the homes that were available at all, or is it that they reviewed them and did not think they were satisfactory?

Dr. GRANT. We have at the current time, Mr. Sickles, 38 places available. It is my understanding that all of these places have, in fact, been reviewed and approved by the staff at St. Elizabeths Hospital.

Nevertheless, they are currently vacant. It is my understanding that there are 10 placements pending at the present time, but places in foster homes are available.

Mr. DANIELS. Both of those memoranda are dated in the year 1960.

Dr. GRANT. 1960.

Mr. DANIELS. Has there been a followup by your office, with St. Elizabeths, to determine their feeling on the placement of patients in these homes that you have outlined?

Dr. GRANT. May I say, Mr. Chairman, in response to that question, that I believe that the relationship between our social worker and the social workers on St. Elizabeths staff who are involved in this program is an excellent relationship.

Our worker has been in almost daily contact with these workers and the relationship is very good. Insofar as I am aware, Mr. Chairman, the basic problem here seems to be in getting patients ready for transference out of the hospital.

While it is true to say, as they at St. Elizabeths Hospital have said, and we would agree with this, that a very large number of patients could in fact be placed in foster homes; one of the basic problems is in preparing those patients to accept the desirability and availability of these homes.

Obviously, if patients have remained in St. Elizabeths for some years, and this is true with some patients, they consider it their home and it is with some reluctance that they would leave and go into a foster home in an area they don't know or to a person they don't know. So it takes some time and effort to prepare these persons for placement. In any view and from the information I have obtained, this constitutes one of the basic problems, in insuring that the patients at St. Elizabeths are adequately prepared to go into the homes that are available.

Mr. DANIELS. Should that be too great a problem when you have 6,700 patients on a 24-hour a day basis at St. Elizabeths Hospital, when Dr. Cameron testified that about 50 percent of those patients could be transferred either to foster homes or to nursing homes?

Dr. GRANT. I would think, Mr. Chairman, that it would be possible to prepare such persons, at least some of them, for placement. Exactly what the problems would be in doing this, of course, I am not aware. Dr. Cameron would have to answer this I think.

Mr. DANIELS. But the point which you make is that since 1960 up to the present time, a period of 3 years, you have continued to make St. Elizabeths Hospital aware of the fact of the availability of these foster homes?

Dr. GRANT. That is correct.

Mr. DANIELS. And you have said that you have always had somewhere between 40 and 60 homes available for placement.

Dr. GRANT. Forty and eighty actually, and we have at the present time 38 placements.

Mr. DANIELS. You may continue.

Dr. GRANT. Well, I don't know what else to say about this, Mr. Chairman. I think perhaps I have covered the subject as best I can. I would be glad to answer any further questions.

Mr. DANIELS. With reference to the cost for the support of these foster homes, those funds I understand come from the Welfare Department?

Dr. GRANT. That is correct.

Mr. DANIELS. Has your office experienced any difficulty in having the funds made available for the payment of fees for these foster homes?

Dr. GRANT. No, sir, we have thus far experienced very little difficulty in securing these homes for the present stipend which, as you may know, is \$110 a month, \$100 for the sponsor and \$10 for the patient.

There is somewhat more difficulty in securing white homes than there is colored, but, nevertheless, as I pointed out, we still have white homes currently available; and, I personally would not feel that it would be necessary at this time to raise that stipend, based upon our experience.

It may be that at some time in the future, should we fill all available homes with patients, we may need to ask for an increase in stipend, but it is rather difficult for me, Mr. Chairman, to justify such an increase based upon the fact that we certainly have homes which are not being filled and we are not using the stipend currently available.

Mr. DANIELS. Does Dr. Cameron know that you have 38 vacancies in foster homes at the present time?

Dr. GRANT. To the best of my knowledge he does. I am not certain of this, Mr. Chairman, but I would think that he probably does and I am sure that the social workers at St. Elizabeths, who are the direct contact between our staff and his, do know of this.

Mr. DANIELS. What in your opinion is the reason for the failure to make the placements?

Dr. GRANT. I think the basic problem, Mr. Chairman, is related to the problem of preparing the patients to leave the hospital. This, of course, must of necessity be a responsibility of St. Elizabeths Hospital. Exactly what the problem is in preparing these patients for going to the home I really don't know.

Mr. DANIELS. Mr. Reisinger.

Mr. REISINGER. Dr. Grant, what is the nature, in a generalized way of course, of this preparation of the patient for placement in a foster home? Could you explain this to us?

Dr. GRANT. Yes. I think there are a couple of things involved in here.

When our social worker finds a home that may be suitable, he, of course, visits to check on the sponsor to make sure this sponsor is a suitable person, that the home is a suitable home, that the sponsor will be able to generally supervise the patient to make sure the patient remains under psychiatric and medical supervision, and to be sure that his sponsor is the kind of person that will continue to remain in contact with our psychiatric social worker so that our social worker will be apprised of any problems that come up.

Our psychiatric social worker visits the home at intervals, usually once a month, or more frequently, depending upon the situation. Insofar as St. Elizabeths Hospital is concerned, of course, it would seem to me that one of its primary jobs is to try to be sure that the patient, a patient who may have been in the hospital for, in some cases, some years, will accept removal from the hospital and transference to this home; this means some work, some counseling, some preparation of this patient along these lines, and a contact sooner or later between the patient and his sponsor to make sure that they are reasonably compatible. This, I think is the kind of thing that needs to be done.

Mr. REISINGER. Has it been, to your knowledge, a consistent, shall we say, position of St. Elizabeths Hospital that they could not reduce their patient caseload because of the unavailability of these homes?

Is that correct to your knowledge?

Dr. GRANT. Well, I have heard, Mr. Reisinger, it is said that St. Elizabeths feels that it is not possible to remove patients from the hospital because of the unavailability of homes, yes. We have just as consistently taken the view that I have reiterated here today, that the numbers of homes I have given to you have been available from the Health Department, but have simply not been used thus far.

Mr. REISINGER. Doctor, approximately, if you know, what was the actual cost to the District of Columbia per patient in the last fiscal year at St. Elizabeths?

Dr. GRANT. It was \$10.71 per day for the last 6 months of the last fiscal year and it was \$10.07 for the first 6 months.

Mr. REISINGER. So that in round figures it is \$305; \$310 a month?

Dr. GRANT. Yes.

Mr. REISINGER. Or then roughly a saving of \$200 per month to the District of Columbia could be effected by the transfer of a patient from the hospital to a foster home?

Dr. GRANT. That saving could not have been effected, Mr. Reisinger, in the last fiscal year because of the way in which these financial arrangements were made, because what happened last year, and in all years prior to last year, was that if patients were removed from St. Elizabeths Hospital the rate went up. The staff remained the same. The cost of operating the hospital remained the same, or perhaps went up. The number of patients fell. The per diem rate was raised. So what happened is that this placed the District in a very peculiar position, where we were paying for foster home care of \$110 a month and at the same time the rate at St. Elizabeths Hospital was raised. We ended up paying twice.

Starting with this fiscal year for the first time we have been in a different situation, because the manner in which the District has reimbursed St. Elizabeths Hospital is no longer being based upon the cost of running St. Elizabeths Hospital. It is based upon the cost of running the upper 10 percent of the State mental hospitals throughout this country.

The upper 10 percent is taken. A number of years are added together; the mean is computed, and this is the rate that we use. In fact, for this fiscal year the rate has been computed at \$9.49 per day per patient based upon this formula that I mentioned.

Under these circumstances should this continue, it is perfectly true that the cost to the District government would fall if the patients were transferred to a foster home, but this is the first year in which this will have happened.

Mr. REISINGER. Doctor, let me understand one aspect of this. The mathematical basis on which the payment by the District was computed in years past would not have increased by the same proportion as roughly \$200 a month, which would have been occasioned by the removal of one patient to a foster home, would it?

Dr. GRANT. Yes, it would.

Mr. REISINGER. It would?

Dr. GRANT. Yes. Let me give you an example, Mr. Reisinger.

Let's assume for a minute that there were 5,000 patients in St. Elizabeths Hospital and the cost of running the hospital was \$20 million, which then would be \$40 a day. If you reduce the number of patients to 4,000 the cost of running the hospital is still \$20 million. You have then raised your per diem to \$50 a day, and this is what actually has been happening over the past many years. As the number of patients fell, the per diem went up and so we ended up paying the same bill.

Mr. REISINGER. Let me ask this. This did not serve as an incentive, but as a retardant to your efforts to make foster home placements?

Dr. GRANT. Insofar as the Department of Public Health is concerned, no, because these homes were made available irrespective of this fact, even though we recognized that this was not going to save the District money in past years, because of the fact that I mentioned. We still have had these homes available, but of course this year this is no longer true. This year if patients are removed from the hospital it will in fact save the District money, obviously, the difference between approximately \$100 a month and approximately \$300 a month.

Mr. REISINGER. Incidentally, what roughly is your estimate of the number of District of Columbia patients now at St. Elizabeths who might be placed in foster homes?

Dr. GRANT. I don't think I would want to give you such an estimate. I think St. Elizabeths has already given such estimates and I would have to accept theirs. Obviously, I am not as familiar with their patients as they are.

Mr. REISINGER. So you would accept their estimates, which run somewhere in the vicinity, I think, of 600 patients at the present time?

Dr. GRANT. For foster homes placement?

Mr. REISINGER. Yes, foster home placement.

Dr. GRANT. Yes.

Mr. REISINGER. In that connection then there is a very substantial saving which could be effected by these foster home placements on an annual basis, is that not correct?

Dr. GRANT. That is correct.

Mr. REISINGER. By inference you suggest to me the nursing home problem. There are people who should be or could be placed in psychiatric nursing homes; is that correct?

Dr. GRANT. That's correct.

Mr. REISINGER. Does the same condition prevail there?

Dr. GRANT. The same condition prevails to some extent. Let me put it this way. There has been no definite program that I am aware of for placement of St. Elizabeths Hospital patients in nursing homes. Nevertheless, may I quote that as of July 1, 1963, this year, there were a total of 1,291 beds available in nursing homes, of which 227 were at that time vacant? The point that I am making, Mr. Chairman, is that I have heard it said that there were no nursing home beds available. There were 227 available as of July 1, 1963.

However, I must say this in connection with that. We don't know whether the nursing home proprietors would have been willing to accept patients at the rate that the Welfare Department was willing to pay them, nor do we know whether these nursing home beds and these nursing homes would have been completely suitable to accept the kind of patients that St. Elizabeths Hospital would have to send them. So, I do make this point. We don't know the answers to either of these questions, but 227 nursing home beds were available at that time.

Mr. DANIELS. For colored as well as white people?

Dr. GRANT. That's correct.

Mr. REISINGER. What is the stipend available for nursing home placement?

Dr. GRANT. I believe it is \$110 a month.

Mr. REISINGER. The same as the foster home?

Dr. GRANT. Yes.

Mr. REISINGER. Would it be your opinion that this stipend should be raised in order to acquire adequate facilities?

Dr. GRANT. I would be rather reluctant to render an opinion on that until I have done a study relative to those particular beds that I was talking about.

If it would appear that these people would not accept these patients with the provisions of the money that we now have, I would say "yes." I would hazard a guess, Mr. Reisinger, without knowing all the facts, that it would be very difficult to locate nursing home beds for patients at St. Elizabeths Hospital based upon a stipend of \$110 a month, and I say that because I have some figures here that indicate the minimum charges made for patients by nursing homes in the District of Columbia. It would indicate to me that the average is around \$170 a month for private patients. That's the average minimum.

There are some that accept less and there are many that take more; but, the average minimum is around about \$170 a month, which indicates to me that there would be considerable reluctance to accept patients at \$110 a month.

Mr. REISINGER. Does your Department contemplate a study of this situation?

Dr. GRANT. We have not contemplated one thus far, but it would seem to me that this would be very definitely in order.

Mr. REISINGER. Doctor, you are a member, I believe, of what is known as the Advisory Group on St. Elizabeths Hospital, appointed by the Secretary of Health, Education, and Welfare, I believe, in May of this year.

Dr. GRANT. Yes.

Mr. REISINGER. Has this problem been discussed in the course of your meetings of this group?

Dr. GRANT. Only to a very limited extent. There have been two meetings of this group, in fact, one that was held, I believe, in May or June and one that was held approximately a month or so ago.

In the intervening time the staff appointed by the HEW to work on this particular problem has studied the problem and has come out with some recommendations which in fact were considered at the last meeting of this group. There was considerable discussion concerning some of the recommendations and I would say generally that, while the committee agreed with some of these recommendations, some of the more important aspects of the problem either were not indicated in the recommendations or, at least, were not agreed upon at that time.

Mr. REISINGER. Doctor, you say recommendations. Is this strictly an interim sort of thing?

Dr. GRANT. I believe that is correct.

Mr. REISINGER. They were not published?

Dr. GRANT. No, they were not published.

Mr. REISINGER. With respect to this Advisory Group of the Secretary, what precisely is its purpose and function?

Dr. GRANT. As I understand it, it is to outline or try to outline the future functions, program, organization, and relationships of St. Elizabeths Hospital, bearing in mind particularly, one, its possible future relationship to whatever we develop in the District of Columbia

in the field of mental health; and, two, its role as a continuing Federal installation to provide for research, training, and similar kinds of facilities as a nationwide demonstration.

Mr. REISINGER. With respect to the second aspect of your stated purpose, the role as a training, research, and so forth function of the Federal Government, there is already a fairly substantial research, training-like program underway in the form of the National Institute of Mental Health; is that not correct?

Dr. GRANT. That is correct; yes.

Mr. REISINGER. What is the relationship between St. Elizabeths and NIMH?

Dr. GRANT. It is my understanding that the relationship is a co-operative one. I believe the superintendent of St. Elizabeths Hospital, organizationally, is responsible to the Secretary of Health, Education, and Welfare. He has no organizational responsibility to the National Institute of Mental Health, to the best of my knowledge.

Mr. REISINGER. Am I correct that National Institute of Mental Health is also organizationally responsible to the Secretary of Health, Education, and Welfare?

Dr. GRANT. Not quite. The National Institute of Mental Health, organizationally, is responsible to the Surgeon General of the Public Health Service, who in turn is responsible to the Secretary of Health, Education, and Welfare.

Mr. REISINGER. The National Institute of Mental Health maintains a certain study grant program. Are we correct in this?

Dr. GRANT. That is correct; yes.

Mr. REISINGER. And I believe that the District of Columbia is the recipient of such a grant.

Dr. GRANT. I think you are thinking, Mr. Reisinger, as I understand it, of the \$50,000 which was made available by the U.S. Public Health Service for the study of the mental health program in the District of Columbia, as was true of other States. If this is what you are implying, the answer to that is "Yes."

Mr. REISINGER. This is what I was directing my attention to, this \$50,000 grant for study.

First of all, organizationally, does that come within your domain?

Dr. GRANT. Yes; this is part of the Department of Public Health; that's correct.

Mr. REISINGER. What precisely is the purpose of this study?

Dr. GRANT. The purpose of this study is to take a look at all of the mental health facilities, programs, and objectives that are being carried out in the District of Columbia, with a view to determining what programs exist, what unmet needs there are, what duplication exists, and with the ultimate purpose of coming up with a recommendation concerning a blueprint for a mental health program of the future in the District of Columbia. This is the real purpose of this program.

Mr. REISINGER. This is basically the followup of the broad outline contained in the President's letter of February 15 to Mr. To-briner; is that correct?

Dr. GRANT. That is correct.

Mr. REISINGER. And I believe therein mentioned was the desire that the District of Columbia program become in effect a model program for national aspirations, if you will.

Dr. GRANT. That is correct; yes.

Mr. REISINGER. Would this blueprint, shall we say, to use your term, once developed, bear on the hospital population at St. Elizabeths?

Dr. GRANT. I think it would have a very definite impact, Mr. Reisinger; yes.

Mr. REISINGER. Explain that in some detail, if you will.

Dr. GRANT. May I point out that there are at least two ways of handling the patient population at St. Elizabeths Hospital or, for that matter, any other institution. One is to prevent people from going in and the other one, of course, is to remove people from the hospital more rapidly. We get involved in both of these areas and, particularly, we will get increasingly involved under the new program that we envision in the District of Columbia.

We have been involved in the removal of patients from St. Elizabeths Hospital in the manner in which we have discussed and we are involved in certain other ways, particularly, through our Public Health Nursing Service, which relates intimately to the discharge of patients at St. Elizabeths Hospital and the availability of orienting these patients back to their community. We hope to be intimately involved in the questions concerning the admission of patients to St. Elizabeths Hospital.

We are currently involved in a number of ways. The chief one is this. We have in the Department of Public Health the District of Columbia General Hospital. In the District of Columbia General Hospital, the general hospital serving the District of Columbia, we have a 200-bed acute psychiatric unit, the function of which is to admit acute psychiatric patients. These patients are evaluated and treated at that unit. Some of these patients ultimately find their way to St. Elizabeths Hospital, primarily because the staff of District of Columbia General Hospital recommends this, based upon the fact that they feel that some of these patients are long-term stay patients; namely, beyond about a 60-day stay.

Last year, approximately, 1,100 patients were sent from the District of Columbia General Hospital to St. Elizabeths Hospital. In addition to this, we have recently started, in fact, just a few months ago, another unit at the District of Columbia General Hospital and this is a day care, and convalescent, and rehabilitation center for psychiatrically oriented patients. This program was started, as I say, a few months ago and it is growing rapidly. Our object here, of course, is to take patients who do not need to go into a hospital, but, rather, who could be taken care of in a day care center operation or an outpatient center.

This is one of the ways in which I believe we will reduce, ultimately, the patient population at St. Elizabeths. The future program that we are calling for in the District of Columbia will call for a marked expansion of this kind of activity; namely, for the development of community mental health centers along the lines that NIMH has recommended, which would include home psychiatric services, a service under which we would provide psychiatric services to emotionally disturbed patients right in their homes. This, in my opinion, would have a very powerful effect upon reducing the number of patients ultimately going into St. Elizabeths Hospital or, for that matter, even into the District of Columbia General Hospital, because we will find many patients who

do not need to go into these hospitals, who could be taken care of at home with some supportive therapy. Some of them could be seen in the outpatient clinics; some of them could be helped and provided service in a day care center; and, we hope to establish additional day care centers. In fact, we already have money appropriated, at least through the Senate this year, to begin to study this particular program in one area of the District. So, we are hoping to establish a number of day care centers for this program.

What I am saying, Mr. Reisinger, is that the future program that we contemplate will have a marked effect, in my opinion, on reducing the patient population at St. Elizabeths Hospital in these ways:

- (1) Reducing the number of patients, that go into the hospital, and
- (2) hopefully, increasing the number that leave.

Mr. DANIELS. Is this home treatment program that you have just described the program that was developed in the Boston Hospital?

Dr. GRANT. It was not originally developed in the Boston Hospital, Mr. Chairman. It has been a program that has existed in Europe for many years. It has been created in this country in Florida, in Boston, and a few other places. It is rather similar, Mr. Chairman, to the program you are now thinking about, yes.

Mr. DANIELS. An article appeared in the Saturday Evening Post on November 23, 1963, under the heading "Dial a Psychiatrist"; have you seen this article?

Dr. GRANT. I have.

Mr. DANIELS. And basically the program you have described is set forth in this article here?

Dr. GRANT. It is very similar to this, although this article does not describe, to the best of my recollection, some of the things that we could include in the program, such as the day care center operation, which I think is a very important part of it; but, essentially, what you are saying is correct; namely, that the kind of program we would develop would be similar in many respects to this, yes.

Mr. DANIELS. If there is no objection at this point, I would like to offer this to be filed with the record. Any objection?

Hearing none, it will be so ordered.

(The article referred to follows:)

[From the Saturday Evening Post, Nov. 3, 1963]

DIAL A PSYCHIATRIST—NOW THE EMOTIONALLY ILL GET FIRST AID, WITH ASTONISHING RESULTS

(By Robert P. Goldman)

The telephone number is Geneva 6-2330. On a muggy, misty morning last summer, a distraught husband in Boston dialed the number and blurted out, "You've got to come here quick. I can't take it anymore. My wife has been acting crazy. She cries all the time, and won't leave the house. She says she's going to kill herself."

Dr. Jacques Drouin, of the Boston State Hospital, drove immediately to the patient's home. He found the woman lying on the living room floor, half naked. He sat down on the floor next to her and said in a gentle tone, "I'm Dr. Drouin, a psychiatrist. I'm here to help you. Please tell me what's wrong. Why are you so unhappy?"

"Nobody wants me," the woman sobbed. "Nobody loves me. I'm worthless, worthless."

"You have a great deal in life," Dr. Drouin reassured her, "a devoted husband, two wonderful daughters. I'll try to help you understand. But if you want to get better, we'll have to work together."

"No one cares about me," she persisted. "They all hate me. They're going to set fire to the house across the street, and then they'll set fire to this house. After that, they'll put garbage in the water to poison me."

"I'll make sure no one hurts you," said Dr. Drouin, "but I don't want you to do anything to harm yourself." Over and over he repeated these words of reassurance and finally got the patient to promise she would not attempt suicide. He prescribed a drug to quiet her and told her he would return the next day.

Two visits later Dr. Drouin discovered that the patient's oldest daughter had recently given birth to a son. This usually joyous event had set off the woman's emotional explosion. She felt that her daughter did not "need her" to help raise the infant. She felt old, isolated, unwanted, of no further value to the people she cared for most deeply.

Dr. Drouin explained the situation to the daughter and obtained her cooperation. Then, after weeks of painstaking treatment in the home, the woman began to understand why she had become so depressed. Gradually her symptoms began to ease. Her delusions disappeared. Recently she told Dr. Drouin, "I'm well enough to look for a part-time job. Oh, yes. I was wrong about my daughter. She asks my advice about the baby and wants me to take care of him very often."

"We were amazed at this woman's progress," says Dr. Drouin. "At first, she showed real signs of paranoia, and we were sure that she was headed for the hospital. But she kept improving. Like many of our patients, this woman did much better than we dared hope."

This case and others like it represent a major triumph for "psychiatric first aid," a completely new and radical approach to helping the emotionally desperate. Instead of waiting for the patient to come to his office, the psychiatrist goes to the patient at the moment he is needed most, right in the home. Once inside the door, he faces an individual and often an entire family in tragic emotional turmoil. He or his assistants may continue giving home treatment for months.

Comprehensive home treatment, known at Boston State as the home treatment service, was started last year after 5 years of research to determine its feasibility. At about the same time a similar program got underway in Pinellas County (St. Petersburg and Clearwater), Fla. The idea is now catching on elsewhere. Limited home programs are in operation in San Mateo, Calif., Oklahoma City, Philadelphia, Washington, D.C., and New York. A dozen other cities are looking for personnel to start similar programs. The Boston unit includes full-time psychiatrists, nurses, and social workers. In Florida general practitioners with special training in psychiatry make the home visits, but they are backed up by part-time psychiatric consultants.

Because it is so far beyond the classical mold of psychotherapy, home treatment is still controversial. A spot check of 40 Boston psychiatrists revealed that many opposed the entire idea. "It's a great time waster and interferes with appointments," one declared. "The doctor must have a sense of control, so why take a chance by going into the home?" A second psychiatrist stated flatly, "I get around home visits by charging a lot for them." And a third added, "I simply refuse to see patients at home. Let the young men handle them."

Against these negative voices, however, there are enthusiastic advocates. "Home psychiatric treatment is a terrific idea, and it's here to stay," says Dr. Robert Felix, Director of the National Institute of Mental Health at Bethesda, Md., one of the largest of the Federal Government's medical research units. "Immediate treatment right within the home makes great good sense. Many a patient who is treated in this fashion will never see the inside of a hospital. In the next 20 years, I believe, home treatment and other emergency psychiatric services will cut the population of State mental hospitals in half. That's a lot when you consider that we have 520,000 patients in all our public mental institutions."

Dr. Alfred S. Friedman, of the Philadelphia Psychiatric Hospital, argues that psychiatry has been too preoccupied with the individual and has often overlooked the problems of family life. "Seeing the family in the natural setting of its home provides a diagnostic advantage," Dr. Friedman says. "At home the family cannot hide its real ways of living, cannot present a false facade of adjustment, as they often do in the office. And the doctor obtains a much clearer picture of what is really going on."

There is another important point in favor of home treatment. Many patients simply will not move 1 inch to seek treatment, no matter how much their distraught relatives may implore them. Their illnesses are actually so disabling

that they cannot leave the house. For such patients, and for many others with "exploding symptoms," home treatment may represent the only means of rescue.

Home treatment also provides help to the seriously disturbed low-income patient who has neither the money nor the motivation to obtain the "normal" types of psychotherapy. In many such cases, if the patient's symptoms annoy outsiders, the police intervene. The patient is likely to be arrested, jailed, and later sent to the hospital. Home treatment saves everyone both trouble and money. At present, the treatment is free, although patients who can afford it will be asked next year to pay up to \$5 a visit. The State, which must pay \$3,500 a year for any hospitalized mental patient, can treat him at home for one-fifth of that amount.

Henry Mirsky, chief psychiatric social worker of the Boston Home Treatment Service (HTS), explains its value this way. "In the idealized version of psychiatry, the well-scrubbed patient goes to the doctor's office or to the clinic and asks for help. That's fine if you happen to be well scrubbed. Many of our patients aren't. They're afraid to set foot outside their homes. Many are in terrible panic states. Least of all do they want to be surrounded by men and women in white coats."

To reach their goals, HTS workers sometimes go through extraordinary gyrations. They have counseled patients locked in bathrooms, cowering in cellars and attics, in backyards and garages. To bring still other patients home for treatment, HTS has tracked them down in bars, bus stations, self-service laundries, supermarkets, and even convents.

Each home-treatment visit is a drama. Recently an HTS psychiatrist walked in on a patient who was alternately leaping, dancing wildly, and banging his head on the floor. In another home, a 28-year-old woman glibly announced that she planned to perform an abortion on herself and produced an ugly-looking instrument she said she would use. In still another household, the patient loosened his tight grip from around his wife's neck just as the psychiatrist appeared on the scene.

One woman, a middle-aged librarian, insisted that Dr. Drouin "move the refrigerator before I talk about my troubles." He took off his coat, leaned his 140-pound, 5-foot-6 frame and shoved. The patient promptly retrieved some letters she had dropped behind the refrigerator, then proceeded to tell him about her acute anxiety, which caused her to believe she was suffering from a brain tumor.

Another patient leads the psychiatrist down to the basement where he has installed a cot, radio, two-burner hotplate, bookshelves, and a clothesline. He is afraid of high places and knows that if he jumps out of a basement window he will not be hurt.

Home treatment service is no substitute for sustained psychotherapy, but it provides a unique kind of "crisis intervention" which cuts short the suffering of patients and their families and often spares them from financial disaster, social ostracism, and hospital commitment.

In its short history HTS has chalked up a remarkable record. More than 300 patients have been treated since the program began in November 1962. Every patient who threatened or attempted suicide is alive and holding his own. Many others have improved so markedly that they have resumed useful activities. Only 66 of the 300 had to be hospitalized, although a few were referred to clinics for part-time care. In addition, 300 relatives, many of them also deeply neurotic, have been counseled.

"If it had not been for home treatment, one-third to one-half of all our patients would have been hospitalized," says Dr. Alvin Becker, the young (33), energetic director of HTS. "This is our basic goal—to keep people out of the hospital."

Many patients require dozens of home visits, but every so often a patient will begin to improve significantly after only a single visit. "Sometimes you can practically see them getting better before you open your mouth," says Dr. Becker. "Some gain emotional strength just by knowing that they have someone on their side, someone who won't call the police or the paddy wagon to haul them away."

The one-visit cure helped a frail, 70-year-old woman who weighed all of 93 pounds. For weeks she had sat alone in her house, because she feared she would "kill someone on the outside."

During a single visit Dr. Becker convinced her this fear was unreal. He took her for a walk and "proved" to her that she was not an uncontrollable maniac about to unleash tremendous strength. She still has a number of other fears that the HTS staff members are working on, but at least now she goes shopping and visits a few friends.

HTS does not understand fully why the one-visit treatment sometimes bears fruit. It has worked, though, even with a few extremely difficult patients, heavy drinkers who have been borderline alcoholics for years. Not long ago Dr. Becker was called to a home in which the husband, a 39-year-old factory worker, was drunk. Missing even a day's work threw the family into financial chaos, so the wife wanted her husband back on the job as soon as possible.

"Why did you drink so much?" Dr. Becker asked.

"Who the hell are you?" the patient shouted.

"I'm a doctor. Your wife called because she's worried about you. Tell me, why did you keep drinking last night?"

For 20 minutes the patient refused to answer, but finally he looked at Dr. Becker woefully and said, "They don't think I can do an honest day's work. They don't want me back on the job."

"That isn't true," said Dr. Becker. "I just called your boss, and he wants you back tomorrow. I'll call him right now and prove it to you."

He did. The patient promised he would drink no more that day and would return to work the following morning. He kept his promise. The patient is still no teetotaler, but he has not missed a day's work in the past 5 months.

"Psychiatric first aid, yes," says Dr. Becker. "But at least the patient has continued to function. He hasn't gotten worse. He's bringing home a weekly paycheck. Of course, we haven't seen the last of him, but for the time being, he is not a problem."

At times the threat of hospitalization is a formidable factor in bringing the patient around. The dread of commitment is so strong that it makes some HTS patients begin to emerge from deep-seated illnesses, paranoia, schizophrenic reactions, depression.

THREATENING THE PATIENT

A 59-year-old carpenter fell into a deep depression because of mounting debts and a feeling that the world rejected him. An HTS psychiatrist visited him, prescribed medicine to improve his mood, and laid out a course of therapy. But the patient seemed to be making absolutely no progress. Day after day he would sit in his underwear in front of television. He refused to talk to his wife. He refused to use the toilet. One day, Psychiatric Social Worker Mirsky dropped in to see the patient. He decided to use a tactic which he had rarely used before.

"Do you like it here, living in this house?" Mirsky asked.

"Yes, I do," the patient replied.

"Well, if you don't take your medicine," Mirsky warned, "we may have to put you in the hospital."

"I don't want that," the patient said. "People never get out of there."

"Then get a glass of water right now and take your medicine."

"OK," the patient said, "but I won't use the toilet. It's broken."

Mirsky tightened two loose bolts on the toilet seat. From that point, the patient began to discuss his troubles. Gradually he started improving. He is back at work now, 3 days a week. He still has many unresolved emotional conflicts, but life is beginning to be bearable once again for him and for his wife.

Threatening the patient and repairing a toilet seat hardly can be characterized as "book psychiatry," but such actions are an important part of home treatment. The therapist often has to practice a kind of psychiatric brinkmanship improvising as he goes along to meet the patient's particular needs. This is the crux of here-and-now therapy.

Only once has an HTS staffer been assaulted. Dr. Drouin walked in on a young woman, who was obviously agitated, pacing up and down a dark hallway and puffing a cigarette. When he announced his purpose, she wheeled around and cracked him across the jaw. Then she drew back quickly and became apologetic. "I'm terribly sorry," she said. "I know I shouldn't have done that."

"Since then," says Dr. Drouin with an amused twinkle, "that patient, a manic-depressive personality, seems to have improved somewhat. Perhaps the punch was therapeutic."

To the delusional patient, and there are many at home untreated for years, the HTS attitude is, "Let's not talk about the lights you say are shining through the windows, the people plotting to take over the government, the fellow you're sure is following you down the street. If you talk that way, you'll only make yourself worse. And people will say you're crazy. Let's talk and think now about what you need to live happily, to begin enjoying things again."

Once the patient views the doctor, nurse and social worker as allies, Dr. Becker explains, "his anxiety gradually is relieved, and there is a decreased need to shut out the world, to use distortion and delusion as psychotic defenses against reality. Finally, H.T.S. employs suggestion to help the patient cope with his immediate problems. The suggestions range from how to get the money for next month's rent to how a distraught new mother should care for her infant.

On most H.T.S. house calls, the psychiatrist is accompanied by a nurse or social worker. The doctor goes right to the patient and speaks to him alone. The nurse or social worker gathers the rest of the family in another part of the house to get its version of "what's going on." Then, the entire family reassembles in one room so the psychiatrist can outline a program of treatment.

The Boston Home Treatment Service serves only the Dorchester section, which surrounds Boston State Hospital and has a population of 180,000. The majority of these residents are lower middle class or blue-collar workers, some of whom are on relief. H.T.S. carries its expanding load with three psychiatrists, a handful of social workers, nurses, an occupational therapist and students-in-training. It provides a 9-to-5 coverage Monday through Friday and has been averaging 25 to 30 new patients per month.

The H.T.S. psychiatrist operates much as a family doctor would in emergency situations. Many psychiatrists believe that this is an ideal role for their colleagues. "A lot of psychiatrists get away from the idea that they are doctors first," said one Boston practitioner. "They forget that they were supposed to treat sick people, no matter what hour of the day they may be called."

And another psychiatrist added, "Psychiatrists are the very people who preach that you should be sensitive and close to the people's needs. Yet they sit on one part of their anatomy listening to only one member of the family's troubles. What we need are family doctors in a psychiatric sense. Certainly home visiting may be a way to get our psychiatrists back in the community."

Mr. REISINGER. Doctor, as I understand it then, the program, the development of which is contemplated by the \$50,000 grant from NIMH, will have the effect of reducing the inflow of patients and also the effect of increasing the outflow of patients presently in the hospital. And it is for this reason that it would have a marked impact on the patient population at the hospital?

Dr. GRANT. Yes, sir.

Mr. REISINGER. You said, in your discussion of the study of the Secretary of Health, Education, and Welfare, that one area of consideration was the future requirements of the District of Columbia in conjunction with St. Elizabeths.

I think that was your first statement.

Dr. GRANT. That is correct.

Mr. REISINGER. Is it not then the case that the study underway in the District of Columbia will develop information which would be, seemingly, absolutely essential for an accurate evaluation of the future role of the hospital as an adjunct to the District of Columbia program?

Dr. GRANT. I would certainly hope so. This is our intention. I think it is inevitable that we must consider the role of the St. Elizabeths Hospital as it relates to the District program; yes.

Mr. REISINGER. What is the contemplated completion date of the Secretary's study?

Dr. GRANT. I don't know the answer to that, Mr. Reisinger. There has been no time set, that I am aware of, for a completion date of

that study. As to the study that was carried out by the staff group, the result of which was the document I mentioned, that part has been completed and was followed by a meeting; but, arising out of that meeting, there were some substantial questions concerning the impact of the recommendation. I am not sure that I understand exactly what is going on at the present time in connection with that committee. Although I would hazard a guess that there will be at least one or, perhaps, more additional meetings of that committee.

Mr. REISINGER. It has been suggested here, I think by Mr. Jones of the Department and perhaps by Dr. Cameron, that a report of that group was contemplated in perhaps January or February of 1964.

You have no knowledge of this?

Dr. GRANT. No; I really don't, one way or another.

Mr. REISINGER. With respect to the District of Columbia study, when is the report contemplated there?

Dr. GRANT. I have no real way of knowing this because one of my problems has been that it has been intimately connected with my proposals for the reorganization of the Department. The proposals have been held up, pending action in the Congress upon our budget, and which we hope will be completed in a very short time now.

Subsequent to this we can move ahead on a reorganization and this will, in effect, also help us to create a committee to study this problem. What I am basically saying is that I really do not know when our study will be completed, although my guess would be, and this is nothing more than a guess, somewhere between 1 and 2 years from now, hopefully closer to 1 than 2.

Mr. REISINGER. In any event, within perhaps a year you will have developed data which I judge is essential to a accurate evaluation of the future role of the St. Elizabeths Hospital, at least, insofar as it relates to the District of Columbia.

Is that true?

Dr. GRANT. That is right; yes.

Mr. REISINGER. I have no more questions.

Mr. DANIELS. Mr. Sickles.

Mr. SICKLES. Dr. Grant, how are the mentally retarded in the District of Columbia cared for?

Dr. GRANT. The mentally retarded are taken care of in a number of ways. The basic way is through a program that the Department of Public Welfare has. They are admitted to an institution in Laurel by a particular procedure; but, this is the basic program for taking care of the mentally retarded.

In addition to this, there are some facilities provided by the Board of Education for teaching some mentally retarded children and there are some facilities in the Department of Public Health for evaluating mentally retarded children; but, I may say that this is also one of the future programs that we are hoping to get into, particularly, with the additional money made available by Congress.

This is another plan that we have ready to go to really develop a program in the field of mental retardation, which will take in to consideration the evaluation of the mentally retarded, the operation of day care centers, treatment facilities, recreational opportunities, vocational training particularly for the children, vocational rehabilita-

tion, and the provision of adequate services to take care of these children, either through day care or inpatient facilities.

Mr. SICKLES. What is your relationship with the Department of Public Welfare. Do you have an indirect relationship?

Dr. GRANT. A cooperative relationship.

Mr. SICKLES. You have no authority over them and they have no authority over you?

Dr. GRANT. Oh, no; except that a bill, and I can't really remember if it has been passed, but it was pending before Congress and I have a suspicion that it has been passed, though I am not certain of this, does say in effect that persons who wish to go to the institution at Laurel voluntarily may do so, provided that the Department of Public Health, after an evaluation of these children, agrees that they are retarded to a degree making necessary their institutionalization. So, we do have some authority in that particular context. We have no specific authority other than a cooperative relationship that we have with the Department of Public Welfare.

Mr. SICKLES. This is going to sound like a silly question, but Dr. Cameron just walked into the room. Have you ever met Dr. Cameron?

Dr. GRANT. Yes, I have.

Mr. SICKLES. Have you ever talked about this problem with Dr. Cameron?

Dr. GRANT. Yes; we talked about it, as a matter of fact, about 2 weeks ago.

Mr. SICKLES. Do you understand our confusion when Dr. Cameron says one thing, and I am sure it is based upon what his subordinates tell him, and then you tell us something which, in the light of what he says, doesn't really make sense?

Can you understand the confusion that I, as a member of this committee, would have?

Dr. GRANT. I can understand clearly this confusion.

Mr. SICKLES. Could you speak to that? Are there some factors that we don't understand, that we don't have enough information about, and we are not asking the right questions?

Apparently, Dr. Cameron says that, because of the lack of funds in the form of stipends, these homes are not available and you say the homes are available.

Where do we go from there?

Dr. GRANT. I can't answer that question, Mr. Sickles.

Mr. SICKLES. Would it be possible to ask Dr. Cameron to come to the stand and have them both here at the same time so we can bring this issue to a head?

It seems to me there might be a simple answer to it. It is certainly not my intention to embarrass anybody, but we have a contradiction in the facts that are being presented.

Dr. Cameron, you walked in quite late. We hadn't dwelled on this particular point too much, although we did earlier in the testimony, but substantially it is this.

In our discussions with you, you have indicated that if more money were available to pay for the folks who will take a patient into their home, then perhaps you would have less population to deal with at St. Elizabeths; and, Dr. Grant says that we do have some 30-odd homes available, and have had, and as a result of the fact that they don't

need any more homes, they have not replaced, for a few years, one individual who left because of the frustration of finding homes that weren't used. So, I was just wondering whether with both of you here, we couldn't bring this to a head and see what the problem is.

**STATEMENT OF DR. DALE C. CAMERON, SUPERINTENDENT,
ST. ELIZABETHS HOSPITAL**

Dr. CAMERON. Mr. Sickles, my comment that there could be a substantial number of additional persons placed in homes was based on two factors: One, a survey which we did of the people that we thought could be placed in foster homes, and this amounted to several hundred. I should not wish you to get the impression that we think that all of those are ready to move immediately. It takes usually a matter of weeks and months to work with each patient in order to get him ready to move to a home, primarily because many of these people have been in the hospital for a very long time and many of them do not wish to leave the hospital. This is factor one.

Factor 2 has to do with the rate of payment for foster homes. There are two rates, as you know, one of approximately \$67, which is essentially a boarding home and does not require the approval of the home as a foster home by the District of Columbia Health Department.

A second rate is \$100 a month for the vendor and \$10 for the client, if you will. To obtain that rate it is necessary that the home be approved by Dr. Grant's Department.

There are 39 homes currently in use in connection with the program, speaking now only to the \$100 program. I believe Dr. Billet testified the other day there were some 39 vacancies in those homes. Because of the problems around this area I asked if Mr. Hicks or Dr. Grant's staff, his social worker, could sit down with the social workers at the hospital and see if they could reconcile any apparent differences that there might appear to be.

They did so yesterday morning and of the 39 vacancies reported, 10 are involved in homes where a match or a fit has been established and where the necessary forms have been submitted to the Health Department for approval and transmittal to the Department of Public Welfare. As soon as those forms are returned to us by the Welfare Department, and approved, those 10 patients will be placed.

As a matter of fact, one of the 10 has since been filled. One of the homes, both Mr. Hick and our workers feel, is perhaps not as satisfactory as it might be because of some problems of the home sponsor. This would leave then 10, plus 1, from 39 is 28 vacancies, of which 6 are in active matching process, where tentative arrangements have been made to put persons in.

These are not arrangements made in the last day or two but have been going on for some time, which leaves 22 actual vacancies for us to work with in those homes.

We have, certainly, far more than 22 patients who are potentially able to go into homes, but we have not yet been able to get a match with anyone, who at the moment is ready, and these other 22 homes. I think we shall, but we will have to do other work with other patients in order to get someone ready to go into these vacancies.

At the same time, we have patients that we have tried to make a fit in some of these homes; and, we have been unable to do so, where there is lack of willingness on the part of the home sponsor to take a particular patient or, as sometimes happens, the particular patient does not want to live in the home presented to him.

Mr. SICKLES. But nothing you have said at this point would indicate that an increase in the rate of consideration would change this picture at all.

Dr. CAMERON. Yes, we think so, because some of the patients we have will require a substantial amount of supervision in a foster home; and, it is our impression, and of course it could only be validated by a change in the rate, that there would be an easier task of placing some of the patients if the rate were increased.

I repeat that this belief on my part can really be validated only by testing it if the rate is changed.

Mr. SICKLES. Let me refer now back to Dr. Grant.

It was my impression that, when you have a running backlog of 39 to 40 homes that aren't being used, it would be the tendency in your Department not to go out and find more homes.

Would that be true?

Dr. GRANT. That is correct. We wouldn't go out normally to find more if these were not being used; that is correct.

Mr. SICKLES. But if St. Elizabeths were to bring to your attention that these just didn't fit, wouldn't this be cause for you to go out and look for homes that might fit, if this request were made?

Dr. GRANT. Yes, it would.

Mr. SICKLES. And so far you have always had some vacancies; so that, it would be reasonable to assume that with the same amount of stipend you could find other homes.

Dr. GRANT. This has been our experience thus far, yes.

Mr. SICKLES. When you have had these that didn't fit, have you requested that Dr. Grant's Department go out and find more homes?

Dr. CAMERON. We have indicated to his social service staff that we think it would be useful to have additional homes available at which to look.

We have not in the past referred patients to Dr. Grant's home finders unless a fit had been achieved. At one time earlier in the arrangement, I think well before Dr. Grant came here and I think before I did, a substantial number of patients were called to the attention of the home-finders' unit, where there were no fits. We just said, "These are patients who are potentially able to go in the, relatively, near future."

This was a rather substantial number and it had been my impression that the Health Department has preferred that we not make referrals, unless we know of a fit. But, because of the discussions that we have been having, both here and that Dr. Grant and I had the other day, though I must hasten to add that Dr. Grant and I did not agree on this particular thing the other day, I have asked our social service department to send to the Health Department referrals on some patients for whom a fit has not yet been found.

It has been our understanding that they did not want such referrals in the past, but we will send a few of that kind. We will continue to try to make fits with the homes available and the patients

that are ready to go; but, in addition, if we have a patient for whom we have been unable to make a fit, we will refer those to the home-finders' unit to see if an additional home might be found for this person.

Dr. GRANT. May I say, Mr. Chairman, that I think it is rather interesting that both Dr. Cameron and I have said exactly the same thing on one key issue, which I think is very important, and I would like to point it out again. I believe he said in his testimony that one of the basic problems revolves around the fact that many of these patients have been in the hospital for many years and it is not an easy matter to sell them on the idea of leaving the hospital and going into a foster home; and, this is exactly what I said; I believe you may remember, Mr. Chairman. I think this is very much a basic part of this problem.

Mr. DANIELS. May I ask you this question?

Do you need the consent of the patient in order to make a fit?

Dr. GRANT. I think Dr. Cameron might speak to that better than I; but, I think it would be very difficult, Mr. Chairman, to just arbitrarily send the patient out of the hospital without a clear understanding on the part of the patient, that this was to be his sponsor and that he was going to live in this home and be supervised. I think you would have more problems that way. You have to get some kind of a fit between the patient and the sponsor; yes, I think so.

Mr. DANIELS. Could the patient be prepared to think of leaving the hospital at some time, that it would be more appropriate and more advisable for that patient to be in a home rather than a hospital?

Dr. GRANT. Yes, this is what St. Elizabeths tries to do and I think this is the crux of the matter. This is not always an easy thing to do. I think Dr. Cameron can speak to this better than I.

Dr. CAMERON. That is quite correct. It usually takes several months. Some patients are easy. Some patients are more difficult.

We have had some where it has taken as long as a year to get a patient ready and willing to go. The problem is if you send him unwillingly he usually would create enough difficulties in the home to cause the home sponsor to ask to have him returned to the hospital.

Mr. DANIELS. Dr. Cameron, has the communication between the Public Health Department and St. Elizabeths Hospital been better since this investigation started than it has been for the past 3 or 4 years?

Dr. CAMERON. Well, I suppose both Dr. Grant and I ought to speak to that issue.

It is my impression that the communications between his Mr. Hicks and our foster care unit has always been quite good, that these people understand each other quite well and meet together very frequently.

Mr. DANIELS. What has been the practice in the past?

Dr. CAMERON. This is what I am describing. It has been the practice in the past. In addition, when I wanted to try to reconcile some slight differences between the figures that Dr. Billett gave the other day and the ones that were given me by my own staff we are able to arrange for the people to get together very quickly and they resolved it very easily.

Mr. SICKLES. Mr. Chairman, it seems to me that, as difficult as it would be for us, even though we might recommend it, to be effective

in securing an increase in the rate of payment to these foster homes, a little more coordination is necessary in order to clearly establish that it is because of the lack of funds that the homes are not available.

It would seem to me that you are well on your way as far as this is concerned. However, when the head of one institution says that he thinks more funds are needed, but the head of the Department says that there are these vacant homes, it seems to me that you have to go the one step further to make sure that you don't have fits and you must request more and specifically say, "Well, we can't make fits on these. We need more."

You have to then have the problem of not being able to get more because of the lack of funds, and unless you get to that point we don't have a sufficient basis here to adopt the recommendation you make that this stipend be increased.

Isn't that a fair assumption? Wouldn't you assume that this would be a logical conclusion from the testimony that we have had before this committee?

Dr. CAMERON. It is one conclusion I suppose that could be reached. I would repeat that in the 39 homes, there are actually 22 that are real vacancies. The others are either in process or will be submitted very promptly.

It does take a long time to get these people ready to go. I think our staffs have worked together quite harmoniously. I believe Dr. Grant might joint me in saying that the mechanism established for carrying out this program is quite awkward.

Would you agree with that, Dr. Grant?

Dr. GRANT. I am not sure that I would agree with this but I think it is something that we are looking into now; and, until we come up with an alternative, I think I wouldn't comment on that further.

Mr. SICKLES. If I may go to another line of questioning while both gentlemen are before us; in my discussions with Dr. Cameron, he put great emphasis on the need for day care, outpatient care and possible change of the law with respect to St. Elizabeths. Dr. Grant this morning is talking about the same thing, as far as the District of Columbia General is concerned.

Is there an area of conflict here? Is there an area of jurisdictional overlap? I wonder if I could have each one of you speak to this. Are you both going to try to do the same thing or is it a question of which one is going to end up having a right to do it?

May I have some comment with respect to this?

Dr. GRANT. Dr. Cameron talked to me about this proposed legislation some time ago and my feeling at that time, which I indicated to him, was that I felt it was premature, until such time as the studies that we have been talking about are completed; because, only at that time, it seems to me, can you determine and agree on exactly what role each agency should play in the particular program. I think that if St. Elizabeths Hospital proposes to develop this program, then there could well be duplication; and there might well be some difficulty in clearly understanding whose job it is to do what.

Mr. SICKLES. Will you speak to that, Dr. Cameron?

Dr. CAMERON. I wonder if I might, before responding directly, since I came in late, inquire whether or not Dr. Grant has indicated his thinking about the regionalization of the city and that sort of thing?

Dr. GRANT. I didn't mention anything about that specifically, no.

Mr. SICKLES. We are going to get to that a little later. I want to ask Dr. Grant about that after we get through with this line of questioning.

Dr. CAMERON. I see. It is somewhat related to the question you are posing. It is my understanding that in trying to develop community centered mental health programs through the legislation recently enacted by the Congress, it was the hope to do this for a variety of reasons; and in doing it, where feasible, to try to utilize existing resources as well as possible.

It would occur to me that St. Elizabeths has a rather substantial resource within the District of Columbia and that it might be useful to consider using it in the overall program for the District.

If the community mental health centers are developed in various sections of the town, then in connection with each of those, and I think Dr. Grant would agree with this, there should be outpatient, day care, and that type of activity.

Dr. GRANT. Yes.

Dr. CAMERON. Then if the city is to be regionalized, this would mean that there might be more than one location at which services were provided.

I would see no conflict at all if District of Columbia General were to develop such facilities or if other places in the city were to develop such facilities and also St. Elizabeths, in order that continuity of care could be given to such patients as are treated in each of the mental health centers.

Mr. SICKLES. It would make no difference in your view that really you have two units of Government providing the same service for the population as long as there is some geographical division of the city?

Dr. CAMERON. This would be my view; yes, sir.

Mr. SICKLES. I wonder if you would speak to that, Dr. Grant, what you think the role of St. Elizabeths should be. This is what you are studying.

Dr. GRANT. I spoke to this briefly at the last committee meeting of the committee appointed by the Secretary of Health, Education, and Welfare.

Basically, I think, as Dr. Cameron has said, that we would hope to develop community mental health centers, each serving a specific population area; and the one I am thinking about now would serve a population of 250,000, with each devoting attention to providing the full gamut of mental health services, including some that I outlined, such as the home care service, outpatient, vocational rehabilitation, recreational facilities, day care center, inpatient care, and so on.

As to how to fit St. Elizabeths into this program, I think there is one obvious fact; or, at least, it is obvious to me. I think that Dr. Cameron agrees with this. Irrespective of the development of this new program, there will need to be, for as long as we can foresee, an institution for medium and long-term care patients. There will still be a number of patients, in fact, a considerable number I think, who will need medium- or long-term care in a hospital; and it would seem to me that St. Elizabeths Hospital, which has traditionally had this role as one of its functions, should of necessity continue to carry out this particular function. So, this, I think, would be an important responsibility, as I see it, of St. Elizabeths Hospital.

Speaking to the other point that Dr. Cameron made, that is, could St. Elizabeths Hospital also serve as one of the new community mental health centers, I think this is very definitely conceivable, possible, and I think may well be desirable; but the basic difference of opinion comes in connection with the organizational responsibility of that unit.

I contend, and did contend at the meeting that I have been referring to, that if it is the District of Columbia's responsibility, and I believe it is, to care for its mentally sick, and if we are developing a program aimed at doing just that in a variety of ways, then I think it is our responsibility, if we are going to develop community mental health centers, for each of these centers to be organizationally related to each other and be within the Department of Public Health.

This is how I would view the component that might be located at St. Elizabeths Hospital; that that component should be part of our total organizational framework. This is not to say that the Federal Government, in IMH, for example, could not put funds into such a project, could not use this as a training and research facility. I still think this could be done. What I am basically saying is that, as I see it, without a great deal more thought that I think needs to go into this, it would seem to me that St. Elizabeths Hospital will play a vital role in providing, one, a medium- and long-term care facility for patients that are going to be here for a long, long time; and, two, one of our community mental health centers in the future.

Mr. SICKLES. I don't know whether you were here when Dr. Barton was testifying in answering some questions by Congressman Goodell. In reviewing one of these I find he said:

For example, the District of Columbia's own idea as to how St. Elizabeths might fit in a program as compared to, for instance, what the Federal Government feels is the role of St. Elizabeths, had been interesting to me, coming from the outside.

They are exactly opposite points of view.

Is he just referring to that one unit that would be located physically at St. Elizabeths? and the question is, "Who would control that unit?"

Dr. GRANT. I believe that this is the major issue at the present time. Dr. Cameron might want to speak, but, as I see it, this is the major issue.

Mr. SICKLES. I would like Dr. Cameron to speak.

Dr. CAMERON. I think he is quite correct. In response to a question the other day I indicated that I thought the Federal Government, since it has substantial responsibility for fostering improved care and treatment for the mentally ill throughout the country, should have a place in which it can carry out training programs directly as well as to make grants for training to the universities as it now does. At a place of its own it could try out new teaching techniques and, if good ones are developed, make them available to other centers or learn from other centers as well if they develop good techniques.

I indicated also that I thought it useful for the Federal Government to operate at least one community mental health center since it is trying, on a consultation basis, to help the States develop these throughout the country—operate one to the end that it would be able to carry out research on organizational and community relationship problems. This would give the Federal Government firsthand experience for its consultation role to other agencies.

It is for these reasons largely that I think it would be useful if St. Elizabeths were used as one of the community mental health centers in Washington, D.C.

I think there is no difference of opinion between Dr. Grant and myself that it should be used in some way, since it is a valuable resource.

The only question would be then as to whether or not the interests of coordination and operating them in a single department, as Dr. Grant has proposed, would outweigh the national needs for a demonstration facility.

Mr. SICKLES. Thank you very much. I want to thank you both. You have been very helpful.

Mr. DANIELS. We are honored here this morning by the presence of the chairman of the full committee.

Mr. Chairman, do you desire to ask any question of either of these doctors?

Mr. POWELL. Thank you, Mr. Chairman.

STATEMENT OF HON. ADAM C. POWELL, CHAIRMAN, COMMITTEE ON EDUCATION AND LABOR

Mr. POWELL. My attention was first drawn to St. Elizabeths Hospital by a newspaper account of the high rate of recidivation among the prisoner patient population of that institution. The committee is grateful to Miss Myra McPherson, of the *Evening Star*, for the exemplary demonstration of the value of fine journalists in a free society.

In the 2 weeks and 2 days since the subcommittee was fully staffed, there have been a number of startling developments.

Perhaps first among these illustrates perfectly the dire need which exists for adequate staffing of congressional committees, so that they may competently discharge the responsibilities assigned to them. It is well to remember that those who molded the legislative branch to perform its primary function—the protection of the public welfare—notable among whom was Mr. Jefferson, assigned various areas of governmental activity to the several committees of the Houses of Congress for precisely this reason. In this area I am afraid that those of us on this committee must admit some measure of fault. It has been over 17 years since the committee last exercised its supervisory jurisdiction in a matter affecting St. Elizabeths Hospital. In these years during which the focus of public attention has been on the rapidly expanding developments in the fields of labor and education our staff has been taxed almost beyond endurance by these areas of highest priority.

In these same years legislation has been enacted which materially affected the population growth at the hospital and the cost of maintaining these patients. Subsequent to the enunciation of the *Durham* rule by the U.S. Court of Appeals for the District of Columbia, there was a comprehensive revision of title 24 of the District of Columbia Code, in such manner as to place all criminal defendants, found not guilty by reason of insanity, in St. Elizabeths. Significantly, in 1954, there were 6 such defendants committed; in 1962 there were 61. An average of 249 such patients were in the custody of the hospital throughout fiscal year 1963. Since January 1 of this year there have been 147 prisoner patients who escaped from the hospital. Statistics

showing the number of these escapees who are in the hospital as a result of the operation of the *Durham* rule and the legislation which followed it are not available; however, an analysis of 18 escapees since January 1, 1963, who been arrested for a subsequent offense ranging from simple assault to rape and murder shows that at least 14 were initially admitted to the hospital under title 24 of the District of Columbia Code. In 1953, legislation was enacted which revised the formula for contribution to construction costs so that the taxpayers of the District of Columbia assumed approximately two-thirds of the cost of such construction, albeit on a deferred amortization basis reflected in the increased payments per patient to the hospital.

Last year the cost of maintaining all prisoners committed from the District of Columbia, approximately \$2 million annually, was transferred from the Federal appropriation to the taxpayers of the District of Columbia. Each of these legislative enactments passed through the Congress without so much as a courtesy advice of their pendency to this, the committee having legislative jurisdiction over the hospital.

An even clearer pattern of bypassing this committee is evident in the area of new construction. The clear intent of title 24, United States Code, section 185, which is a limited authorization for the operating funds for the hospital, was that the hospital return to this committee for authorization for major alterations or new construction at the hospital. Nonetheless and despite the fact that the well-staffed office of the General Counsel of the Department of Health, Education, and Welfare was well aware of this circumstance, this committee has been consistently bypassed in the normal cycle of authorization and appropriation. I am not presently advised of the total sums so appropriated, but it clearly exceeds \$12 million, and is I am certain much higher. One such building, Howard Pavilion, the maximum security facility, appears from our testimony to have been at odds with the best psychiatric practice at the time it was planned, and now only 5 years after, it is recommended that an undetermined amount of money be expended to remodel this facility to comply with the best practices. In addition thereto, approximately \$8 million to erect additional facilities of a similar character is requested.

Secondly, our study indicates an astonishing absence of cooperation between the hospital and various agencies of the District of Columbia. One classic illustration of this condition is in the matter of reporting of prisoner escapees. It is axiomatic that the earliest possible notification to the police enhances the likelihood of immediate apprehension of the escapee, yet the officials of the hospital most immediately concerned with the problem are not advised of the routine nature in which the present method of reporting escapees is handled and express to the committee a willingness to confer with the police to improve the notification procedure, if the committee deems it advisable. It would seem to me that the custodian of a Federal prisoner would be most anxious to establish the most expeditious procedure for apprehension of an escapee—particularly in view of a criminal provision which makes the willful or negligent complicity in an escape from custody a felony chargeable against the custodian.

We find, also, that both the present Superintendent and his predecessor have consistently argued for additional funds, lamenting that perhaps as high as 50 percent of the present patient population of the

hospital could be adequately cared for outside the hospital if the required facilities were available. Among these facilities are psychiatric foster homes. There are approximately 360 such patients in the hospital, based on the estimates presented by the Superintendent for whom there is no legal authority for such placement; yet this committee has never been asked for authorization for such expenditure. There are based on the same estimates about 750 such patients who may be placed in foster homes by the District of Columbia Department of Health; nonetheless since the local government established a home-finding unit in 1960 only 92 patients have been referred by the hospital and there are at the present time 39 vacancies available.

Taking the maximum estimates given to us by the hospital, it would be possible to save the taxpayers almost \$2.4 million annually, should the necessary authorization be enacted. I repeat, this committee has not until this time been asked for the enabling legislation to make this possible.

On February 15, 1963, the President directed letters to the Secretary of the HEW and to the District Commissioners. It is apparent from reading the two letters together that it was his intent that HEW extend every possible assistance to the District in developing a comprehensive community mental health program to serve as a model for the entire Nation. In May, an advisory group on the future of St. Elizabeths Hospital was established by the Secretary to evaluate the future role of the hospital. It was instructed to report in January 1964. In September, there was finalization of a grant to the District of Columbia, by NIMH, an agency under the jurisdiction of the Secretary, for the purpose of conducting a study to develop a comprehensive mental health program for the District of Columbia, with instructions to complete its study in 1 year. Now it is apparent that if the hospital is to serve the function of a general mental hospital for the District, then its future must be evaluated in terms of the comprehensive mental health program for this will in large measure determine the patient population of the hospital. Yet the study of the future role of the hospital is to be completed months before it is known what the hospital bed requirements of the District will be. This is clearly a situation in which the order of priority is in my opinion reversed and at an estimated cost of \$50,000. Moreover, the members of this subcommittee were not even advised of the pendency of either study by the Superintendent when they visited the hospital, and he is a member of the Secretary's advisory group.

I want to congratulate the committee and Mr. Reisinger for the job you are doing and to again repeat what I said at the beginning, that this was brought to my attention by a newspaper article in the Evening Star.

There are certain things that I believe the committee should go into further.

One is the discrepancy in the statistics of the Police Department and those of St. Elizabeths Hospital on the number of escapes that are presently at large. The Police Department indicates there are 44 and the hospital says that there are 29. I think this should be resolved.

Mr. DANIELS. Our next witness, Mr. Chairman, is Deputy Chief Layton of the District of Columbia Police Department.

Mr. POWELL. Very well.

Mr. DANIELS. We had planned to go into the matter.

Mr. POWELL. This to me is a serious thing that is immediately facing us, especially, when I read the report prepared by Mr. Reisinger of the number of rearrests, and I see here such things as sexual psychopath, rape, sodomy, housebreaking, robbery, first-degree murder, armed robbery, forgery, housebreaking, intent to commit rape. This is a serious problem that immediately faces us in the District of Columbia and I would like the committee to really resolve this discrepancy.

The next thing that has come to my attention from this committee's preliminary findings is that the Howard Pavilion which is only 5 years old, built at a cost of more than \$7 million, is incorrectly designed for the optimum treatment of prisoner patients.

I would like the committee to find out who were the people consulted in this seeming waste of money which in 5 years proves to be obsolete.

It appears that it was obsolete before it was built and that \$8 million is needed now to build the correct kind of building. Also, I note this committee has requested Health, Education, and Welfare to furnish a list of moneys so spent. There is no law that gives any other committee the power to authorize the appropriation of any money for construction at St. Elizabeths Hospital. This committee has original authority. A careful reading of section 185 shows it is a limited authorization. There is nothing in this law that gives any authority to another committee to authorize a new building or major alterations of existing buildings.

I think this is very important; and, maybe if this clear violation of the law hadn't taken place \$7 million wouldn't have been squandered on a building which, according to the best professional advice we have gotten, does not meet the needs of prisoner patient treatment. The proof of it is that two new buildings are already needed at the cost of \$8 million when the other is only 5 years old.

I know the holidays are coming; but, if necessary, I will seek more money for the committee and go into this because these statements that I have made should be resolved one way or the other.

I am very happy Deputy Chief Layton is here and I hope when Mr. Layton testifies that Dr. Cameron will be present at the same time to resolve this situation of the number of escapees at large in the District of Columbia.

I wish that I could spend more time with the subcommittee, but, we have now functioning eight committees so I can't be here all the time, and you do have a complete staff.

That is all I have to say.

Mr. DANIELS. Thank you, Mr. Chairman.

I might say, Mr. Chairman, that counsel researched this question of the law on appropriations and brought it to my attention yesterday, and we did intend going into that.

Mr. POWELL. He brought it to my attention. I appreciate it, too, because it is clear and I have requested Health, Education, and Welfare to give you a list of all the moneys that they have spent on alterations and buildings.

Thank you.

Mr. DANIELS. Charlie, do you have any questions?

Mr. RADCLIFFE. Yes, Mr. Chairman, I do have a question.

Dr. Cameron, when you first met with us, I believe informally, you indicated that the home care program and the nursing home program were two solutions to overcrowding.

Dr. CAMERON. Yes.

Mr. RADCLIFFE. Are there any problems with nursing home care other than the ones you mentioned that would correct the problems you have had with the home care?

Dr. CAMERON. No; I think not. I mentioned that the welfare rate for nursing home treatment is the same as the foster home rate, \$100 per month, plus \$10 for the recipient.

I would be of the opinion that that rate is substantially inadequate to find suitable nursing homes.

Mr. RADCLIFFE. Assuming an adequate rate, if you had an adequate rate, would it take, for example, months to prepare an individual for the nursing home?

Dr. CAMERON. This could go a little more rapidly I believe than the foster home placements because the majority, or a substantial number at least, of those who would be suitable for nursing home placement are quite feeble—wheelchair, bed patients, and so on. While of course it is useful to try to get as good a fit as possible between a nursing home and the patient, it isn't as crucial a problem in that situation as it would be in a foster home where you are living in daily, 24-hour-a-day immediate contact with certain members of the family. In the nursing home you have different personnel on duty at different times of the day and usually substantially more patients, and then many of the patients that we would like to place, as I mentioned, are so feeble that even if they did have some objection to being there, they would not be able to implement their objections very substantially. Many of these people probably would not realize that they had indeed been changed to another facility.

Mr. RADCLIFFE. The reason I am asking these questions is that in terms of your total population at St. Elizabeths, in terms of the number of people you have spoken about that could receive care outside of St. Elizabeths, it seems to me in the foster home situation that actually you are dealing with placement problems and requirements that would permit you to place only say 25 to 30 patients a year, and that if you have similar problems, even under the best of conditions, with nursing home, actually neither of these solutions that you refer to in our first meeting would have any great effect in terms of the total problem of reducing your population.

Dr. CAMERON. You may recall I just said that I think this would not be as difficult for the nursing home patient as for the foster home patient.

Also, you may recall that at that first informal meeting these two mechanisms that we are now talking about were not the only considered in connection with improving the services at St. Elizabeths.

I have suggested that I think the patient-staff ratio is low. If that were improved we could then work more rapidly with the existing patients to the end of preparing them for nursing and foster homes.

We have on our staff approximately 35 social workers. It was 17 I believe 2 or 3 years ago. The Chief of our Social Service Department has done unusually well in recruiting social workers to add to the staff in a short market and some very substantial advances have been made

in this area, but 35 social workers in relations to some almost 8,000 patients is a rather low ratio.

Mr. RADCLIFFE. I have no more questions.

Mr. DANIELS. Just one further question counsel would like to ask.

Mr. REISINGER. Doctor, our attention thus far in this nursing home-foster home program has been directed to the District of Columbia patients.

Dr. CAMERON. Yes, sir.

Mr. REISINGER. You have said previously that there are patients numbering perhaps 2,000, roughly that, who are not the District of Columbia's responsibility.

Dr. CAMERON. Yes, sir.

Mr. REISINGER. And further you said that there is no authorization for expenditure of funds by the hospital to place these patients in either nursing homes or foster care homes.

Am I correct there?

Dr. CAMERON. Yes; if you would permit me to qualify it by saying that there are some agencies who have patients at St. Elizabeths Hospital who pay for their treatment just as the District of Columbia government pays for the treatment of District of Columbia residents, so I was speaking of the patients for whom no political subdivision nor other agency is financially responsible.

It is for that particular group that I think it would be useful that our appropriations be available for foster and nursing homes.

Mr. REISINGER. With respect to the area where there is no responsibility or authority, shall we say, for placements of this character, have you requested legislation prior to this time to authorize expenditures by the hospital for that purpose?

Dr. CAMERON. This matter has been discussed at the departmental level, Mr. Reisinger, and the General Counsel's office has worked with us on the development of draft legislation.

The decisions on this point have not been finally resolved at the departmental level and they have not gone forward from there.

Mr. REISINGER. Doctor, in reviewing this problem I noted I believe in February of 1960 you were testifying in conjunction with Dr. Overholser before Mr. Fogarty's subcommittee relative to this identical problem.

At that time, then, you were aware of this condition and this necessity for authorization, is that correct?

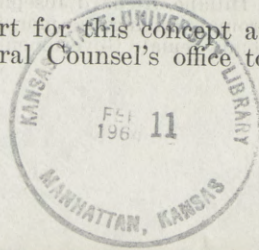
Dr. CAMERON. I don't recall the testimony that you refer to, but I will certainly accept your word that you found it.

Mr. REISINGER. It is present in the record, my only question being this: That it has been somewhat over 3 years now that you were aware of the necessity for this authorization.

Has it taken that long to get any action out of the General Counsel's office at the Department?

Dr. CAMERON. I shouldn't like to place the responsibility on the General Counsel's office, and if it is over 3 years it is very little over because I came to St. Elizabeths only in August of 1960. It would have taken obviously some time to think through the problem and present the ideas to the Department.

This was done. There was sufficient support for this concept at the departmental level to authorize the General Counsel's office to



work with us in developing a draft bill. Then the question arose I believe, as to the outcome of the study about which Dr. Barton, Mr. Jones, and others spoke. At the time the draft legislation was complete I believe it was the Department's view that its consideration for introduction might well be deferred pending the recommendations of that committee.

Mr. DANIELS. All right. We thank both of you gentlemen for being here this morning.

Our next witness is Deputy Chief of Police John G. Layton, Chief of Detectives, Metropolitan Police Department, District of Columbia.

Do you have a prepared statement?

STATEMENT OF JOHN B. LAYTON, DEPUTY CHIEF OF POLICE, CHIEF OF DETECTIVES, METROPOLITAN POLICE DEPARTMENT, DISTRICT OF COLUMBIA

Mr. LAYTON. No, Mr. Chairman, I do not.

At the request of the committee counsel the Department furnished to the committee a listing of some of the escapees that had come to our knowledge in the Department as having been arrested on some other criminal offense while they were away from the hospital. This information has been furnished and I have not made any prepared statement beyond the information furnished in that.

Mr. DANIELS. I have before me a letter written by the Metropolitan Police under apparently your signature, John B. Layton, Deputy Chief of Police, Chief of Detectives, dated November 7, addressed to me.

Is that the report to which you just referred?

Mr. LAYTON. Yes; it is.

Mr. DANIELS. If there is no objection I offer this for the record. (Statement referred to follows:)

GOVERNMENT OF THE DISTRICT OF COLUMBIA,
METROPOLITAN POLICE DEPARTMENT,
Washington, D.C.

To: John B. Layton, Deputy Chief of Police, Chief of Detectives.

Subject: Report on escapees from St. Elizabeths Hospital.

SIR: A review of Detective Division files for the current year discloses the following information concerning inmates of St. Elizabeths Hospital who have been reported to this Department as escapees from that institution and subsequently arrested on the charge indicated during the time they were away from the institution.

Amburgey, Calvin T.: White, 28 years of age. Reported on May 21, 1963. Charge: Forgery and uttering, case No. 34442; arrested for housebreaking while out.

Bowser, J. B.: Negro, 38 years of age. Reported on February 5, 1963. Charge: Sexual psychopath, case No. 33458; arrested for drunk while out.

Bryant, King: Negro, 34 years of age. Reported on March 25, 1963. Charge: Unauthorized use of auto, case No. 33645; arrested while out for unauthorized use of auto.

Cummings, Charles L.: White, 18 years of age. Reported on June 20, 1963. Charge: Housebreaking and larceny, case No. 34031; arrested while out for stolen auto in Atlanta, Ga.

Darnell, Basil: White, 41 years of age. Reported on May 20, 1963. Charge: Indecent exposure, case No. 33952; arrested while out for housebreaking.

Dillane, Richard Joseph: White, 22 years of age. This subject left the hospital grounds during the morning of June 8, 1963, and entered the apartment of two young female Government workers by way of an unlocked kitchen window. He

assaulted one with intent to rape. Further efforts were thwarted by a knock at the front door of the apartment at which time he fled by way of the bedroom window and returned to the hospital. He was arrested on a warrant on June 12, 1963, at the hospital. He was transferred from the District of Columbia jail to St. Elizabeths on August 26, 1963, pending trial.

Hayde, Richard Leo: White, 31 years of age. Charge: Rape and sodomy. This subject was committed to St. Elizabeths on November 8, 1961, after having been found not guilty by reason of insanity on charges of rape and sodomy. Case No. 5990. On September 2, 1963, Hayde left the hospital grounds without permission. At 5:25 p.m. the same date, he was arrested in the basement of 3848 South Capitol Street where he had lured a 7-year-old female and had taken indecent liberties with her person. He was transferred from the District of Columbia jail to St. Elizabeths on September 30, 1963, pending trial.

Moore, James A.: White, 35 years of age. Reported on January 21, 1963. Charge: Housebreaking, case No. 33396. Arrested while out for housebreaking in Arlington, Va.

Robert, Barbara: White, 20 years of age. Reported on April 22, 1963. Charge: Auto theft, case No. 33545. Arrested while out for accessory in the murder of Leon Tatelman.

Rollins, Eugene W.: White, 34 years of age. Reported on April 1, 1963. Charge: Assault and housebreaking, case No. 33554. Arrested while out for murder of Leon Tatelman.

Smallwood, John Andrew: Negro, 20 years of age. Charge: Rape, housebreaking, and assault with intent to rob. This subject was indicted on the above charges and on July 31, 1963, was committed to St. Elizabeths by the U.S. attorney's office for 90 days pretrial examination. On September 5, 1963, the subject eloped from the hospital. Subsequently, Smallwood committed a housebreaking and a series of holdups. Case closed with the death of this defendant on September 28, 1963.

Smith, Donald Leroy: White, 36 years of age. Reported on May 28, 1963. Charge: Forgery and uttering, case No. 33995. Arrested while out for forgery in New York City.

Snyder, James R.: Negro, 31 years of age. Reported on August 6, 1963. Charge: First degree murder, case No. 34390. Arrested while out for unauthorized use of auto.

Spells, Thomas W.: Negro, 40 years of age. Reported on January 15, 1963. Charge: Armed robbery, case No. 33379. Arrested while out for carnal knowledge.

Spitzer, Charles W.: White, 22 years of age. Reported on June 20, 1963. Charge: Unauthorized use of auto, robbery and assault on police officer, case No. 33555. Arrested while out for stolen auto in Georgia.

Taltavull, Richard A.: White, 26 years of age. Reported on May 11, 1963. Charge: Unauthorized use of auto, case No. 33915. Arrested while out for the murder of Leon Tatelman, accessory and robbery.

Tribby, Willard G.: White, 35 years of age. Reported on June 2, 1963. Charge: Forgery and uttering, case No. 34022. Arrested while out for unauthorized use of auto.

Watson, Brice D.: Negro, 22 years of age. Reported on August 7, 1963. Charge: Housebreaking, assault, and intent to commit rape, case No. 34401. Arrested while out for housebreaking and rape. Watson was reported missing from the hospital at 12:10 a.m. the morning of August 7, 1963; at 4 p.m., August 8, 1963, this department received a complaint from a 56-year-old white female that Watson had broken into her apartment about 6:40 a.m. that date and had kept her captive in her own apartment until 3:45 p.m. The subject forced her to have sexual relations with him three times during this time. He was transferred from the District of Columbia jail to St. Elizabeths on August 30, 1963, pending trial.

Following is a listing of escapees reported to this department and still at large as of November 1, 1963, and the offenses with which they were originally charged:

Armstrong, Harold M.: Negro, 22 years of age. District of Columbia prisoner. Charge: Interstate transportation of stolen vehicle. (November 15, 1962.)

Bell, Julius: Negro, 32 years of age. Reported missing on October 27, 1963.

Bergervin, Thomas: White, 28 years of age. Committed as a sexual psychopath. (October 8, 1960.)

Boyd, Ben: White, 57 years of age. No criminal offense noted. (December 29, 1962.)

Brown, Eldridge S.: Negro, 30 years of age. District of Columbia prisoner. Charge: Narcotic violation, G/L, P/L, assault and disorderly.

Bryant, King: Negro, 34 years of age, reported on March 25, 1963. Charge: Unauthorized use of auto, case No. 33645; arrested while out for unauthorized use of auto.

Chronister, Melvin L.: White, 55 years of age. District of Columbia prisoner. Charge: Sodomy. (June 13, 1962.)

Clark, David E. M.: White, 33 years of age. Reported missing October 20, 1963.

Crutchfield, Charles R.: Negro, 36 years of age. District of Columbia prisoner. Charge: Sexual psychopath (exposing himself).

Curry, Haywood: Negro, 30 years of age. District of Columbia prisoner. Charge: Mayhem. (October 20, 1960.)

Duncan, Jannie: Negro, 36 years of age, indicted for first-degree murder. On March 11, 1956, the above subject, residing at 3222 14th Street NE., with a business address of 1622 7th Street NW., in company with Edward James, Negro, 27 years of age, and Calvin Simms, Negro, 29 years of age, while in premises 1622 7th Street NW., fatally beat Orell Duncan, Negro, 38 years of age. They removed the body of Orell Duncan from the premises and buried him in a shallow grave south of Richmond, Va., where it was later recovered. The three defendants were indicted for first-degree murder. On December 21, 1956, Jannie Duncan was sentenced to serve 15 years to life after being convicted of second-degree murder. She was later confined to St. Elizabeths Hospital. On January 14, 1963, a Federal warrant charging Jannie Washington Duncan with unlawful flight to avoid confinement after conviction for murder was issued.

Eaglin, William F.: Negro, 53 years of age. District of Columbia prisoner. Charge: Numerous sex offenses. (April 26, 1961.)

Ferguson, Stephen M.: White, 19 years of age. Reported missing October 28, 1963.

Folson, Charles E.: Negro, 32 years of age. District of Columbia prisoner. Charge: Arson.

Friend, Francis W.: White, 29 years of age. District of Columbia prisoner. Charge: Armed robbery.

Grier, Pearl F.: Negro, 44 years of age. District of Columbia prisoner. Charge: Mental observation. (January 15, 1962.)

Halbfinger, Edward: White, 47 years of age. Admitted to St. Elizabeths on February 7, 1961 on order of court after acquittal by reason of insanity of false pretenses, U.S. 100 and 101-61. Granted conditional release October 2, 1962. Residing in city since November 30, 1962; has not contacted the hospital since August 1963. Warrant has been issued against this subject for forgery.

Harden, Leo: Negro, 36 years of age. District of Columbia prisoner. Charge: Assault and destroying private property. (October 20, 1961.)

Harris, Clarence A.: Negro, 25 years of age. District of Columbia prisoner. Charge: Narcotic violation. (September 30, 1961.)

Hayden, Jack: White, 41 years of age. District of Columbia prisoner. Charge: First-degree murder and sex pervert.

Heinzel, Louise: White, 29 years of age. District of Columbia prisoner. Charge: Car theft and homicide. (January 6, 1961.)

Ireland, Joseph: White, 48 years of age. District of Columbia prisoner. Charge: Sexual psychopath.

Jacobs, John W.: Negro, 45 years of age. District of Columbia Prisoner. Charge: Sexual psychopath. (July 19, 1962.)

LeForest, Steven: White, 26 years of age. No offense noted.

Lewis, Harry K.: Negro, 42 years of age. District of Columbia prisoner. Charge: Housebreaking.

Lewis, Joe: Negro, 25 years of age. District of Columbia prisoner. Charge: Assault on police officer.

Marple, Kenneth E.: White, 23 years of age. District of Columbia prisoner. Charge: Unauthorized use of auto. (June 27, 1959.)

McDade, Patrick Arthur: Negro, 39 years of age. District of Columbia prisoner. Charge: Robbery.

Norris, Sheril, alias Sharon A. Andrews: White, 19 years of age. Charge: Unauthorized use of auto. Transferred from Alderson Prison for Women.

Perry, Louis: Negro, 57 years of age. District of Columbia prisoner. Charge: Robbery.

Powell, Richard V.: White, 37 years of age. District of Columbia prisoner charged with forgery and uttering; October 25, 1963.

Purcell, Katherine: Negro, 57 years of age. No criminal offense noted.

Ragsdale, Donald: Negro, 29 years of age. District of Columbia prisoner. Charge: Armed robbery.

Robinson, Willie J.: Negro 47 years of age. No criminal offense noted. (June 28, 1961.)

Salmon, Lawrence M.: White, 53 years of age. District of Columbia prisoner. Charge: Unauthorized use of auto.

Schmucker, Vernon: White, 45 years of age. District of Columbia prisoner. Charge: False report to the police. (March 19, 1959.)

Short, Haskel P.: White, 21 years of age. District of Columbia prisoner. Charge: Armed robbery.

Smith, Olander: Negro, 78 years of age. No criminal offense noted.

Statler, John F.: White, 73 years of age. District of Columbia prisoner. Charge: False pretense and criminal assault.

Tatem, John A.: White, 53 years of age. District of Columbia prisoner. Charge: Carnal knowledge and incest.

Watson, Paul: Negro, 40 years of age. District of Columbia prisoner. Charge: Drunk and disorderly. (October 4, 1961.)

Williams, Donald L.: Negro, 26 years of age. District of Columbia prisoner. Charge: Robbery.

Williams, Samuel E.: Negro, 22 years of age. District of Columbia prisoner. Charge: Bad checks.

Wyatt, Samuel H.: Negro, 26 years of age. District of Columbia prisoner. Charge: Rape and robbery.

Your attention is also invited to the following information relative to inmates committed to St. Elizabeths Hospital by the court who are classified as "out-patients," but have committed offenses while in this status:

Frank Alden Bowers, white, 21 years of age: Found not guilty by reason of insanity on July 16, 1962, and committed to St. Elizabeths Hospital. This Department filed detainers with the hospital on July 18, 1962, in favor of Montgomery County, Md., Charleston, W. Va., and Cleveland, Ohio, all charging false pretenses.

On September 20, 1963, information was received that the subject was working at the offices of Wilkinson-Cragon-Barker, attorney at law, 1616 H Street NW. When members of the Detective Division responded to take the subject into custody, a call was placed to the office of Assistant U.S. Attorney Altschuler who stayed the service of the warrant. Montgomery County later notified this Department to return their warrant; Charleston, W. Va., soon thereafter did the same. A warrant is still on file in this Department from Cleveland, Ohio. The subject is living at St. Elizabeths Hospital and working at the above law offices.

Howard Willard Buzzell, white, 39 years of age: This subject was committed to St. Elizabeths Hospital in 1950 after having been indicted on the charge of indecent act on a minor child. On May 10, 1963, he is alleged to have committed indecent acts on two boys, ages 10 and 11 years. The subject was classified as an outpatient at this time. He is presently awaiting trial having been indicted on 6 counts.

Alton Augustus Jones, Negro, 41 years of age: The above subject left St. Elizabeths Hospital on August 18, 1962, to visit his sister who lives near the hospital. Later that day, the subject lured his 11-year-old niece out of the house and sexually assaulted her several times during the night. Criminal records indicate he was arrested for drunk and disorderly on July 12, 1962.

Jones was tried and found not guilty by reason of insanity. On April 11, 1963, he was transferred from the District of Columbia Jail to St. Elizabeths Hospital.

Willard Washington Jones, Negro, 26 years of age: The subject is now a patient at St. Elizabeths Hospital. This Department received a warrant from the police department, Arlington, Va., charging this subject with storebreaking. Evidence had been conclusive that the subject had sold two adding machines and a quantity of new Hot Shoppe silverware to a local secondhand store.

Investigation revealed that the crime had been committed while the subject was a patient at the hospital. Information received from the subject's sister was that the hospital permitted him to leave the grounds for the purpose of finding

work and that he would come to her home and force her to give him money. The subject's mother was also interviewed and she confirmed the information that the subject forced both his sisters and herself to give him money. She further stated she had advised the hospital authorities of the foregoing, but they would not, or could not, keep him at the hospital. Subject's mother also stated that the subject would get drunk and when this happened, he would "fall out," and would be returned to the hospital if notified. The subject's mother also stated that he was in the hospital as a result of his threatening to kill her and his father. The father has since died.

Thomas Willie Whalem, Negro, 20 years of age: This subject was committed to St. Elizabeths Hospital on July 1, 1956, on the charge of homicide. In June of 1962, Whalem was permitted to return to his home as an outpatient.

On September 28, 1962, he raped and robbed a female cab driver while on the grounds of St. Elizabeths Hospital. On June 28, 1963, he was found guilty of robbery and assault with intent to commit rape and sentenced to from 6 to 18 years.

The three following cases also appear to be of interest to point up the problems encountered in connection with escapees:

John Dennis Hemphill, white, 31 years of age: Committed as a sexual psychopath.

This subject was arrested on May 22, 1957 for taking indecent liberties with the person of a 12-year-old boy. On June 28, 1957, Hemphill was committed to St. Elizabeths Hospital as a sexual psychopath. (Sex Squad case No. 4977). There was no missing person report on Hemphill when he left the hospital on some undetermined date. However, on February 27, 1960, he was positively identified as the person who took indecent liberties with the persons of two boys, 7 and 10 years respectively, while in a wooded area at Nichols Avenue and Overlook Street SE. (case No. 5691). At this time, Hemphill was described as an elopee from St. Elizabeths Hospital. On March 24, 1960, another complaint was received from a 9-year-old boy who identified Hemphill as the man who had taken indecent liberties with his person (case No. 5713). Metropolitan Police Department records indicate that the hospital reported Hemphill returned as of February 1, 1961, and that as of October 2, 1963, he was still a patient there. There is no further record of arrest according to the criminal records of this Department.

Joseph Walker Jamerson, white, 21 years of age: This subject was originally committed as a juvenile after having been detained for a series of housebreakings, unauthorized use of auto, petit larceny, robberies and destroying private property. He escaped July 22, 1959, and on April 28, 1960 was recommitted after having been arrested on a warrant charging him with assault with intent to commit carnal knowledge on an 11-year-old female (case No. 5726). Jamerson escaped while being transferred from court to St. Elizabeths. He was again arrested on May 7, 1962, at which time the above warrant was nolle prossed and the district attorney recommended Jamerson be returned to the hospital. A check was made at the hospital at which time a doctor advised that because Jamerson had been gone over 2 years, they had discharged him as having made a "social recovery" in his absence. Since then, he has not been arrested for any felony. He has two misdemeanor arrests.

James Jay McDonald, Negro, 48 years of age: This subject was found not guilty by reason of insanity on September 13, 1960, on the charge of interstate transportation of fraudulent checks. On October 9, 1959, detainees were placed with the hospital in favor of the following jurisdictions: Winchester, Va.; Danville, Va.; Roanoke, Va.; Baltimore, Md.; and Macon, Ga.

The subject escaped from the hospital on February 5, 1962, and became very active in passing bad checks on the East coast until he was again arrested and returned to the hospital on January 12, 1963. The detainees were again filed with the hospital.

Respectfully submitted,

JOHN L. SULLIVAN,

Inspector, Special Investigations Squad.

MR. DANIELS. Can you tell this committee how many escapees were brought to your attention by St. Elizabeths Hospital since January 1 of this year?

Mr. LAYTON. Since January 1 of this year there are some 88 individuals who have been brought to our attention as escapees or on unauthorized leave from the hospital. Some of these have been reported missing on more than one occasion.

We have in recent days attempted to correlate the information that we have in the Police Department on the escapees or those missing from the hospital reported to our Department and those that are carried on the records of St. Elizabeths as having absconded or escaped or have been placed on unauthorized leave.

We find that there have been 117 reports made to the precinct in that area of persons missing from St. Elizabeths Hospital. There have been some occasions apparently where persons were arrested for an offense and they then were placed in the status of being on unauthorized leave.

As I say, some of the individuals have been away more than one time, two or three times.

Mr. DANIELS. Will you clarify this point? You said that there were some 88 escapees since the beginning of the year, but there were 117 reports. What is the difference between those two figures?

Mr. LAYTON. The difference is in reporting some of those individuals as having been away more than one time. For instance, on a list furnished our missing persons bureau by St. Elizabeths Hospital near the top of the list one is S. A. Andrews. Andrews was reported missing on February 10; he was returned the same date and reported missing again on May 11.

Also in the case of one K. W. Bryant, there were two occasions in March, March 18 and again March 25, when he was reported missing, so that there are occasions where the same individual is reported missing on more than one occasion.

Mr. DANIELS. Of this number, how many are presently at large?

Mr. LAYTON. We currently in our records carry a total number of open cases or these still away from the hospital of 43. Of that number, 26 of those were reported missing during this year, that is, since January 1 of 1963.

Mr. DANIELS. When there is an elopement or an escape from St. Elizabeths would you describe the procedure by which such escape or elopement comes to the attention of the Police Department?

Mr. LAYTON. Yes, Mr. Chairman. Our department would receive a telephone call from someone at the hospital. My understanding is that the original report is generally made from the ward from which the individual is missing. On receipt of that call the scout car is dispatched to the hospital, to the particular ward. The policemen who respond are given a report that the individual is missing, the circumstances under which he is missing, a description, and some personal history information that might be helpful in locating the individual.

The scout car then makes an official report of that individual being an escapee. This goes in over our teletype system and is directed through that teletype system to each of the units in the Police Department, each of the police precincts.

In addition to that, a lookout is flashed also over the police radio notifying all of our people who are in the vehicles and on the radio that this individual is missing.

In addition to that, the missing persons bureau in the Detectives Division picks up the report. They make what we call an assignment on that. They assign it to a detective in the missing persons bureau. It is his particular assignment to run out the information that is given, that is, as to where this individual might be located.

In the Detective Division, wherever we have a photograph available and in most cases we did, we have a system whereby we project that photograph for the viewing of the detectives at our rollcalls. We do that for several days, and of course the lookout is read to each of the rollcalls, not only in the Detective Division, but in each of the precinct units.

Mr. DANIELS. Where the missing patient is a prisoner are any further steps taken?

Mr. LAYTON. Yes. In the case of an individual who is a prisoner the hospital initiates a letter to the U.S. Attorney's Office and as a result of that a bench warrant is generally issued for the individual, so that in the event he is located out of town, the Marshal's Office is notified and he is turned over to the U.S. Marshal's Office for return to the hospital generally.

Mr. DANIELS. Of prisoner patients who have escaped since the beginning of the year, how many are at large at the present time.

Mr. LAYTON. My records, Mr. Chairman, indicate that of those who have been reported to the Police Department since January 1, 1963, 23 prisoner patients are still at large. The figure I gave just a little bit ago of 26 includes 3 who according to our information are on civil commitment. They were reported missing to us.

Mr. DANIELS. Of those prisoner patients who have been apprehended since the beginning of the year by the Police Department, were they involved in the commission of any further crime since the time of their elopement or escape?

Mr. LAYTON. Some of them were, yes.

Mr. DANIELS. Can you describe the type and the nature of the crime?

Mr. LAYTON. May I say by way of explanation for the committee that the information furnished to the committee and which I have available to me here now are those where our Police Department was aware, either made an arrest ourselves or where there was some communication from another jurisdiction that brought these to our attention.

I do note in trying to correlate our figures and our information with St. Elizabeths that there are some prisoner patients who were arrested in other jurisdictions. They could have and in most cases would have been returned through the U.S. Marshal's Office and would not have come directly to the attention of the Metropolitan Police Department by means of the hospital then notifying the Metropolitan Police that this individual had been returned.

However, in answer to your question, Mr. Chairman, those that had come to our attention, we have offenses as the individual being arrested and charged with housebreaking, one for drunkenness, unauthorized use of an automobile, another stolen automobile—this was out of town—another for housebreaking, another for attempted rape, another for taking indecent liberties with a minor child, housebreaking, and an accessory in a murder case and robbery—I have two in

that category—another for housebreaking and robbery, another for forgery, for unauthorized use of an automobile, carnal knowledge, stolen automobile, and another stolen automobile, another rape, and that is the end of my list.

Mr. DANIELS. I have before me a memorandum of the U.S. Marshal's Office advising that during this year 1963 there are still 27 warrants outstanding. Can you explain the difference between your figure of 23 criminal patients still being at large and this figure of warrants of the marshal's?

Mr. LAYTON. There is one other factor, Mr. Chairman, in the fact that those warrants are outstanding. There is one individual, Rollins by name, who is now in custody of the Virginia authorities in connection with the murder there.

This would probably account for one of those warrants that I would guess has not been executed in that case. Again in checking over some of these figures we have a record of one individual being in a New Jersey mental institution at the present time and I think there probably are one or two others who are in custody out of town and the marshal's warrant may not yet have been executed and served to return that individual to this jurisdiction.

Mr. REISINGER. Chief, with respect to this notification procedure that you have outlined, the telephonic communication, then report to the squad car and so on, would there be advantage or is there a practical way—let us put it that way—to speed up the fact of this escape coming to the attention of the Deputy Chief who is acting at the time of the report?

In fewer words, is there a manner in which this could be done more expeditiously than through the teletype report and so on?

Mr. LAYTON. Of course the report that we get now, and it would still need to be initiated by the hospital of course when they learned that an individual was missing from the hospital grounds, this is made immediately to the precinct. That does follow the routine in any report. Our teletype system then follows very quickly.

Now, I would say that so far as the Deputy Chief in charge of the Department at the particular time—during night tours of duty I would think you are referring to particularly—he would not ordinarily be advised of every incident that is reported to our police precincts. There could and can be an arrangement whereby the Police Department might require that, when the original report is made, this type of case be brought directly to the attention of the official in command of the Department at that time.

Mr. REISINGER. I am thinking particularly now of one case involving I think assault with intent to commit rape by a patient who had been committed under a "not guilty by reason of insanity" verdict in a previous rape case and I am thinking specifically of the *Dillane* case.

If my recollection serves me correctly the second offense took place almost immediately upon the patient leaving the hospital and I think in the general area of the hospital.

Mr. LAYTON. This is correct.

Mr. REISINGER. In a situation of that character if the hospital were to notify the lieutenant in charge of the communications, he is in fairly constant touch or is able at any time to contact the acting chief throughout the tour, is that correct?

Mr. LAYTON. He is, that is correct, sir.

Mr. REISINGER. And in a situation like that, assuming that you were acting as you have in the past, a matter involving a crime of this character would receive greater attention than a shoplifter, perhaps.

Would that be a matter for more immediate consideration, would you say?

Mr. LAYTON. I would say so, yes, sir.

Mr. REISINGER. Does it become feasible then to initiate a system whereby the report is made directly to the lieutenant of communications who immediately contacts the acting chief?

Mr. LAYTON. Yes, sir, this is quite possible.

Mr. REISINGER. Am I correct that the lieutenant in charge of communications also has immediate access at least to criminal records?

Mr. LAYTON. Yes, the criminal records are in that same section in our communications and record section.

Mr. REISINGER. So that, if it were a District of Columbia commitment which had gone through the Department at an earlier time, at the same time the lieutenant is notifying the acting chief, he could also pull the record, determine the nature of the prior offense, so-called *modus operandi*, for instance, items of that kind, is that correct?

Mr. LAYTON. This he would have immediately in his office, the criminal record, just the bare criminal record.

The other information relating to for instance, what we ordinarily term our lineup sheet, is the record where that is kept. That is kept in the Detective Division on the third floor. The communication and record section is on the fourth floor, but this personal history information is kept in our identification bureau with other similar information, but it is available around the clock.

Mr. REISINGER. Would you feel it is desirable to set up a type of coordination where the most responsible law enforcement officials now on duty, the acting chief, for example, in the 4 to 12 and 12 to 8 tours could make the decision, for example, whether to supplement the search by detectives from, say, the sex squad if it were a rape case?

Do you think this is a desirable case?

Mr. LAYTON. Yes, sir. In those cases where we have those serious offenses I think that that is desirable. As I say, not every incident is brought to the deputy's attention, but certainly it is part of the present responsibility of the official in command of the communications section to bring things to the attention of the deputy and I would certainly agree that wherever we have an escape of a prisoner patient or in the case of a prisoner from the jail or something of this kind, this would and should be brought to his attention.

Mr. REISINGER. And it would be practical for some member of the Department to work out a new type of communications of this

character with the hospital without anything more than a conference, is that correct?

Mr. LAYTON. Yes, I would not call it particularly new. I think it would follow the procedures that we have now. I think that all that would be necessary would be simply to have our chief direct the commanding officer of the communications section to bring these types of things to the attention of the deputy so that there is that coordination.

As I say, this is done routinely and outstanding cases or anything of monument, serious fire, or whatever, whatever the incident may be, are brought to his attention presently.

So it would simply mean in my judgment a matter of requiring the lieutenant in these particular cases to see that they get to the attention of the deputy in charge of the Department.

Mr. REISINGER. Now, I believe it is axiomatic, but I would like your opinion nonetheless. Am I correct that the more immediately the enforcement official is advised of an escape, the greater the likelihood of apprehension?

Mr. LAYTON. I would say yes, generally, particularly where the notice of the escape is made immediately.

In other words, there could be situations where the individual would have been gone for some period of time before it is found out. In this case of course, he has some time to get out, but, where the knowledge of his escape is known immediately, then it does facilitate the getting him into custody more quickly.

Mr. DANIELS. Mr. Sickles.

Mr. SICKLES. Have the police procedures been reviewed recently in light of these serious escapes?

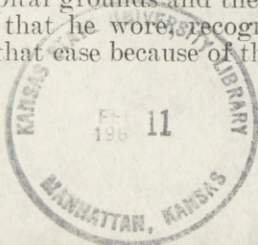
Mr. LAYTON. Yes. There was a conference between the Chief of Police and Dr. Cameron following the notice back in October after the escape of Smallwood and his subsequent shooting of two policemen and there has been some thought given to the kind of thing that Mr. Reisinger has suggested here now as to ways that we can have readily available personal history information in the case of prisoner patient escapees.

Mr. SICKLES. Has there been any pattern in the method of escape or at least in the behavior after escape which would be helpful for the apprehension of future escapees, as, for example, a general tendency to go home, so that you might go their first to look for them?

Mr. LAYTON. Of course, this is one of the things that we do routinely, is to cover the home or homes of relatives of friends, where they might go and there have been cases where they did this, went to their homes and were taken into custody because of that.

Mr. SICKLES. How would you describe your working relationship with the officials at St. Elizabeths?

Mr. LAYTON. We feel it is very good, Mr. Sickles. There is no friction between our people and St. Elizabeths and they do call us directly. We have had cases even where in one case a description of an assailant over in the 11th precinct was given to one of the members of the guard force on the hospital grounds and they did, because of some of the peculiar clothing that he wore, recognize him as a patient and we were able to clear that case because of the cooperation with us.



Mr. SICKLES. Do the police consider this escapee problem a rather major and serious problem?

Mr. LAYTON. I would say yes, we consider it a serious problem. If we go by percentages, the number might be said to be a small percentage.

However, we feel it is a concern because the number of these people who have committed serious crimes while they have been away from the hospital makes greater work for the Police Department.

More importantly, I think, it subjects some of our citizens to offenses which they might not otherwise be subjected to.

Mr. SICKLES. In light of that, what responsibility or at least what concern does the Police Department express with respect to the operation of the hospital, as far as a review of the security facilities and the recommendations in connection therewith?

Has the Police Department made any recommendations with respect to security at the hospital?

Mr. LAYTON. To my knowledge, it has not. This I personally think is a little bit out of the field of the operation of the Police Department. We are not experts in the penal field. There was a visit to the hospital grounds by the Chief of Police and the maximum security ward appears at least to have been set up with precautions to prevent the escape of individuals.

However, it appears that the largest number by far of those who leave the hospital grounds are those people who have been released from the maximum security ward and have been judged by the doctors at St. Elizabeths to be at the stage where they can be given greater leeway and freedom of movement.

This is an area I think that the Police Department can't exercise very much judgment upon.

Mr. SICKLES. Are you saying then that you think the cooperation with the staff is excellent and the police have no recommendation as far as doing something to curb the escapee problem that exists?

Mr. LAYTON. Well, I think this is a matter of judgment. The arrangement is such that the psychiatrists at St. Elizabeths determine at what stage they will recommend an individual for less than maximum security on them. They also make recommendations to permit them ground privileges and subsequently leave from the hospital grounds.

It is an area where the psychiatrists, I believe from our conferences with Dr. Cameron, think that there comes a stage where, in order to rehabilitate these people, they must have the opportunity to determine when they can be granted leave of one kind or another.

The only thing I think that we could say is if these individuals are to be kept within the grounds, then there needs to be more security beyond the maximum security ward.

Dr. Cameron did point out to us when we visited the hospital that their west side service, for instance, is housed in an older building that doesn't have the same means of recreational facilities with the same degree of protection that he would want, but there is this area where, in order to confine people, there needs to be more security features than is true in the buildings and facilities outside of the maximum security ward.

On the other hand, the theory, as I understand it, is to permit the doctors to determine when people will be granted more freedom than they have in the maximum security ward.

Mr. SICKLES. Then I would judge perhaps that you would not feel that it would serve any purpose to have some expert on penal institutions review the security procedures that apply in St. Elizabeths?

Mr. LAYTON. No, my personal judgment would be that that would be advisable, Mr. Sickles.

Mr. SICKLES. I assume you heard the suggestion that there be some attempt, by fence or otherwise, to set off one section where those who are classed as criminally insane would be set aside from the rest and even though they would have some freedom, that there would still be sort of an outer wall or outer gate to keep them from escaping.

Have you given any consideration to that?

Mr. LAYTON. I would think in my judgment that this also would serve to make some kind of a barrier while still giving these particular patients some additional freedom.

They wouldn't be in a situation where they could leave the grounds without anything standing in their way.

Mr. SICKLES. Do you think that any purpose would be served if there were some provision that criminals who had performed certain criminal acts, let's say murder or rape or something in that category, before they could be released from maximum security there would have to be some review board, whether it be police or otherwise, of not just those in St. Elizabeths, but of other people who are interested citizens of the community, that they might have to review the history with respect to this patient before they could give the approval to remove him from maximum security?

Would there be any merit to this idea?

Mr. LAYTON. I would think that there would be merit to that kind of an approach. I would hesitate to say that the police should be in the position of making a judgment on whether or not they could or should be released.

It might well be that the police department could give some advice as to what they know of the individual from past experience, but I would hesitate to say that the police ought to be in the position of making a judgment on the individual's release. It would seem to me that the psychiatrist and some of the members of the community might take part in that kind of a judgment.

Mr. SICKLES. Thank you very much. I heard the quorum bells ring. I think we are probably on our way.

Mr. DANIELS. Any questions?

Mr. RADCLIFF. No, I have no questions.

Mr. DANIELS. Thank you very much, Chief.

Mr. LAYTON. Thank you, Mr. Chairman.

Mr. DANIELS. I have been furnished with a memorandum here as to the guard forces assignment at St. Elizabeths Hospital which I shall offer at this point for the record, and in addition thereto I have a report from the U.S. Marshal as to warrants that have been issued in connection with escapees from St. Elizabeths Hospital which report is dated November 12.

Without objection this will also go into the record.

(Statement referred to follows:)

St. Elizabeths Hospital, Department of Health, Education, and Welfare—Guard force assignments

Location	Tour of duty	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Patrol duty and special assignments	Day..... Evening..... Night.....	4 3 2	4 4 2	4 3 3	4 3 3	4 3 3	4 3 2	3 3 2
No. 1 gate	Day..... Evening..... Night.....	1 1 1	1 1 1	1 1 1	1 1 1	1 1 1	1 1 1	1 1 1
No. 3 gate	Day..... Evening..... Night.....	1 0 0	1 0 0	1 0 0	1 0 0	1 0 0	1 0 0	1 0 0
No. 4 gate	Day..... Evening..... Night.....	1 1 0	1 0 0	1 1 1	1 1 1	1 0 0	1 0 0	1 0 0
John Howard pavilion, front sally port	Day..... Evening..... Night.....	1 1 1	1 1 1	1 1 1	1 1 1	1 1 1	1 1 1	1 1 1
John Howard pavilion, rear sally port	Day..... Evening..... Night.....	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0
Regular days off		9	7	7	6	7	8	10
Total 1		27	27	27	27	27	27	27

1 Excludes 1 position for overall supervision.

NOTE.—Insert for record: Requested by Ad Hoc Committee on Investigation of St. Elizabeths Hospital, Nov. 13, 1963.

Procedure followed when a bench warrant is procured for an escapee from St. Elizabeths Hospital

When a person, either who has been committed to St. Elizabeths Hospital pursuant to the mandatory commitment provisions of the District of Columbia Code relative to criminal defendants, or a defendant, who while serving a criminal term in a Federal detention institution has been administratively transferred to St. Elizabeths Hospital, escapes therefrom, the hospital, by letter, notifies the U.S. Attorney for the District of Columbia. This official procures a bench warrant from the court charging the person with escape from St. Elizabeths Hospital, and forwards it for execution, to the U.S. Marshal's Office for the District of Columbia.

After the warrant is received in the Marshal's Office, it is referred immediately to the warrant squad, where it is administratively processed, and thereafter assigned to a Deputy Marshal for execution.

In processing a warrant, a picture of the escapee and all pertinent information that may assist in apprehending subject, are obtained from the Metropolitan Police Department Identification Bureau and St. Elizabeths Hospital files. Additionally, "wanted" notices are placed with the Federal Bureau of Investigation and Metropolitan Police Identification Bureau.

Once the warrant has been assigned for execution, all leads are checked out, and the investigation continues until the subject is apprehended and returned to the hospital. Should the investigation disclose that the subject has fled this jurisdiction, his photograph and pertinent information, such as addresses and names of friends, are forwarded for investigation and/or apprehension to the U.S. Marshal's Office in the Federal district where the subject is believed to be located. If the subject is arrested in another jurisdiction, unless local charges are pending against him, he is immediately returned to the hospital.

Should the subject be arrested in another jurisdiction on local charges, and the officials there are not aware that he is a fugitive from St. Elizabeths, he will be identified by the Federal Bureau of Investigation from fingerprints that are routinely forwarded to the agency by law enforcement officers.

Upon being identified, the Marshal's Office here will be informed of the subjects apprehension, whereupon the warrant will be forwarded to the marshal in the Federal district of arrest, with a request he lodge a detainer with the local authorities until the warrant can be executed and the fugitive returned to the hospital.

If the escaped subject is a transferee from a Federal detention institution to the hospital, in addition to the procedure outlined above, the Federal Bureau of Investigation procures a warrant from the U.S. Commissioner here, charging the subject with a violation, title 18, United States Code 1073 (flight to avoid confinement after conviction of a felony).

Thus, in such cases, two Federal warrants may be outstanding for the subject's arrest, and, the Federal Bureau of Investigation conducts an investigation concurrently with the U.S. Marshal's Office.

It should be noted that the Metropolitan Police Department also conducts an investigation leading to the arrest of escaped subjects from St. Elizabeths Hospital.

Statistical report on escapees from St. Elizabeths Hospital

Warrants for escapees issued in 1963-----	63
Escapees apprehended in District of Columbia by U.S. Marshal on warrants issued in 1963-----	12
Warrants issued in 1963 forwarded to Marshals in other jurisdictions for execution-----	(21)
Escapees arrested in other jurisdictions-----	12
Escapees arrested by local police and/or voluntarily returned to hospital ¹ -----	12
	36

Warrants issued in 1963 currently outstanding-----	27
Warrants issued for escapees from 1958 through Nov. 8, 1963-----	188
Escapees apprehended or voluntarily returned to hospital on warrants outstanding from 1958 through Nov. 8, 1963-----	149

Warrants issued from 1958 through Nov. 8, 1963, currently outstanding-----	39
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¹ All escapees arrested on 1963 warrants in other jurisdictions were charged with local offenses in those areas.

NOTE.—9 of the total 1963 warrants currently outstanding are lodged in other jurisdictions; 3 of the 9 warrants have been placed as detainers against escapees who are serving sentences in other jurisdictions.

18 of the 1963 warrants outstanding are in this jurisdiction; 4 of these have been placed as detainers against escapees who are serving terms for local offenses committed since their escape from St. Elizabeths Hospital.

NOTE.—14 of the 39 warrants outstanding since 1958 have been lodged as detainers against escapees in this and other jurisdictions.

Mr. DANIELS. We shall now adjourn and the next hearing will be called at the request of the Chair.

(Whereupon, at 12:20 p.m., the subcommittee was adjourned.)



