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MENTAL HEALTH

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JUN 11 1963
MANHATTAN, KANSAS

HEARINGS

BEFORE A

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

EIGHTY-EIGHTH CONGRESS

FIRST SESSION

ON

H.R. 3688

A BILL TO PROVIDE FOR ASSISTANCE IN THE CONSTRUCTION AND INITIAL OPERATION OF COMMUNITY MENTAL HEALTH CENTERS, AND FOR OTHER PURPOSES

H.R. 3689

A BILL TO ASSIST STATES IN COMBATING MENTAL RETARDATION THROUGH CONSTRUCTION OF RESEARCH CENTERS AND FACILITIES FOR THE MENTALLY RETARDED

H.R. 2567

A BILL TO AMEND THE PUBLIC HEALTH SERVICE ACT IN ORDER TO PROVIDE A BROADENED PROGRAM IN THE FIELD OF MENTAL HEALTH AND ILLNESS OF GRANTS FOR PREVENTION, RESEARCH, TRAINING, SALARIES, FACILITIES SURVEY, AND CONSTRUCTION OF FACILITIES FOR TREATMENT OF THE MENTALLY ILL AND MENTALLY RETARDED

MARCH 26, 27, AND 28, 1963

Printed for the use of the
Committee on Interstate and Foreign Commerce

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MENTAL HEALTH

MARCH 26, 1963

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

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

Mr. ROBERTS. The Subcommittee on Public Health and Safety will come to order.

We are meeting today to consider H.R. 3688 and H.R. 3689, bills introduced by Mr. Harris on behalf of the administration to establish comprehensive community mental health centers and construction of research centers and facilities for the mentally retarded. We are considering these bills together since they deal with an interrelated health program which must be met within the framework of a national mental health program.

Identical bills have been introduced by the gentlemen from New York, Mr. Farbstein, H.R. 3939 and H.R. 3940; and Mr. Halpern, H.R. 3947 and H.R. 3948; our colleagues, Mr. Boland of Massachusetts, HR. 4622 and H.R. 4623; Mr. Pepper of Florida, H.R. 4663 and 4664, and Mr Flood of Pennsylvania, H.R. 5023. In addition, the gentleman from Pennsylvania, Mr. Dent, has introduced H.R. 2567, dealing with the same subjects.

Title I of H.R. 3688, the "Community Mental Health Centers Act of 1963" authorizes appropriations of such sums as Congress may determine for a 5-year matching grant program, beginning July 1, 1964, to assist in the construction of community mental health facilities. The purpose of these centers would be to provide coordinated services for the prevention or diagnosis of mental illness or the care, treatment, or rehabilitation of mentally ill patients and are intended to serve principally those persons residing in or near the area in which the facility is located. The Federal and State shares of the cost of construction are patterned after the matching requirements of other Federal health facilities construction programs.

Under title II of the act, grant funds would be made available for each fiscal year beginning July 1, 1965, to defray the initial costs of staffing the centers constructed with the assistance provided under title I.

H.R. 3689, known as the Mental Retardation Facilities Construction Act of 1963 authorizes project grants in the amount of $30 million over a 5-year period, beginning July 1, 1963, for the construction of special centers for research on mental retardation, and related aspects of human development, up to 75 percent of the total cost. Title II of the

act authorizes a 5-year grant program beginning July 1, 1964, for the construction of public and nonprofit facilities especially designed for the diagnosis, treatment, education, training, or custodial care of the mentally retarded. The bill earmarks $45 million of the sums appropriated during the program for facilities associated with a college or university hospital or other appropriate part of the educational institution.

The problems of the mentally ill and the mentally retarded have been long neglected and generally misunderstood by the public. The record is very clear, however, that we are spending billions of dollars annually to care for hundreds of thousands of mentally ill and retarded patients in our public institutions. Many of these unfortunate people are confined to facilities which are unable to provide minimal care for lack of adequate staff and space. In addition, almost half the patients have been in these hospitals for a decade or more. The concept of comprehensive community mental health centers, in which the patient receives care close to home, would radically change the approach to the treatment of the mentally handicapped. New knowledge, techniques, and drugs have made this possible.

To combat mental retardation requires improved community services and an accelerated research effort into its causes. Studies show that the incidence of mental retardation can be reduced by proper prenatal care. A comprehensive program can do much to improve conditions in this vital area of concern.

The President in his message on mental illness and mental retardation has referred to the need for national programs requiring a new approach by using Federal resources to stimulate State, local and private action with emphasis on prevention, treatment and rehabilitation. However, the initial cost of implementing these programs is beyond the capacity of the States and local communities and requires short-term Federal assistance. The bills before us are directed toward those goals.

We are very pleased at this time to call as our first witness the Honorable Claude Pepper who has introduced H.R. 4663 and H.R. 4664.

Copies of the bills referred to in the opening statement along with agency reports will be placed in the record at this time.

(The bills and reports referred to follow:)

[H.R. 3688, 88th Cong., 1st sess.]

A BILL To provide for assistance in the construction and initial operation of community mental health centers, and for other purposes

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

TITLE I—CONSTRUCTION OF COMMUNITY MENTAL HEALTH CENTERS

AUTHORIZATION OF APPROPRIATIONS

SEC. 101. There are authorized to be appropriated, for grants for construction of public and other nonprofit community mental health centers, for the fiscal year ending June 30, 1965, and each of the next four fiscal years such sums as the Congress may determine.

ALLOTMENTS TO STATES

SEC. 102. (a) For each fiscal year, the Secretary shall, in accordance with regulations, make allotments from the sums appropriated under section 101 to the several States on the basis of (1) the population, (2) the extent of the need for community mental health centers, and (3) the financial need of the respective States; except that no such allotment to any State, other than the Virgin Islands, American Samoa, and Guam, for any fiscal year may be less than $100,000. Sums so allotted to a State for a fiscal year and remaining unobligated at the end of such year shall remain available to such State for such purpose for the next fiscal year (and for such year only), in addition to the sums allotted for such State for such next fiscal year.

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

(c) Upon the request of any State that a specified portion of its allotment under this title be added to the allotment of such State under title II of the Mental Retardation Facilities Construction Act of 1963 (relating to grants to States for construction of facilities for the mentally retarded), and upon (1) the simultaneous certification to the Secretary by the State agency designated as provided in the State plan approved under this title to the effect that it has afforded a reasonable opportunity to make applications for the portion so specified and there have been no approvable applications for such portion or (2) a showing satisfactory to the Secretary that the need for facilities for the mentally retarded in such State is substantially greater than for community mental health centers, the Secretary shall, subject to such limitations as he may by regulation prescribe, promptly adjust the allotments of such State in accordance with such request and shall notify such State agency and the State agency designated under the State plan approved under title II of the Mental Retardation Facilities Construction Act of 1963, and thereafter the allotment as so adjusted shall be deemed the State's allotments for purposes of this title and such title II.

REGULATIONS

SEC. 103. Within six months after enactment of this title, the Secretary shall, after consultation with the Federal Hospital Council (established by section 633 of the Public Health Service Act), by regulations prescribe—

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

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

(c) General standards of construction and equipment for centers of different classes and in different types of location.

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

STATE PLANS

SEC. 104. (a) After such regulations have been issued, any State desiring to take advantage of this title shall submit a State plan for carrying out its purposes. Such State plan must—

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

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

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

(4) set forth a program for construction of community mental health centers (A) which is based on a statewide inventory of existing facilities and survey of need; (B) which conforms with the regulations prescribed by the Secretary under section 103(a); and (C) which meets the requirements for furnishing needed services to persons unable to pay therefor, included in regulations prescribed under section 103(d);

(5) set forth the relative need determined in accordance with the regulations prescribed under section 103(b) for the several projects included in such programs, and provide for the construction, insofar as financial resources available therefor and for maintenance and operation make possible, in the order of such relative need;

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

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

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

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

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

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

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

APPROVAL OF PROJECTS AND PAYMENTS FOR CONSTRUCTION

SEC. 105. (a) For each project for construction pursuant to a State plan approved under this title, there shall be submitted to the Secretary through the State agency an application by the State or a political subdivision thereof or

by a public or other nonprofit agency. If two or more such agencies join in the construction of the project, the application may be filed by one or more of such agencies. Such application shall set forth—

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

(2) plans and specifications therefor in accordance with the regulations prescribed by the Secretary under section 103(c);

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

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

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

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

The Secretary shall approve such application if sufficient funds to pay the Federal share of the cost of construction of such project are available from the allotment to the State, and if the Secretary finds (A) that the application contains such reasonable assurance as to title, financial support, and payment of prevailing rates of wages and overtime pay; (B) that the plans and specifications are in accord with the regulations prescribed pursuant to section 103; (C) that the application is in conformity with the State plan approved under section 104 and contains an assurance that in the operation of the center there will be compliance with the applicable requirements of the State plan and of the regulations prescribed under section 103(d) for furnishing needed services for persons unable to pay therefor, and with State standards for operation and maintenance; (D) that the services to be provided by the center, alone or in conjunction with other facilities owned or operated by the applicant or affiliated or associated with the applicant, will be part of a program providing, principally for persons residing in a particular community or communities in or near which such center is to be situated, at least those essential elements of comprehensive mental health services for mentally ill persons which are prescribed by the Secretary in accordance with regulations; and (E) that the application has been approved and recommended by the State agency and is entitled to priority over other projects within the State in accordance with the regulations prescribed pursuant to section 103(b). No application shall be disapproved by the Secretary until he has afforded the State agency an opportunity for a hearing.

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

PAYMENTS FOR CONSTRUCTION

SEC. 106. (a) Upon certification to the Secretary by the State agency, based upon inspection by it, that work has been performed upon a project, or purchases have been made, in accordance with the approved plans and specifications, and that payment of an installment is due to the applicant, such installment shall be paid to the State, from the applicable allotment of such State, except that (1) if the State is not authorized by law to make payments to the applicant, the payment shall be made directly to the applicant, (2) if the Secretary, after investigation or otherwise, has reason to believe that any act (or failure to act) has occurred requiring action pursuant to section 107, payment may, after he has given the State agency notice of opportunity for hearing pursuant to such section, be withheld, in whole or in part, pending corrective action or action based on such hearing, and (3) the total of payments under this subsection with respect to such project may not exceed an amount equal to the Federal share of the cost of construction of such project.

(b) In case an amendment to an approved application is approved as provided in section 105 or the estimated cost of a project is revised upward, any additional

payment with respect thereto may be made from the applicable allotment of the State for the fiscal year in which such amendment or revision is approved.

WITHHOLDING OF PAYMENTS

SEC. 107. Whenever the Secretary, after reasonable notice and opportunity for hearing to the State agency designated as provided in section 104(a)(1), finds—

(1) that the State agency is not complying substantially with the provisions required by section 104 to be included in its State plan or with regulations under this title; or

(2) that any assurance required to be given in an application filed under section 105 is not being or cannot be carried out; or

(3) that there is a substantial failure to carry out plans and specifications approved by the Secretary under section 105; or

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

the Secretary may forthwith notify the State agency that—

(A) no further payments will be made to the State under this title, or

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

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

JUDICIAL REVIEW

SEC. 108. (a) If the Secretary refuses to approve any application for a project submitted under section 105, the State agency through which such application was submitted, or if any State is dissatisfied with his action under section 104(b) or section 107, such State, may appeal to the United States court of appeals for the circuit in which such State is located, by filing a petition with such court within sixty days after such action. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary, or any officer designated by him for that purpose. The Secretary thereupon shall file in the court the record of the proceedings on which he based his action, as provided in section 2112 of title 28, United States Code. Upon the filing of such petition, the court shall have jurisdiction to affirm the action of the Secretary or to set it aside, in whole or in part, temporarily or permanently, but until the filing of the record, the Secretary may modify or set aside his order. The findings of the Secretary as to the facts, if supported by substantial evidence, shall be conclusive, but the court, for good cause shown, may remand the case to the Secretary to take further evidence, and the Secretary may thereupon make new or modified findings of fact and may modify his previous action, and shall file in the court the record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence. The judgment of the court affirming or setting aside, in whole or in part, any action of the Secretary shall be final, subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code. The commencement of proceedings under this subsection shall not, unless so specifically ordered by the court, operate as a stay of the Secretary's action.

RECOVERY

SEC. 109. If any facility with respect to which funds have been paid under section 106 shall, at any time within twenty years after the completion of construction—

(1) be sold or transferred to any person, agency, or organization (A) which is not qualified to file an application under section 105, or (B) which is not approved as a transferee by the State agency designated pursuant to section 104, or its successor, or

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

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

STATE CONTROL OF OPERATIONS

SEC. 110. Except as otherwise specifically provided, nothing in this title shall be construed as conferring on any Federal officer or employee the right to exercise any supervision or control over the administration, personnel, maintenance, or operation of any facility with respect to which any funds have been or may be expended under this title.

TITLE II—INITIAL STAFFING OF COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTERS

AUTHORIZATION OF APPROPRIATIONS

SEC. 201. For the purpose of assisting in the establishment and initial operation of comprehensive community mental health centers, there are authorized to be appropriated for each fiscal year beginning after June 30, 1965, such sums as may be necessary for grants by the Secretary, in accordance with this title, to assist in meeting the cost of initial staffing of community mental health centers.

APPLICATIONS AND GRANTS

SEC. 202. Grants under this title with respect to any center may be made only upon application, and only if—

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

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

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

DURATION AND AMOUNT OF GRANTS

SEC. 203. Grants for staffing of any center under this title may be made only for the period beginning with the commencement of the operation of such center and ending with the close of four years and three months after the month in which such operation commenced. Such grants with respect to any center may not exceed 75 per centum of the cost of such staffing for the period ending with the close of the fifteenth month following the month in which such operation commenced, 60 per centum of such cost for the first year thereafter, 45 per centum of such cost for the second year thereafter, and 30 per centum of such cost for the third year thereafter.

PAYMENTS

SEC. 204. Payment of grants under this title may be made (after necessary adjustment on account of previously made overpayments or underpayments) in advance or by way of reimbursement, and on such terms and conditions and in such installments, as the Secretary may determine.

REGULATIONS

SEC. 205. The Secretary shall, after consultation with the National Advisory Mental Health Council (appointed pursuant to the Public Health Service Act), prescribe general regulations concerning eligibility of centers and the terms and conditions for approving applications under this title.

TITLE III—GENERAL

DEFINITIONS

SEC. 301. For purposes of this Act—

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

(b) The term "community mental health center" means a facility providing services for the prevention or diagnosis of mental illness, or care and treatment of mentally ill patients, or rehabilitation of such persons, which services are provided principally for persons residing in a particular community or communities in or near which the facility is situated;

(c) The term "nonprofit community mental health center" means a community mental health center which is owned and operated by one or more nonprofit corporations or associations no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual;

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

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

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

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

(1) if the State plan, as of the date of approval of the project application, contains standards approved by the Secretary pursuant to section 104(c) the amount determined by the State agency in accordance with such standards; or

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

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

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

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

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

CONFORMING AMENDMENT

SEC. 302. (a) The first sentence of section 633(b) of the Public Health Service Act is amended by striking out "eight" and inserting in lieu thereof "twelve". The second sentence thereof is amended to read: "Eight of the twelve appointed members shall be persons who are outstanding in fields pertaining to medical facility and health activities, three of whom shall be authorities in matters relating to the operation of hospitals or other medical facilities and one of whom shall be an authority in matters relating to mental health, and the other four members shall be appointed to represent the consumers of services provided by such facilities and shall be persons familiar wtih the need for such services in urban or rural areas."

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

[H.R. 3689, 88th Cong., 1st sess.]

A BILL To assist States in combating mental retardation through construction of research centers and facilities for the mentally retarded

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

TITLE I—GRANTS FOR CONSTRUCTION OF CENTERS FOR RESEARCH ON MENTAL RETARDATION AND RELATED ASPECTS OF HUMAN DEVELOPMENT

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

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

"AUTHORIZATION OF APPROPRIATIONS

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

"APPLICATIONS

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

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

"(2) the application contains or is supported by reasonable assurances that (A) for not less than ten years after completion of construction, the

facility will be used for the research, or research and related purposes, for which it was constructed, (B) sufficient funds will be available for meeting the non-Federal share of the cost of constructing the facility, and (C) sufficient funds will be available, when the construction is completed, for effective use of the facility for the research, or research and related purposes, for which it was constructed; and (D) all laborers and mechanics employed by contractors or subcontractors in the performance of work on construction of the center will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Davis-Bacon Act, as amended (40 U.S.C. 276a–276a–5), and will receive compensation at rates not less than the rates determined in accordance with and subject to the provisions of the Contract Work Hours Standards Act (Public Law 87–581); and the Secretary of Labor shall have, with respect to the labor standards specified in this clause (D) the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 64 Stat. 1267), and section 2 of the Act of June 13, 1934, as amended (40 U.S.C. 276c).

"(b) In acting on applications for grants, the Surgeon General shall take into consideration the relative effectiveness of the proposed facilities in expanding the Nation's capacity for research and related purposes in the field of mental retardation and related aspects of human development, and such other factors as he, after consultation with the national advisory council or councils concerned with the field or fields of research involved, may by regulation prescribe in order to assure that the facilities constructed with such grants, severally and together, will best serve the purpose of advancing scientific knowledge pertaining to mental retardation and related aspects of human development.

"AMOUNT OF GRANTS; PAYMENTS

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

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

TITLE II—GRANTS FOR CONSTRUCTION OF FACILITIES FOR THE MENTALLY RETARDED

AUTHORIZATION OF APPROPRIATIONS

SEC. 201. There are authorized to be appropriated, for grants for construction of public and other nonprofit facilities for the mentally retarded, for the fiscal year ending June 30, 1965, and each of the next four fiscal years such sums as the Congress may determine; except that $5,000,000 of the sums so appropriated for the fiscal year ending June 30, 1965, and $10,000,000 of the sums so appropriated for any of the next four years shall be available only for grants for construction of facilities for the mentally retarded which are associated with a college or university hospital (including affiliated hospitals) or other appropriate part of a college or university.

ALLOTMENTS TO STATES

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

(b) In accordance with regulations of the Secretary, any State may file with him a request that a specified portion of its allotment under this title be added to the allotment of another State under this title for the purpose of meeting a portion of the Federal share of the cost of a project for the construction of a facility for the mentally retarded in such other State. If it is found by the Secretary that construction of the facility with respect to which the request is made

would meet needs of the State making the request and that use of the specified portion of such State's allotment, as requested by it, would assist in carrying out the purposes of this title, such portion of such State's allotment shall be added to the allotment of the other State under this title, to be used for the purpose referred to above.

(c) Upon the request of any State that a specified portion of its allotment under this title be added to the allotment of such State under title I of the Community Mental Health Centers Act of 1963 (relating to grants to States for construction of community mental health centers), and upon (1) the simultaneous certification to the Secretary by the State agency designated as provided in the State plan approved under this title to the effect that it has afforded a reasonable opportunity to make applications for the portion so specified and there have been no approvable applications for such portion, or (2) a showing satisfactory to the Secretary that the need for the community mental health centers in such State is substantially greater than for the facilities for the mentally retarded, the Secretary shall, subject to such limitations as he may by regulation prescribe, promptly adjust the allotments of such State in accordance with such request and shall notify such State agency and the State agency designated under the State plan approved under title I of the Community Mental Health Centers Act of 1963, and thereafter the allotments as so adjusted shall be deemed the State's allotments for purposes of this title and such title I.

REGULATIONS

SEC. 203. Within six months after enactment of this title, the Secretary shall, after consultation with the Federal Hospital Council (established by section 633 of the Public Health Service Act and hereinafter in this title referred to as the "Council"), by regulations prescribe—

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

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

(c) General standards of construction and equipment for facilities of different classes and in different types of location.

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

STATE PLANS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

APPROVAL OF PROJECTS AND PAYMENTS FOR CONSTRUCTION

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

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

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

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

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

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

Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. 133z–15) and section 2 of the Act of June 13, 1934, as amended (40 U.S.C. 276c); and

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

The Secretary shall approve such application if sufficient funds to pay the Federal share of the cost of construction of such project are available from the allotment to the State, and if the Secretary finds (A) that the application contains such reasonable assurance as to title, financial support, and payment of prevailing rates of wages; (B) that the plans and specifications are in accord with the regulations prescribed pursuant to section 202; (C) that the application is in conformity with the State plan approved under section 204 and contains an assurance that in the operation of the facility there will be compliance with the applicable requirements of the State plan and of the regulations prescribed under section 203(d) for furnishing needed facilities for persons unable to pay therefor, and with State standards for operation and maintenance; and (D) that the application has been approved and recommended by the State agency and is entitled to priority over other projects within the State in accordance with the regulations prescribed pursuant to section 203(b). No application shall be disapproved by the Secretary until he has afforded the State agency an opportunity for a hearing.

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

PAYMENTS FOR CONSTRUCTION

SEC. 206. (a) Upon certification to the Secretary by the State agency, based upon inspection by it, that work has been performed upon a project, or purchases have been made, in accordance with the approved plans and specifications, and that payment of an installment is due to the applicant, such installment shall be paid to the State, from the applicable allotment of such State, except that (1) if the State is not authorized by law to make payments to the applicant, the payment shall be made directly to the applicant, (2) if the Secretary, after investigation or otherwise, has reason to believe that any act (or failure to act) has occurred requiring action pursuant to section 207, payment may, after he has given the State agency notice of opportunity for hearing pursuant to such section, be withheld, in whole or in part, pending corrective action or action based on such hearing, and (3) the total of payments under this subsection with respect to such project may not exceed an amount equal to the Federal share of the cost of construction of such project.

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

WITHHOLDING OF PAYMENTS

SEC. 207. Whenever the Secretary, after reasonable notice and opportunity for hearing to the State agency designated as provided in section 204(a)(1), finds—

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

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

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

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

the Secretary may forthwith notify the State agency that—

(5) no further payments will be made to the State under this title, or

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

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

until the State repays or arranges for the repayment of Federal moneys to which the recipient was not entitled.

JUDICIAL REVIEW

SEC. 208. (a) If the Secretary refuses to approve any application for a project submitted under section 205, the State agency through which such application was submitted, or if any State is dissatisfied with his action under section 204(b) or section 207, such State, may appeal to the United States court of appeals for the circuit in which such State is located, by filing a petition with such court within sixty days after such action. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary, or any officer designated by him for that purpose. The Secretary thereupon shall file in the court the record of the proceedings on which he based his action, as provided in section 2112 of title 28, United States Code. Upon the filing of such petition, the court shall have jurisidiction to affirm the action of the Secretary or to set it aside, in whole or in part, temporarily or permanently, but until the filing of the record, the Secretary may modify or set aside his order. The findings of the Secretary as to the facts, if supported by substantial evidence, shall be conclusive, but the court, for good cause shown, may remand the case to the Secretary to take further evidence, and the Secretary may thereupon make new or modified findings of fact and may modify his previous action, and shall file in the court the record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence. The judgment of the court affirming or setting aside, in whole or in part, any action of the Secretary shall be final, subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code. The commencement of proceedings under this subsection shall not, unless so specifically ordered by the court, operate as a stay of the Secretary's action.

RECOVERY

SEC. 209. If any facility with respect to which funds have been paid under section 206 shall, at any time within twenty years after the completion of construction—

(1) be sold or transferred to any person, agency, or organization (A) which is not qualified to file an application under section 205, or (B) which is not approved as a transferee by the State agency designated pursuant to section 204, or its successor, or

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

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

STATE CONTROL OF OPERATIONS

SEC. 210. Except as otherwise specifically provided, nothing in this title shall be construed as conferring on any Federal office or employee the right to exercise any supervision or control over the administration, personnel, maintenance, or operation of any facility with respect to which any funds have been or may be expended under this title.

DEFINITIONS

SEC. 211. For purposes of this title—

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

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

(c) The term "nonprofit facility for the mentally retarded" means a facility for the mentally retarded which is owned and operated by one or more nonprofit corporations or associations no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual;

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

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

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

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

(1) if the State plan, as of the date of approval of the project application, contains standards approved by the Secretary pursuant to section 204(c), the amount determined by the State agency in accordance with such standards; or

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

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

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

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

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

CONFORMING AMENDMENT

SEC. 212. (a) The first sentence of section 633(b) of the Public Health Service Act is amended by striking out "eight" and inserting in lieu thereof "twelve." The second sentence thereof is amended to read: "Eight of the twelve appointed members shall be persons who are outstanding in fields pertaining to medical facility and health activities, three of whom shall be authorities in matters relating to the operation of hospitals or other medical facilities and one of whom shall be an authority in matters relating to the mentally retarded, and the other four members shall be appointed to represent the consumers of services provided by such facilities and shall be persons familiar with the need for such services in urban or rural areas."

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

[H.R. 2567, 88th Cong., 1st sess.]

A BILL To amend the Public Health Service Act in order to provide a broadened program in the field of mental health and illness of grants for prevention, research, training, salaries, facilities survey, and construction of facilities for treatment of the mentally ill and mentally retarded

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Mental Health Act of 1962".

SEC. 2. The Public Health Service Act is amended by adding at the end thereof the following new title:

"TITLE VIII—PROGRAM IN THE FIELD OF MENTAL HEALTH AND ILLNESS

"STATEMENT OF PURPOSE

"SEC. 801. The purpose of this title is to encourage the several States to bring about changes in their laws concerning mental health and to assist them in bringing about administrative changes that will—

"(1) make professional treatment as well as custody the acceptable standard of hospitalization;

"(2) provide for differentiation between the need for treatment and the need for institutionalization;

"(3) provide in suitable instances for treatment without hospitalization;

"(4) make proper provision for voluntary admission to mental hospitals and facilities and relegate court commitment to special instances of demonstrable need;

"(5) ease stringency of admissions and discharge from institutions and facilities;

"(6) facilitate, without interference to any existing reciprocal agreements, acceptance of patients whether legal residents of the State or not;

"(7) clarify and update the responsibility of relatives for patients in mental institutions and facilities;

"(8) distinguish between the administrative responsibility of the State for the welfare and safekeeping of patients from the professional responsibility for their medical care;

"(9) provide treatment for all types of patients in all mental health institutions with the understanding that psychiatric wards of general hospitals may limit duration and type of treatment according to their capabilities;

"(10) establish State mental health agencies with well defined authority to:

"(a) assume overall responsibility for services to the mentally ill and mentally retarded;

"(b) coordinate State and local community mental health services, with provision for central administrative reporting and file systems;

"(c) give recognition to the responsibility of the family of the patient;

"(d) provide for cooperation with private institutions and facilities; and

"(e) provide screening and referral services to schools and other institutions of learning.

"(11) operate mental hospitals as part of an integrated community service by affording outpatient care and treatment as well as inpatient services to include professional consultation to schools, law courts, and domiciliary treatment centers for the aged;

"(12) establish, in suitable State hospitals, programs of training mental health workers and for research into the problems of mental health, mental illness, and mental retardation;

"(13) review laws, programs, and proposals to retain, insofar as possible, the individual rights of patients in mental hospitals and other mental facilities;

"(14) require inventory of their existing facilities for the treatment of mental health, mental illnees, and mental retardation, including rehabilitation;

"(15) formulate a plan for construction of facilities which—

"(a) will be responsive to modern methods of treatment;

"(b) will take account of shifts in population, urbanization, location of learning centers, the availability of workers; and

"(c) will take due account of the organization of county and community facilities for the treatment of the mentally ill.

"DEFINITIONS

"SEC. 802. For the purposes of this title—

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

"(2) The term 'nonprofit', when used with reference to any agency, organization, or institution, means an agency, organization, or institution no part of the net earnings of which inure, or may lawfully inure, to the benefit of any private shareholder or individual.

"(3) The term 'Council' means the National Advisory Mental Health Council.

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

"(5) The term 'construction' includes construction of new buildings, expansion, remodeling, and alteration of existing buildings, and initial equipment of any such buildings, including architects' fees, but excluding the cost of off-site improvements and the acquisition of land.

"(6) The term 'facility' means any building, office, or clinic established by a town, city, county, or other level of government for the prevention or treatment of mental illness and retardation that shall have been approved by the State.

"(7) The term 'Federal share' when used with respect to any construction project means the proportion of the cost of construction of such project paid with a grant under part B of this title which may not exceed 66⅔ per centum of the cost thereof nor be less than 33⅓ per centum of the cost thereof.

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

"(9) The population of each State and of all the States shall be determined by the Secretary on the basis of the latest figures certified by the Secretary of Commerce.

"TRANSFER OF ALLOTMENTS

"SEC. 803. A State agency for any State may submit to the Surgeon General a request, in writing, that a specified amount of any allotment to such State under this title which, but for this section, would be paid to such State to carry out a State plan administered or supervised by such State agency, be added to the corresponding allotment of any other State for the purpose of making a grant to any public or nonprofit agency, organization, or institution which is (1) otherwise eligible for a grant from such an allotment of such other State, (2) specified in such request, and (3) located in such other State. The Surgeon General shall add such amount to the allotment of such other State and shall make a grant of such amount to such agency, organization, or institution, as the case may be, if he determines that the making of such grant is consistent with the purpose of this title and will be used in such a manner as to be of direct benefit to the State filing such request. In order to carry out the provisions of this section, the Surgeon General may by regulation modify or make inapplicable any provisions of this title.

"PART A—GRANTS FOR RESEARCH, TRAINING, AND SALARIES

"AUTHORIZATION OF APPROPRIATIONS

"SEC. 811. For the fiscal year beginning July 1, 1963, and for each succeeding fiscal year, there is hereby authorized to be appropriated—

"(1) $100,000,000 to enable the Surgeon General to make grants as provided in this part for investigations, experiments, demonstrations, studies, and research projects for the development of improved methods of preventing and diagnosing mental illness and mental retardation, and relating to

the care, treatment, and rehabilitation of the mentally ill and the mentally retarded;

"(2) $100,000,000 to enable the Surgeon General to make grants as provided in this part to assist in the training of personnel (a) at schools, colleges, or other institutions of learning, (b) at institutions for the mentally ill or mentally retarded, or (c) in community mental health programs; and

"(3) $200,000,000 to enable the Surgeon General to make grants as provided in this part to be used in paying or supplementing the salaries of individuals, whether they be teacher, trainee, professional, or other, working with the mentally ill, mentally retarded, or in community mental health programs.

"Funds appropriated pursuant to the provisions of this section shall remain available until expended.

"ALLOTMENT

"SEC. 812. From the sums appropriated pursuant to paragraphs (1), (2), and (3) of section 811 for any fiscal year, the Surgeon General shall allot to each State amounts which bear the same ratio to such sums, respectively, as the population of such State bears to the population of all the States except that no State shall receive any allotment when the State effort index falls below the average of the preceding five years. Effort index may be described as the relation of State expenditure for each resident mentally ill patient to State expenditures for all purposes.

"GENERAL REGULATIONS

"SEC. 813. Within six months after the date of enactment of this title, the Surgeon General, acting on the advice and with express approval of the Secretary and Council, shall establish—

"(1) the minimum qualifications necessary for individuals to qualify for grants from amounts appropriated pursuant to section 811 but in nowise shall this be construed as prescribing or requiring in the States a particular table of organization or administrative structure;

"(2) the general types of public or nonprofit agencies, organizations, facilities, or institutions to include universities and institutions of learning which will be eligible to receive grants from amounts appropriated pursuant to section 811(1);

"(3) the minimum standards for training and for the personnel conducting such training to be eligible for a grant under section 811 (2) (3); and

"(4) general methods of administration of the State plan by such State agency as is designated.

"STATE PLANS

"SEC. 814. (a) After the Surgeon General has established the regulations as provided in section 812, any State which wishes to participate in the program under this part must submit to the Surgeon General a State plan in such form as he may prescribe which—

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

"(2) contains assurances satisfactory to the Surgeon General that the State agency designated in accordance with paragraph (1) will have authority to carry out such plan in accordance with this part;

"(3) provides for the establishment of a State advisory council which is representative of the agencies, organizations, and institutions, public and nonpublic, which are eligible to participate in the program under this part to consult with the State agency in carrying out the State plan;

"(4) provides for such methods of administering the State plan as will tend to accomplish the purpose of this title as set forth in section 801;

"(5) provides for affording to every applicant for a grant under this part an opportunity for a hearing before the State agency;

"(6) provides that the State agency will make such reports in such form and containing such information as the Surgeon General may from time to time reasonably require, and give the Surgeon General, upon demand, access to the records upon which such information is based; and

"(7) provides that the State agency will from time to time review its program under this part and submit to the Surgeon General any modifications thereof which it considers necessary.

"(b) The Surgeon General shall approve any State plan and any modification thereof which complies with the provisions of subsection (a). If any such plan or modification thereof shall have been disapproved by the Surgeon General for failure to comply with subsection (a), the Council shall, upon request of the State agency, afford it an opportunity for hearing. If the Council determines that the plan or modification complies with the provisions of such subsection, the Surgeon General shall thereupon approve such plan or modification.

"APPROVAL OF APPLICATIONS; PAYMENTS

"SEC. 815. (a) Each application for a grant under this part shall be submitted by the applicant to its State agency and, if determined to be in compliance with the State plan and approved by the State agency, shall be submitted by the State agency to the Surgeon General. Each such application shall set forth, in such form and detail as the Surgeon General may prescribe—

"(1) the purpose or purposes for which any grant made under this part and pursuant to such application will be used and the manner of achieving such purpose or purposes,

"(2) the amount of non-Federal funds, if any, which will be used to achieve such purpose or purposes,

"(3) the name of each individual who will be responsible for administering any activities for which any grant made pursuant to such application is used, and

"(4) assurances satisfactory to the Surgeon General that (A) any such grant will be used solely to achieve the purpose or purposes set forth in such application, in the manner set forth therein, and (B) the applicant will make such reports to the Surgeon General, in such form and containing such information, as may be reasonably necessary to enable the Surgeon General to perform his duties under this part.

"(b) The Surgeon General shall not disapprove any application submitted to him as provided in this part until he has afforded the State agency an opportunity for a hearing.

"(c) If the appropriate State allotment under section 812 is adequate therefor, upon approving an application under this part, the Surgeon General shall certify to the Secretary of the Treasury the amount of the grant to be made pursuant to such application and shall designate the appropriation from which it is to be paid. Such certification shall provide for payment to the State, except that if the State is not authorized by law to make payments to the applicant such certification shall provide for payment direct to the applicant.

"PART B—SURVEY AND CONSTRUCTION OF FACILITIES FOR THE TREATMENT OF THE MENTALLY ILL AND MENTALLY DEFICIENT

"SURVEY

"SEC. 821. (a) In order to assist the State is carrying out the purposes of section 801(15), there is hereby authorized to be appropriated the sum of $2,000,000, to remain available until expended. Sums appropriated under this section shall be used for making payments to States which have submitted, and had approved by the Surgeon General, State applications for funds for carrying out such purposes.

"(b) The Surgeon General shall approve a State application for funds for carrying out the purposes of section 801(9) which—

"(1) designates a single State agency as the sole agency for the administration of the application, or designates such agency as the sole agency for supervising the administration of the application;

"(2) provides for utilizing the State advisory council which is established pursuant to section 814(a)(3) to consult with the State agency in connection with the survey to be carried out under this section; and

"(3) provides for the making of an inventory and survey containing all information required by the Surgeon General and for developing a construction program that can be used for carrying out the other sections of this part.

"(c) Each State shall be entitled to an allotment of such proportion of any appropriation made pursuant to subsection (a) as its population bears to the population of all the States, and within such allotment shall be entitled to receive 50 per centum of its expenditures in carrying out the purposes of section

801(9) in accordance with its application; except that no such allotment to any State shall be less than $25,000. The Surgeon General shall from time to time estimate the sum to which each State will be entitled under this section, during such ensuing period as he may determine, and shall thereupon certify to the Secretary of the Treasury the amount so estimated, reduced or increased, as the case may be, by any sum which the Surgeon General finds that his estimate for any prior period was greater or less than the amount to which the State was entitled for such period.

"(d) Any funds paid to a State under this section and not expended for the purposes for which paid shall be repaid to the Treasury of the United States.

"AUTHORIZATION OF APPROPRIATIONS FOR CONSTRUCTION OF FACILITIES

"SEC. 822. In order to assist the States in constructing needed facilities for the treatment of the mentally ill and mentally deficient, including rehabilitation facilities, there is authorized to be appropriated for the fiscal year beginning July 1, 1963, and for each succeeding fiscal year the sum of $100,000,000.

"ALLOTMENT

"SEC. 823. From the sums appropriated pursuant to section 822 for any fiscal year, each State shall be entitled to an allotment for such year of an amount which bears the same ratio to such amount as the population of such State bears to the population of all the States.

"REGULATIONS

"SEC. 824. Within six months after the date of enactment of this title, the Surgeon General, with the advice and approval of the Council and the Secretary, shall by general regulation establish—

"(1) the number of hospital beds required to provide adequate services for mentally ill and mentally deficient individuals in each State, and the general method or methods by which such beds will be distributed throughout the State giving due regard to population, but no hospital to be constructed with funds received under this part shall have a capacity in excess of one thousand beds;

"(2) the number of facilities, the adequacy of their services, and their distribution throughout the State;

"(3) general standards of construction and equipment for such hospitals and facilities; and

"(4) general methods of administration of the State plan by the designated State agency.

"STATE PLANS

"SEC. 825. (a) After the regulations provided for in section 824 have been issued, any State desiring to participate in the program under this part must submit to the Surgeon General a State plan in such form as he may prescribe which—

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

"(2) contains assurances satisfactory to the Surgeon General that the State agency designated in accordance with paragraph (1) will have authority to carry out such plan in accordance with this part;

"(3) provides for utilizing the State advisory council which is established pursuant to section 814(a)(3) to consult with the State agency in administering or supervising the State plan;

"(4) sets forth a construction program for hospitals and other facilities for the treatment of mentally ill and mentally deficient individuals, including rehabilitation facilities, which (A) is based on a statewide inventory of such existing hospitals and facilities and a survey of need for such hospitals and facilities; (B) conforms with the regulations of the Surgeon General prescribed under section 824 (1) and (2); and (C) in the case of a State which has developed a program under section 821, conforms to the program so developed except for any modifications required in order to comply with regulations prescribed pursuant to section 824 (1) and (2);

"(5) sets forth the relative need determined in accordance with the regulations prescribed under section 824 for the several projects included in such programs, and provides for the construction, insofar as financial resources available therefor and for maintenance and operation make possible, in the order of such relative need;

"(6) provides such methods of administration of the State plan as the Surgeon General prescribes by regulation under section 824(4) and as will tend to accomplish the purpose of this title as set forth in section 801;

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

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

"(9) provides that the State agency will make such reports in such form and containing such information as the Surgeon General may from time to time reasonably require, and give the Surgeon General, upon demand, access to the records upon which such information is based; and

"(10) provides that the State agency will from time to time review its hospital and facility construction program and submit to the Surgeon General any modifications thereof which it considers necessary.

"(b) The Surgeon General shall approve any State plan and any modification thereof which complies with the provisions of subsection (a). If any such plan or modification thereof shall have been disapproved by the Surgeon General for failure to comply with subsection (a), the Council shall, upon request of the State agency, afford it an opportunity for hearing. If the Council determines that the plan or modification complies with the provisions of such subsection, the Surgeon General shall thereupon approve such plan or modification.

"(c) The State plan may include standards for determination of the Federal share of the cost of projects approved in the State. Such standards shall provide equitably (and, to the extent practicable, on the basis of objective criteria) for variations between projects or classes of projects on the basis of the economic status of areas, relative need as between areas for additional facilities, and other relevant factors. No such standards shall provide for a Federal share of more than 66⅔ per centum or less than 33⅓ per centum of the cost of construction of any project. The Surgeon General shall approve any such standards and any modifications thereof which comply with the provisions of this subsection.

"APPROVAL OF PROJECTS

"SEC. 826. (a) Each application for a grant under this part shall be submitted by the applicant to its State agency and, if determined to be in compliance with the State plan and approved by the State agency, shall be submitted by the State agency to the Surgeon General. If two or more agencies, organizations, or institutions join in the construction of the project, the application may be filed by one or more of them. Each such application shall set forth, in such form and detail as the Surgeon General may prescribe—

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

"(2) plans and specifications therefor in accordance with the regulations prescribed by the Surgeon General under section 824(4);

"(3) reasonable assurance that title, as defined in section 802(7), to such site is or will be vested in one or more of the agencies, organizations, or institutions filing the application or in a public or other nonprofit agency, organization, or institution which is to operate the facility;

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

"(5) reasonable assurance that the rates of pay for laborers and mechanics engaged in construction of the project will be not less than the prevailing local wage rates for similar work as determined in accordance with Public Law 403 of the Seventy-fourth Congress, approved August 30, 1935, as amended; and

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

"(b) The Surgeon General shall approve such application if (1) sufficient funds to pay the Federal share of the cost of construction of such project are available from the allotment to the State, and (2) it is entitled to priority over other projects within the State in accordance with the regulations pre-

scribed pursuant to section 824(3). No application shall be disapproved until the Surgeon General has afforded the State agency an opportunity for a hearing.

"PAYMENTS

"SEC. 827. (a) Upon approving an application under section 826 the Surgeon General shall certify to the Secretary of the Treasury an amount equal to the Federal share of the estimated cost of construction of the project and designate the appropriation from which it is to be paid. Such certification shall provide for payment to the State, except that if the State is not authorized by law to make payments to the applicant the certification shall provide for payment direct to the applicant. Upon certification by the State agency, based upon inspection by it, that work has been performed upon a project, or purchases have been made, in accordance with the approved plans and specifications, and that payment of an installment is due to the applicant, the Surgeon General shall certify such installment for payment by the Secretary of the Treasury.

"(b) Amendment of any approved application shall be subject to approval in the same manner as an original application. Certification under subsection (b) may be amended, either upon approval of an amendment of the application or upon revision of the estimated cost of a project. An amended certification may direct that any additional payment be made from the applicable allotment for the fiscal year in which such amended certification is made.

"(c) The funds paid under this section for the construction of an approved project shall be used solely for carrying out such project as so approved.

"(d) If any facility for which funds have been paid under this section shall, at any time within twenty years after the completion of construction—

"(1) be sold or transferred to any person, agency, or organization,

"(A) which is not qualified to file an application under this section, or

"(B) which is not approved as a transferee by the State agency designated pursuant to section 825(a)(1), or its successor, or

"(2) cease to be a public or nonprofit agency, organization, or institution,

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

"COMPLIANCE

"SEC. 828. Whenever the Surgeon General, after reasonable notice and opportunity for hearing to the mental health agency of the State (or, in the case of payments to any political subdivision or other organization, such subdivision or organization) finds that, with respect to money paid to the State, subdivision, or organization out of appropriations under section 811 (1), (2), or (3) or section 821 or section 822, there is failure to comply substantially with either—

"(a) the provisions of this title;

"(b) the plan submitted under section 814; or

"(c) the regulations;

the Surgeon General shall notify such State mental health agency, political subdivision, or organization that further payments will not be made to the State, subdivision, or organization from such appropriations under such section (or in his discretion that further payments will not be made to the State, subdivision, or organization from such appropriations for activities in which there is such failure), until he is satisfied that there will no longer be any such failure. Until he is so satisfied the Surgeon General shall make no further certification for payment to such State, subdivision, or organization from appropriations under such section, or shall limit payment to activities in which there is no such failure."

"SEC. 3. (a) The Act of July 1, 1944 (58 Stat. 682), as amended, is hereby further amended by renumbering title VIII (as in effect prior to the enactment of this Act) as title IX and renumbering sections 801 through 814 (as in effect prior to the enactment of this Act), and references thereto, as sections 901 through 914, respectively.

(b) Section 1 of the Public Health Service Act is amended to read as follows:

"SHORT TITLE

"SECTION 1. Titles I through VIII, inclusive, of this Act may be cited as the 'Public Health Service Act'."

SEC. 4. Effective as of July 1, 1963, sections 303 and 304 of the Public Health Service Act are repealed.

EXECUTIVE OFFICE OF THE PRESIDENT,
BUREAU OF THE BUDGET,
Washington, D.C., March 22, 1963.

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

DEAR MR. CHAIRMAN: This is in response to your request for the views of the Bureau of the Budget on H.R. 3688, a bill to provide for assistance in the construction and initial operation of community mental health centers, and for other purposes.

This bill would authorize appropriations for Federal grants to assist in the construction and initial operation of comprehensive community mental health centers. The bill would carry out recommendations of the President pertaining to mental illness in his special message to the Congress on mental illness and mental retardation. As the President indicated in his message, if a broad new mental health program such as he has suggested is enacted, it will be possible within a decade or two to reduce the number of patients now under custodial care in State mental institutions by 50 percent or more. Accordingly, the major purpose of the President's proposals is to encourage the development of comprehensive community mental health centers "which will return mental health to the mainstream of American medicine."

You are advised that enactment of H.R. 3688 would be in accord with the President's program.

Sincerely yours,

PHILLIP S. HUGHES,
Assistant Director for Legislative Reference.

COMPTROLLER GENERAL OF THE UNITED STATES,
Washington, March 29, 1963.

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

DEAR MR. CHAIRMAN: Your letter of February 22, 1963, acknowledged February 25, transmitted copies of H.R. 3688 for our comments. The bill is to provide assistance in the construction and initial operation of community mental health centers.

Title I of the bill provides in accordance with the format of the Public Health Service Act, authorization for grants by the Secretary of Health, Education, and Welfare for the purpose of assisting public and nonprofit agencies in a program of constructing community mental health centers. The grant program authorized is for the 5-year period beginning July 1, 1964, and ending June 30, 1969. Title II of the bill authorizes grants for the establishment and initial operation of comprehensive community health centers to public and nonprofit agencies or organizations who have constructed such facilities under grants made under title I. These grants specifically are to assist in meeting the cost of initial staffing of community mental health centers and are to be in reducing amounts for each year of operation for a total period of 4 years and 3 months after commencement of operations.

This Office has no special information concerning the subject matter of the proposed legislation and, therefore, we have no recommendation to make on the merits of the bill.

In our review of the proposed legislation, however, we observed certain matters which we feel should be brought to the attention of the committee. Section 102(c) provides that, at the request of any State, a specific portion of its allotment under title I of the proposed bill may be added to the allotment of the State

under title II of the Mental Retardation Facilities Construction Act of 1963 (H.R. 3689) if certain conditions are met. This authority could result in weakening the effectiveness of the budgetary and appropriation processes because substantial Federal grants could be used by the States in amounts that might vary considerably from the amounts that would be included in the Federal appropriation for each program. Consideration should be given to the placing of specific limitation on the amounts of allotments eligible for transfer between the two programs. Also we should like to point out that this subsection, by its reference to title II of the Mental Retardation Facilities Construction Act of 1963, which referenced "act" is presently in bill form, would be without effect in the event the referenced "act" failed of enactment. We are making similar comments in our report to your committee on S. 3689 respecting like provisions.

Title II of the bill provides for grant assistance to meet the costs of initial staffing of the comprehensive community mental health centers the construction of which is to be assisted under title I of the bill. However, the bill does not define "initial staffing" in terms of the types of costs that would be eligible for Federal assistance nor does it indicate the extent to which fees received by the operators of the centers are to reduce the Federal grants for initial staffing. We suggest that these matters be specifically covered in the bill.

The proposed legislation providing grant assistance for construction of centers under title I does not appear to embrace any community mental health centers already under construction. Additionally the grants provided under title II for the initial staffing costs appear to cover only agencies which have received Federal assistance under title I and would not benefit agencies otherwise operating mental health centers.

No provision is made in the bill nor in legislation applicable to other grant programs now authorized by the Public Health Service Act, as amended, to require a grantee to keep adequate cost records of the projects to which the Federal Government makes financial contributions, or specifically authorizing the Secretary of Health, Education, and Welfare or the Comptroller General to have access to the grantee's records for purposes of audit and examination. In view of the increase in grant programs over the last several years we feel that in order to determine whether grant funds have been expended for the purpose for which the grant was made the grantee should be required by law to keep records which fully disclose the disposition of such funds. We also feel that the agency as well as the General Accounting Office should be permitted to have access to the grantee's records for the purpose of audit and examination. We therefore suggest that consideration be given to amending the bill to include such requirements with respect to the proposed new program, or preferably to an amendment of the Public Health Service Act to cover all grant programs therein authorized. The latter could be accomplished by the following language:

"RECORDS AND AUDIT

"(a) Each recipient of assistance under this Act shall keep such records as the Secretary of Health, Education, and Welfare shall prescribe, including records which fully disclose the amount and disposition by such recipient of the proceeds of such grants, the total cost of the project or undertaking in connection with which such funds are given or used, and the amount of that portion of the cost of the project or undertaking supplied by other sources, and such other records as will facilitate an effective audit.

"(b) The Secretary of Health, Education, and Welfare and the Comptroller General of the United States or any of their duly authorized representatives shall have access for the purpose of audit and examination to any books, documents, papers, and records of the recipients that are pertinent to the grants received under this Act."

In administering the above provision we do not contemplate making a detailed examination of the books and records of every recipient of a grant, or even a major part of them. However, selective checks may be made to provide reasonable assurance that grant funds are being properly applied or expanded.

Sincerely yours,

JOSEPH CAMPBELL,
Comptroller General of the United States.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, March 7, 1963.

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

DEAR MR. CHAIRMAN: This letter is in response to your request of February 22, 1963, for a report on H.R. 3688, a bill to provide for assistance in the construction and initial operation of community mental health centers, and for other purposes.

This bill embodies a legislative proposal submitted to the Congress by this Department and designed to carry out the President's recommendation for the development of comprehensive community mental health programs contained in his message to the Congress on mental illness and mental retardation. (A copy of our letter of February 11, 1963, to the Speaker is enclosed herewith.)

For the reasons stated in the President's message and in our letter to the Speaker, we strongly urge enactment of this bill.

A 5-year estimate of the cost of this bill, as required by Public Law 801, 84th Congress (5 U.S.C. 642a), was transmitted to you on March 4, 1963.

Sincerely,

WILBUR J. COHEN, *Assistant Secretary.*

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, February 11, 1963.

Hon. JOHN W. MCCORMACK,
Speaker of the House of Representatives,
Washington, D.C.

DEAR MR. SPEAKER: I am enclosing for your consideration a draft of a bill to provide for assistance in the construction and initial operation of community mental health centers, and for other purposes. This legislative proposal is designed to carry out the President's recommendations for the development of comprehensive community mental health programs contained in his message to the Congress on mental illness and mental retardation.

The draft bill would authorize inauguration of Federal grant programs aimed at stimulating and assisting States and communities in developing community-centered mental health programs. Title I authorizes construction grants to provide the basic facilities required for such programs. Title II authorizes short term operating grants to help ease the financial impact on communities which undertake the initiation of comprehensive community health programs.

TITLE I—CONSTRUCTION OF COMMUNITY MENTAL HEALTH CENTERS

Title I would establish a 5-year grant program to assist in the construction of public and other nonprofit community mental health centers—i.e., facilities for the prevention, diagnosis, or treatment of mental illness or for the rehabilitation of persons recovering from mental illness.

Appropriations of such sums as Congress may determine would be authorized during the period July 1, 1964, through June 30, 1969. Funds would be allotted among the several States on the basis of population, extent of need for community health centers, and the financial need of the respective States, with a minimum of $100,000 for any State. States would be given the alternative of varying the Federal share of the costs of construction of projects, on the basis of standards set by the State, between 45 percent and 75 percent or of choosing a uniform Federal share—which would not be less than 45 percent and could go as high as 75 percent for some States—for all projects in the State.

Applications would be submitted to the Secretary of Health, Education, and Welfare after approval by the State agency designated to administer the State plan for purposes of this title of the bill.

A State advisory council, composed of representatives of State agencies, and of nongovernment organizations or groups, concerned with planning, operation, or utilization of community mental health centers or other mental health facilities, as well as representatives of consumers of services provided by such centers or facilities, would consult with the State agency in carrying out the State plan. The plan would have to set forth a construction program based on a survey of need for the centers and provide for construction in accordance with relative need for the centers insofar as permitted by available financial resources. The State plan would also have to meet several other requirements set forth in the

bill, such as requirements for proper and efficient methods of administration, hearings for unsuccessful applicants, and standards for maintenance and operation of facilities.

Eligibility for grants would be limited to projects which alone, or in conjunction with other facilities owned or operated by the applicant, or affiliated or associated with the applicant, will provide, principally for persons residing in or near the particular community or communities in which such center is situated those essential elements of comprehensive mental health services which the Secretary prescribes in accordance with regulations. The priority of projects to be approved would be based on the relative need of the different areas in the State, and special consideration would be given to those projects which will be part of or closely associated with a general hospital and projects which alone, or in conjunction with other facilities owned or operated by the applicant or affiliated or associated with the applicant, will provide comprehensive mental health services for a particular community or communities.

TITLE II—INITIAL STAFFING OF COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTERS

The provisions of title II have a dual objective. First, they recognize that the shifting of focus in the prevention and treatment of mental illness to community centered programs will require the development of new or revised methods of financing such services, and that during this transitional period some temporary operating aid to communities will be required. Second, these provisions are designed to stimulate and encourage the establishment of comprehensive, coordinated mental health services. One of the primary reasons for focusing on community centered programs is that it is only in such programs that services for persons at different stages in a progressive care program can be effectively provided and coordinated. Since the initiation of such a comprehensive community program will place the greatest financial burden on the community—for the operation as well as the construction of mental health centers—special project grants to meet part of the initial staffing costs of such centers are authorized by this title.

Eligibility for project grants for this purpose would be limited to facilities for which a grant has been made under title I, operated by public or nonprofit agencies which will provide—as a minimum—diagnostic services, inpatient care, outpatient care, and all day care for the mentally ill persons.

The provisions relating to duration and amount of grants underscore the concept of temporary Federal aid, with no continuation of Federal operating assistance after the center has been fully established as a going concern in the community. For the first 15 months of the center's operation the Federal grant may not exceed 75 percent of the staffing costs of the center, and for the following 3 years the Federal participation in such costs may not exceed 60 percent, 45 percent, and 30 percent, respectively.

To assure coordination between this grant program and certain mental health project grants authorized under the Public Health Service Act, provision is made in this title for consultation by the Secretary with the National Advisory Mental Health Council in the development of regulations concerning eligibility of institutions and the terms and conditions for approving applications.

OTHER PROVISIONS

The third title of the draft bill consists of definitions and conforming amendments. Among these provisions is an amendment to the Public Health Service Act which would increase the number of appointed members of the Federal Hospital Council from 8 to 12 so as to assure the inclusion of persons familiar with mental health facility needs and administration.

The provisions of this proposed legislation are essential to the launching of a major national effort to replace our traditional method of isolating the mentally ill in large custodial institutions with community programs which can prevent or arrest mental illness in its early stages, reduce the time and cost of inpatient treatment, and facilitate the early rehabilitation of mental patients. The enactment of these proposed new authorities—which will supplement and reinforce the research, training, and other provisions of existing law relating to mental health—will provide the statutory foundation for one of the most dramatic and satisfying victories in our conquest of the major diseases and impairments of man.

I shall appreciate it if you would refer the enclosed draft bill to the appropriate committee for consideration.

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

Sincerely,

ANTHONY J. CELEBREZZE, *Secretary.*

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, March 4, 1963.

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

DEAR MR. CHAIRMAN: By letter dated February 11, 1963, we transmitted to the Speaker of the House of Representatives a draft bill to provide for assistance in the construction and initial operation of community mental health centers, and for other purposes. This legislative proposal, introduced as H.R. 3688, has been referred to your committee for consideration.

Enclosed are estimates of appropriations, expenditures, and personnel required during the first 5 years of the program authorized by the bill.

Sincerely,

ANTHONY J. CELEBREZZE, *Secretary.*

COMMUNITY MENTAL HEALTH CENTERS ACT OF 1963

Estimate of additional costs, 1964–68

[In thousands of dollars]

Item	1964	1965	1966	1967	1968
Appropriation requirements:					
Grants for:					
Construction of community mental health centers		35,000	50,000	65,000	80,000
Initial staffing of facilities			17,000	38,000	62,000
Direct program expenses		130	310	665	910
Total		35,130	67,310	103,665	142,910
Expenditures:					
Grants for:					
Construction of community mental health centers		3,500	12,000	34,000	53,000
Initial staffing of facilities			15,000	35,000	57,000
Direct program expenses		115	280	615	850
Total		3,615	27,280	69,615	110,850
Man-years of employment		10	27	53	76

DEPARTMENT OF LABOR,
OFFICE OF THE SECRETARY,
Washington, March 27, 1963.

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

DEAR CONGRESSMAN HARRIS: This is in further reply to your request for our comments on H.R. 3688, a bill to provide for assistance in the construction and initial operation of community mental health centers, and for other purposes; and H.R. 3689, to assist States in combating mental retardation through construction of research centers and facilities for the mentally retarded.

We wholeheartedly favor enactment of these bills which are designed to stimulate action at all levels of Government in combating mental illness and retardation. As the President pointed out in his special message to the Congress on February 5, 1963, "We as a nation have long neglected the mentally ill and the mentally retarded. The neglect must end, if our Nation is to live up to its own standards of compassion and dignity and achieve the maximum use of its manpower."

We note with approval that the bills contain adequate labor standards protection for laborers and mechanics employed on the federally assisted construction projects which they authorize.

The Bureau of the Budget advises that there is no objection to the presentation of this report from the standpoint of the administration's program.

Yours sincerely,

W. WILLARD WIRTZ,
Secretary of Labor.

EXECUTIVE OFFICE OF THE PRESIDENT,
BUREAU OF THE BUDGET,
Washington, D.C., March 19, 1963.

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

DEAR MR. CHAIRMAN: This is in response to your request for the views of the Bureau of the Budget on H.R. 3689, a bill to assist States in combating mental retardation through construction of research centers and facilities for the mentally retarded.

H.R. 3689 would authorize appropriations for the construction of research centers on mental retardation and related aspects of human development; and the construction of facilities for the mentally retarded. As the President indicated in his special message to the Congress on mental illness and mental retardation, we have an obligation to prevent mental retardation, whenever possible. and to ameliorate it when it is present. The President has recommended a comprehensive program to attack this affliction. This bill, together with other actions taken or recommended under existing and proposed legislation, would carry out the President's recommendations.

You are advised that the enactment of H.R. 3689 would be in accord with the President's program.

Sincerely yours,

PHILLIP S. HUGHES,
Assistant Director for Legislative Reference.

COMPTROLLER GENERAL OF THE UNITED STATES,
Washington, March 29, 1963.

B–74254.

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

DEAR MR. CHAIRMAN: Your letter of February 22, 1963, acknowledged February 25, transmitted copies of H.R. 3689 for our comments. The bill is to assist States in combating mental retardation through construction of research centers and facilities for the mentally retarded.

Title I would amend title VII of the Public Health Service Act by designating the present provisions as part A and adding part B which would provide grant authority in the Surgeon General of the United States to assist in meeting costs of constructing centers for research on mental retardation and related purposes. This grant authority would cover the period from July 1, 1963, to June 30, 1968.

Title II would authorize project grants by the Secretary of Health, Education, and Welfare for construction of public and other nonprofit facilities for the mentally retarded with stated amounts being for the purpose of assisting public and nonprofit agencies in constructing facilities for the mentally retarded which are associated with a college or university hospital or other appropriate part of a college or university. The grant program authorized is for the 5-year period beginning July 1, 1964, and ending June 30, 1969.

This Office has no special information concerning the subject matter of the proposed legislation and therefore, we have no recommendation to make on the merits of the bill.

In our review of the proposed legislation we observed certain matters which we feel should be brought to the attention of the committee. Title I of S. 3689 adds a new part B to title VII of the Public Health Service Act. The present provisions of law in this title, which under the proposed bill have been redesignated as part A, authorize grants for the construction of facilities for research

in the sciences related to health. The following explanations and qualifications are contained therein:

(*a*) Under subsection (a) of section 706, title VII, Public Health Service Act, as amended, 42 U.S.C. 292e(a) grants are authorized for construction of facilities "to be used for research, or research and purposes related thereto (including research training)."

(*b*) The subsection also provides the formula for determining the proportionate part of the Federal grants, when applied to the construction of multipurpose facilities, which relates to use of the facility for health research.

(*c*) Subsection (c) of this section provides in determining the amount of the grant, that there should be excluded from the cost of construction other Federal grants made with respect to construction of the same facility and the non-Federal matching funds required as a condition of the other Federal grants.

The proposed legislation which covers a similar type grant program contains none of these qualifying provisions. We suggest that your committee may wish to consider the advisability of including similar provisions with respect to the subject legislation.

Section 707, title VII, Public Halth Service Act, 42 U.S.C. 292f, also provides for the recapture of a certain portion of the Federal payments if, within 10 years, (1) the applicant of the facility ceases to be a public or nonprofit installation, and (2) the facility shall cease to be used for the research purposes for which it was constructed. We feel that a similar provision should be included in title I of H.R. 3689.

Section 202(c) provides that, at the request of any State, a specified portion of its allotment under title II of the proposed bill may be added to the allotment of the State under title I of the Community Health Center Act of 1963 (H.R. 3688) if certain conditions are met. This authority could result in weakening the effectiveness of the budgetary and appropriation processes because substantial Federal grants could be used by the States in amounts that might vary considerably from the amounts that would be included in the Federal appropriation for each program. Consideration should be given to the placing of specific limitations on the amounts of allotments eligible for transfer between the two programs. Also we should like to point out that this subsection, by its reference to title I of the Community Health Center Act of 1963, which referenced "act" is presently in bill form, would be without effect in the event the referenced "act" failed of enactment. We have made similar comments in our report to your committee on S. 3688 respecting like provisions.

No provision is made in the bill nor in legislation applicable to other grant programs now authorized by the Public Health Service Act, as amended, to require a grantee to keep adequate cost records of the projects to which the Federal Government makes financial contributions, or specifically authorizing the Secretary of Health, Education, and Welfare or the Comptroller General to have access to the grantee's records for purposes of audit and examination. In view of the increase in grant programs over the last several years we feel that in order to determine whether grant funds have been expended for the purpose for which the grant was made, the grantee should be required by law to keep records which fully disclose the disposition of such funds. We also feel that the agency as well as the General Accounting Office should be permitted to have access to the grantee's records for the purpose of audit and examination. We therefore suggest that consideration be given to amending the bill to include such requirements with respect to the proposed new program, or preferably to an amendment of the Public Health Service Act to cover all grant programs therein authorized. The latter could be accomplished by the following language:

"RECORDS AND AUDIT

"(a) Each recipient of assistance under this Act shall keep such records as the Secretary of Health, Education, and Welfare shall prescribe, including records which fully disclose the amount and disposition by such recipient of the proceeds of such grants, the total cost of the project or undertaking in connection with which such funds are given or used, and the amount of that portion of the cost of the project or undertaking supplied by other sources, and such other records as will facilitate an effective audit.

"(b) The Secretary of Health, Education, and Welfare and the Comptroller General of the United States or any of their duly authorized representatives shall

have access for the purpose of audit and examination to any books, documents, papers, and records of the recipients that are pertinent to the grants received under this Act."

In administering the above provision we do not contemplate making a detailed examination of the books and records of every recipient of a grant, or even a major part of them. However, selective checks may be made to provide reasonable assurance that grant funds are being properly applied or expended.

Sincerely yours,

JOSEPH CAMPBELL,
Comptroller General of the United States.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., March 7, 1963.

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

DEAR MR. CHAIRMAN: This letter is in response to your request of February 22, 1963, for a report on H.R. 3689, a bill to assist States in combating mental retardation through construction of research centers and facilities for the mentally retarded.

This bill embodies a legislative proposal submitted by this Department to the Congress and designed to carry out the President's recommendation on the above-mentioned subject contained in his message to Congress on mental illness and mental retardation. (A copy of our letter of February 11, 1963, to the Speaker, transmitting the bill, is enclosed herewith.)

For the reasons stated in the President's message, in our letter to the Speaker, and in the report of the President's Panel on Mental Retardation, we strongly urge the enactment of this bill.

A 5-year estimate of the cost of this bill, as required by Public Law 801, 84th Congress (5 U.S.C. 642a), was transmitted to you on March 4, 1963.

Sincerely,

WILBUR J. COHEN,
Assistant Secretary.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, February 11, 1963.

Hon. JOHN W. MCCORMACK,
Speaker of the House of Representatives,
Washington, D.C.

DEAR MR. SPEAKER: I am enclosing for your consideration a draft of a bill to assist the States in combating mental retardation through construction of research centers and facilities for the mentally retarded.

The bill carries out the President's recommendations on these subjects contained in his message to the Congress on mental illness and mental retardation. It is also specifically responsive to proposals contained in the report of the President's Panel on Mental Retardation.

The draft bill would provide authority for two new grant programs. Title I would authorize grants by the Surgeon General for the construction of centers for research on mental retardation and related aspects of human development. Title II would authorize grants by the Secretary of Health, Education, and Welfare for construction of facilities for the care and treatment of the mentally retarded.

TITLE I—GRANTS FOR CONSTRUCTION OF CENTERS FOR RESEARCH ON MENTAL RETARDATION AND RELATED ASPECTS OF HUMAN DEVELOPMENT

The draft bill would add a new part B to the health research facilities title (title VII) of the Public Health Service Act. It would establish a 5-year program of grants to public or other nonprofit institutions to assist in the construction of centers for research on mental retardation and related aspects of human development. Appropriations of $6 million would be authorized for the fiscal year ending June 30, 1964; $8 million for the fiscal year ending June 30, 1965; $6 million each for the fiscal years ending June 30, 1966, and June 30, 1967; and $4 million for the fiscal year ending June 30, 1968.

Up to 75 percent Federal matching would be available for costs of construction of facilities for research, or research and related purposes, relating to human development, whether biological, medical, social or behavioral, which may assist in finding the causes, and means of prevention of mental retardation, or in finding means of ameliorating the effects of mental retardation. Provision is made for the development of program policies by the Surgeon General with the assistance of appropriate national advisory councils.

This program is designed to meet the needs identified by the President's Panel on Mental Retardation for an intensive, integrated research effort into problems of mental retardation and related aspects of human development, through the creation of a coordinated series of selected centers engaged in broadly based multidisciplinary programs. The development of an intensive, programed research effort is an essential step in providing increasingly effective treatment of the mentally retarded and in the eventual prevention of mental retardation.

TITLE II—GRANTS FOR CONSTRUCTION OF FACILITIES FOR THE MENTALLY RETARDED

Title II of the draft bill would authorize the Secretary of Health, Education, and Welfare to make project grants for the construction of public and other nonprofit facilities specially designed for the diagnosis, treatment, education, training, or custodial care of the mentally retarded, including facilities for training specialists.

Appropriations of such sums as Congress may determine would be authorized during the period July 1, 1964, through June 30, 1969. Five million dollars of the sums appropriated for the fiscal year ending June 30, 1965, and $10 million of the sums appropriated for each of the next 4 fiscal years would be available only for facilities associated with college or university hospitals or other appropriate parts of a college or university. The funds appropriated would be allotted among the States on the basis of population, extent of need for facilities for the mentally retarded, and the financial need of the States, with a minimum of $100,000 for any State. States would be given the alternative of varying the Federal share of the cost of construction of projects, on the basis of standards set by the State, between 45 percent and 75 percent or of choosing a uniform Federal share—which would not be less than 45 percent and could go as high as 75 percent for some States—for all projects in the State.

Applications would be submitted to the Secretary after approval by the State agency designated by the State to administer the State plan.

A State advisory council, composed of representatives of State agencies concerned with planning, operation, or utilization of facilities for the mentally retarded and of non-Government organizations or groups concerned with education, employment, rehabilitation, welfare, and health, as well as representatives of consumers of the services involved, would consult with the State agency in carrying out the State plan. The plan would have to set forth a construction program based on a survey of need for facilities and provide for construction in accordance with relative need for facilities insofar as permitted by available financial resources. The plan would also have to meet several other requirements set forth in the bill, including provision for methods of administration necessary for proper and efficient operation of the plan, hearings for unsuccessful applicants, and standards of maintenance and operation of facilities constructed.

Priority of projects to be approved under the State plan would be based on relative need of the different areas in the State, with special consideration for those facilities which will provide comprehensive services for a particular community or communities.

Facilities for the care of the mentally retarded are not only in short supply but many are seriously inadequate and of an improvised nature. No other segment of our handicapped population is subjected to care, treatment and custody in facilities which are so obsolete from the functional and structural point of view. Moreover, the segmentalized approach to care of the mentally retarded, in which essential services must be obtained from separate and scattered institutions, frequently means that essential services are, in fact, not available. The President's Panel on Mental Retardation made a thorough study of this problem. The provisions of this title of the draft will carry out the recommendations made in its report.

I shall appreciate it if you would refer the enclosed draft bill to the appropriate committee for consideration.

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

Sincerely,

ANTHONY J. CELEBREZZE, *Secretary.*

COMPTROLLER GENERAL OF THE UNITED STATES,
Washington, March 4, 1963.

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

DEAR MR. CHAIRMAN: Your letter of February 15, 1963, forwarded for our report and comments H.R. 2567.

This bill which bears the short title of "Mental Health Act of 1962" would add a new title VIII to the Public Health Service Act. The bill is divided into two parts. Part A provides appropriate authorizations for grants by the Surgeon General to the States for research, training, and salaries to assist in the care, treatment, and rehabilitation of the mentally ill and mentally deficient. Part B authorizes appropriations for grants by the Surgeon General to the States for purposes of survey and construction of facilities for the treatment of the mentally ill and mentally deficient. The provisions of both parts of the bill follow generally the format of other grant programs contained in the Public Health Service Act, 42 U.S.C. 201, et seq.

This Office has no special information concerning the subject matter of the proposed legislation and therefore we have no recommendations to make on the merits of the bill.

In our review of this proposed legislation however, we observed certain matters which we feel should be brought to the attention of the Committee. We note for your consideration other laws under the Public Health Service Act which provide similar authority with respect to grants under mental health programs. The Alaska Mental Health Enabling Act adding sections 371 and 372 to the Public Health Service Act, appearing in 42 U.S.C. 273 and 274, embraces similar benefits to those contained in the proposed legislation for the former Territory of Alaska. In view of the conflict, these provisions under the Alaska Act appear to be for repeal upon enactment of H.R. 2567. Also the Hospital Survey and Construction Act of 1946 adding title VI to the Public Health Service Act, appearing in 42 U.S.C. 291 et seq., provides grant authority for surveys and construction of hospitals generally. The term "hospital" under this law is defined as including mental institutions. See 42 U.S.C. 291i(e). Since the same coverage is provided under part B of H.R. 2567 as to mental hospitals, you may want to delete the word "mental" appearing in the definition of the term "hospital" in section 631(e) of the Public Health Service Act, as amended, 42 U.S.C. 291i(e), or otherwise distinguish the two programs.

We note also that the bill contains no provision requiring the recipient of the grants to keep records of expenditures or to authorize the Surgeon General or the Comptroller General to have access to the recipient's records for purposes of audit or examination. We believe that in grant programs the Congress and the department or agency concerned should be interested in determining that the funds granted are being used and applied for the purpose intended. Any program requiring voluntary disclosures by the recipients of the grants or a State for the purpose of determining that the funds granted are being applied for the purpose intended falls short in the fulfillment of this purpose. We therefore suggest that a provision similar to the following be added to the bill:

"(a) Each recipient of assistance under this title shall keep such records as the Surgeon General shall prescribe, including records which fully disclose the amount and disposition by such recipient of the proceeds of such grants, the total cost of the project or undertaking in connection with which such funds are given or used, and the amount of that portion of the cost of the project or undertaking supplied by other sources, and such other records as will facilitate an effective audit.

"(b) The Secretary of Health, Education, and Welfare and the Comptroller General of the United States or any of their duly authorized representatives shall have access for the purpose of audit and examination to any books, documents, papers, and records of the recipients that are pertinent to the grants received under this title."

In administering the above provision we do not contemplate making a detailed examination of the books and records of every recipient of a grant. However, selective checks may be made to provide reasonable assurance that grant funds are being properly applied or expended.

Sincerely yours,

JOSEPH CAMPBELL,
Comptroller General of the United States.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, March 27, 1963.

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

DEAR MR. CHAIRMAN: This letter is in response to your request of February 15, 1963, for a report on H.R. 2567, a bill to amend the Public Health Service Act in order to provide a broadened program in the field of mental health and illness of grants for prevention, research, training, salaries, facilities survey, and construction of facilities for treatment of the mentally ill and mentally retarded.

The bill would amend the Public Health Service Act by adding a new title—title VIII—and repealing sections 303 and 304 of that act. The new title would include two parts: Part A—Grants for Research, Training, and Salaries; and Part B—Survey and Construction of Facilities for the Treatment of the Mentally Ill and Mentally Deficient.

Under part A, the Surgeon General would be authorized to make grants to States, with appropriations authorized for each year beginning July 1, 1963, as follows:

(1) One hundred million dollars for investigations, experiments, demonstrations, studies, and research projects for the development of improved methods of preventing mental illness and mental retardation, and relating to the care, treatment, and rehabilitation of the mentally ill and the mentally retarded.

(2) One hundred million dollars to assist in the training of personnel at schools, colleges, and other institutions of learning; at institutions for the mentally ill or mentally retarded; or in community mental health programs.

(3) Two hundred million dollars for paying or supplementing the salaries of teachers, trainees, professional personnel, and others working with the mentally ill, mentally retarded, or in community mental health programs.

Under part B, the Surgeon Genetral would be authorized to make grants in aid to the States for surveys and construction of facilities for the treatment of the mentally ill and mentally deficient, with appropriations as follows:

(1) Two million dollars for construction surveys, to remain available until expended.

(2) One hundred million dollars annually, beginning July 1, 1963, for construction of facilities for the treatment of the mentally ill and mentally deficient, including rehabilitation facilities.

Mental illness and mental retardation are among the Nation's most critical health problems. In his special message on mental illness and mental retardation, February 5 ,1963, President Kennedy proposed two national programs, one for mental health, the other to combat mental retardation. The President emphasized three major objectives for these programs: Seeking out the causes of mental illness and of mental retardation and eradicating them; strengthening the underlying resources of knowledge and especially of skilled manpower which are necessary to mount and sustain an attack on mental disability; and strengthening and improving the programs and facilities serving the mentally ill and mentally retarded. To implement these programs the President recommended intensified activity under various on-going programs and the enactment of legislative authority for new programs. Administration bills designed to implement these recommendations have been introduced as H.R. 3688 providing for construction and staffing of comprehensive community mental health centers; H.R. 3689 for combating mental retardation through the construction of research centers and of facilities for the care, treatment, and rehabilitation of the mentally retarded; and H.R. 3386 which would amend the Social Security Act to provide for planning for comprehensive action to combat mental retardation, and for an expansion and improvement of the maternal and child health and crippled children's programs aimed at the prevention of mental retardation.

Although we are in full accord with the objectives of H.R. 2567 which closely parallel the objectives emphasized by the President in his message, we feel that the programs proposed by the administration represent the most desirable approach to the achievement of these objectives, and we therefore urge enactment of the administration bills in lieu of H.R. 2567.

We are advised by the Bureau of the Budget that there is no objection to the presentation of this report from the standpoint of the administration's program.

Sincerely,

ANTHONY J. CELEBREZZE, *Secretary.*

Mr. ROBERTS. I will also place in the record before the close of the hearing today certain communications from Governors of States and other public officials in connection with this important subject.

Mr. Pepper.

STATEMENT OF HON. CLAUDE PEPPER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. PEPPER. Thank you very much.

Mr. Chairman and members of the committee, I am very grateful for the privilege of appearing before your honorable committee in support of the bills which I have introduced which in turn are the bills introduced by the distinguished chairman of this committee. All of our bills have the full endorsement of the present administration.

H.R. 4663 would authorize grants-in-aid to public and nonprofit institutions for the construction of centers for research in mental retardation and related aspects of human development, to assist in means of finding causes thereof and the means of prevention or means of ameliorating its effects. The bill would authorize $8 million for each of the fiscal years 1964–66 and $4 million for 1967 and for 1968 for this purpose. The Surgeon General of the U.S. Public Health Service would administer the program and approve or disapprove applications for grants which could not exceed 75 percent of the necessary cost of construction.

H.R. 4663 would also authorize grants to public and nonprofit institutions for the construction of facilities for the care and treatment of the mentally retarded, including facilities connected with college and university hospitals or other appropriate parts of colleges or universities under State plans approved by the Surgeon General upon the basis of population, the extent of the need for the facilities and the financial needs of the respective States. Under the bill, $5 million would be appropriated for this purpose for the fiscal year ending June 30, 1965, and $10 million for each of the next 4 years.

Title I of H.R. 4664 would authorize the Secretary of Health, Education, and Welfare to make allotments to States on the basis of approved plans for the construction of public and other nonprofit community mental health centers on the basis of appropriations determined by Congress beginning with the year ending June 30, 1965. The primary factors which the Secretary would take into account are population, the extent of the need for such centers in each State, and the financial needs of the respective States.

Title II of the bill would authorize the Secretary to make grants to public or nonprofit institutions to which a grant was made under title I to meet the cost of the initial staffing of community mental

health centers on the basis of appropriations determined by Congress. Any such grant may not exceed 75 percent of the staffing cost during the first 15 months, 60 percent for the next year, and 45 and 30 percent, respectively, for the next 2 years.

Mr. Chairman and members of the committee, Congress recognized this problem during World War II. During the war I was chairman of the Subcommittee on Wartime Health and Education of the Senate Committee on Education and Labor, which made a study of the problems and needs with respect to mental illness and mental ill health in the United States. That subcommittee held a number of hearings on the health needs of our veterans and our civilian population.

In January 1945 the subcommittee issued its interim report No. 3 in which the staggering extent of mental illness was first disclosed. For example, the report pointed out that of 4,212,000 young men 18 to 37 years of age who were rejected for military duty by the Selective Service as of June 1, 1944, 1,282,000 or over 25 percent of the total rejected were for mental diseases and deficiencies. The report stated:

> It has long been known that approximately two-thirds of the illness encountered in general medical practice is essentially neuropsychiatric in origin and that half of the patients in hospitals at any one time are there because of serious mental disorders. Indeed, one may safely predict that in any group of 15-year-olds 1 out of 22 will someday be committed to a mental institution.

Our subcommittee recommended the establishment of community psychiatric clinics, hospitals in planned medical centers, and for the training and education of professional personnel. The subcommittee said:

> From a longer range point of view, the establishment of child-guidance clinics in all communities is urgently needed to prevent early social maladjustments.

You may recall, Mr. Chairman, that in 1946 the chairman of your full committee then, the late Honorable Percy Priest, Representative from Tennessee, sponsored H.R. 4512, and I sponsored in the Senate S. 1160. These two bills were merged into Public Law 487 of the 79th Congress which authorized the establishment of the National Institute of Mental Health at Bethesda, a broad national program of research into the causes and prevention of mental ill health, training of personnel in the treatment of psychiatric disorders with some experimental research in community mental health centers.

This act gave the impetus to Congress for a rapid growth in the appropriations for a national mental health program. This growth is reflected in the following figures of Federal funds provided in 1946, 1950, and 1963. Funds for this activity were $66,000 in 1946; $10,019,000 in 1950, and $143,599,000 in 1963.

In 1949 Florida had only one State mental health hospital at Chattahoochee. It was 540 miles from Miami. It had at that time only 3,000 beds and 6,000 patients. Many patients from south Florida had to spend their time in Tampa jails during their travel to the hospital at Chattahoochee.

May I interpolate, Mr. Chairman, I was chairman of the Veterans' Committee in the Senate for a number of years. I recall on one occasion I sent telegrams to the sheriffs of Florida and my recollection is that I got replies that 25 veterans in Florida were in the jails of our State because there were not any adequate mental institution for

them to go to. I think we still have very deficient facilities in our veteran setup in Florida. We did not have any provision to take care of psychiatric cases with our veterans. The nearest to our State was in Augusta, Ga. So this pertains not only to the civilian population but there are very many great needs also in the veterans field.

In the Miami area there was only one nonpublic institution. It had no psychiatrist and no neurologist.

At the present time there are in addition to the State mental hospital at Chattahoochee, the South Florida Mental Hospital in West Hollywood just outside of Dade County, the Northeast State Hospital and the George Pierce Wood Memorial Hospital.

Dade County now has facilities at the Jackson Memorial Hospital, the above-mentioned South Florida State Mental Hospital, a new day-care center at the veterans facility at Coral Gables, a mental health department within the Dade County Health Department, and the Dade County Child Guidance Clinic.

But the record clearly shows that these facilities in Florida are wholly inadequate to meet the pressing needs in the field of mental health. The Florida Association for Mental Health pointed out in December 1962:

> At Chattahoochee many patients are housed in substandard, unsafe, old buildings. It would be preferable to eliminate the need for these buildings rather than to replace them.

The association recommended that facilities be provided for mentally retarded patients and special facilities for older nonpsychotic offenders.

The South Florida Mental Hospital at West Hollywood in December 1962 had about 430 geriatric patients, one-third of the total. Of the 430, about one-half are not really mentally ill, although they do suffer from mental lapses which are concomitant with old age. In addition, 70 percent of those on the hospital's waiting list are in this category.

You may recall, Mr. Chairman, that in the mental health appropriation for the fiscal year ending June 30, 1963, made by Congress, $4,200,000 was included to assist the States in developing broad State mental health care programs. The State of Florida has taken advantage of this appropriation by making use of a Federal grant thereunder for the development of a comprehensive program of mental health care in Florida.

Moreover, the American Psychiatric Association with the assistance of the State and local mental health groups made a survey and held hearings in Miami on July 25–27, 1962, in Miami and other hearings in Pensacola, Tallahassee, Jacksonville, Orlando, and Tampa. This survey, summarized in the October 1962 monthly bulletin of the Mental Health Society of Greater Miami, expressed the need as follows:

> Facilities and services for the mentally ill and seriously disturbed children—more and better services for the patient coming out of the mental hospitals, low-cost clinics, psychiatric services in general hospitals, day and night hospitals, more and better facilities for the senior citizen, psychiatric services in the courts, jails and stockades and probation services, better legal definitions of sane and insane, more appropriations for training and research.

It also recommended that the seven different State units which now deal with mental illness should be combined into one State department

of mental health, regional treatment centers for children, and community mental health centers. Similar recommendations have been made by the Florida Association for Mental Health.

Mr. Chairman, Florida, and particularly south Florida, lacks the proper facilities for the proper care of the mentally ill and the mentally retarded. Federal facilities for all practical purposes do not exist in Florida. Almost all of the seriously mental sick veterans must be sent to the veterans' hospitals at Augusta and Atlanta, Ga., and at Gulfport, Miss. These hospitals have long waiting lists.

Incidentally, if I may interpolate again, a little while ago in Miami we had a case of a psychiatric patient who threatened to kill the police. He called up my secretary and demanded that she get him into the veterans' hospital and threatened to do her bodily injury if she didn't do it. Finally the police had to lock him up and keep him for several days until they could make arrangements to send him up to Augusta, Ga., because there was not any room, even for that dangerous patient, in the veterans' hospital at Coral Gables. That is significant of the shortage there is even in the field of the veterans.

In the 2-year period 1959–61 the following data shows that Florida expended less than 2 percent of the total State expenditures for the care and treatment of mentally ill persons. In the United States the comparable figure was about 3 percent. The table at the end of my testimony with respect to all Florida State mental health hospitals and the South Florida Hospital clearly shows the inadequacy of mental health facilities in Florida.

The State of Florida and all the communities therein now spend per capita respectively $2.60 and 21 cents in 1960 in comparison with $5.19 and 36 cents for the United States.

Mr. Chairman, I need not relate the details or the data published by the Joint Information Services of the American Psychiatric Association and the National Association of Mental Health in its 1962 edition of 15 indices of mental health. These data show clearly the great need for expanded community health centers, for the staffing of these centers with highly trained professional personnel, and for the construction and servicing of facilities for the mentally retarded. Florida in these respects is highly deficient.

It is my belief that the quicker Congress passes the legislation now before your subcommittee, the faster the comprehensive mental health programs will be able to get underway. Dade County, which is my own county, needs it; Florida requires it; the national health and safety and defense demand it. We must move forward to conquer the great emergency created by existing mental ill health and the lack of facilities for treatment and prevention.

I urge you strongly to report these bills out favorably at the earliest possible convenience and pleasure of your honorable committee.

I would like to leave as a part of my statement, Mr. Chairman, a little table where I have some data about the number of patients and the amount with relation to my State in this field.

Mr. ROBERTS. Without objection, that will be included as part of your statement.

(The table referred to follows:)

Data on Florida and south Florida State mental hospitals

	1959–61 budget	Number of patients	Patient-days	Cost per diem
Florida	$28,923,198	9,466	6,919,039	$4.18
South Florida	5,209,700	1,018	743,581	7.01
	Estimated 1961–63 budget	Estimated number of patients	Estimated days	Estimated cost per diem
Florida	$38,630,483	10,166	7,420,815	$5.21
South Florida	7,158,206	1,423	1,038,790	6.89

Mr. ROBERTS. Has the gentleman concluded?

Mr. PEPPER. Yes, sir.

Mr. ROBERTS. Thank you for your statement. We appreciate your appearance very much.

I have no questions.

Mr. Rogers from Florida.

Mr. ROGERS of Florida. Mr. Chairman, I am pleased to see my colleague from Florida here. We are very pleased to have your feelings on this bill which will be very helpful to the committee.

Mr. PEPPER. Thank you. It is one of the needs of our State, Mr. Chairman, and all those who are interested in this subject are doing a great service to the country to meet this challenge.

I am glad to see my distinguished colleague here on this committee. Thank you very much for your kindness.

Mr. ROBERTS. The distinguished gentleman from Arkansas, the chairman of the full committee.

Mr. PEPPER. I am certainly glad to see the lead taken in this field by your distinguished chairman. I want to support him in any way I can.

Mr. HARRIS. Thank you, Mr. Chairman.

I want to express my thanks to our colleague from Florida for his interest and for taking time from his busy schedule to come to this committee. We have known of course that his interest as exemplified in his statement here today has of course existed over a long period of years. We recognize the importance of this legislation.

I introduced the legislation the gentleman referred to at the request of the President, after HEW submitted it here. It of course comes down as the administration measure. As chairman of the committee, it is my hope that with the valuable assistance and information from the gentleman from Florida and other colleagues in the House who are interested in the program, we will be able to work out a satisfactory program to meet the needs in this field.

Mr. PEPPER. Thank you very much, Mr. Chairman.

Mr. ROBERTS. The gentleman from Colorado.

Mr. BROTZMAN. Thank you, Mr. Chairman.

Mr. Pepper, I have a question or two. Do I understand your testimony is on behalf of a bill that is exactly like H.R. 3688? Is that correct?

Mr. PEPPER. That is correct. I introduced the same bills that the distinguished chairman has introduced to show my interest in and

my long connection with this subject and my desire to help in any way I could to progress this legislation.

Mr. BROTZMAN. Now I understand you to say that Florida was spending less than 2 percent of her State budget, is that correct?

Mr. PEPPER. That is right.

Mr. BROTZMAN. Do you happen to know what this would be in dollars and cents that the State of Florida has spent in the last year for the mental health needs of the people in the State?

Mr. PEPPER. I think Florida spent in 1961–63 the figure of $38,630,483 for the biennium.

Mr. BROTZMAN. That was in the last biennium, is that right?

Mr. PEPPER. That took care of 10,166 patients. That was for the State.

Mr. BROTZMAN. Now generally speaking, what type of a mental health law have you in the State of Florida?

Mr. PEPPER. Well, we have legislation which simply provides the State institutions to which mental patients may be sent when they are adjudicated to be mentally incapable or of such mental disorder as should require that kind of attention. Then there is a type where under our law you may go sort of voluntarily without being adjudicated, providing a doctor, of course, certifies that it is desirable for you to do so. So there are two ways you may enter, one is the voluntary process an the other is an adjudication by the county judge.

We have several of these institutions around over the State. As I have said, up until a few years ago we only had one over in west Florida, a place named Chattahoochee. I think it is in Mr. Fuqua's district. It was in Mr. Sikes' district. Now we have several others around over the State. There are a good many more in south Florida but as I say the facilities we have are not nearly adequate to meet the problems. All of them are vastly overcrowded.

I have known personally of many instances of patients who could not be admitted to any of our institutions because they did not have the beds or the room for them. These institutions do not have the money to provide the staffing that they should have. While our average is lower than the national average, I think our State is making a relatively comparable effort, but I think that this problem is so vast and so immense that it is just not being adequately met and we need Federal help.

Mr. BROTZMAN. I think you testified that the county judge is the determiner of whether or not a person has to be committed to an institution.

Mr. PEPPER. That is right.

Mr. BROTZMAN. Or they can go voluntarily if they choose.

Mr. PEPPER. That is right.

Mr. BROTZMAN. Now this 2-percent figure in the State of Florida, does this include expenditures for capital improvements as well as for professional care to care and maintain these people?

Mr. PEPPER. No, I think that figure relates only to operating expenses. I do not believe that includes the capital outlay, the buildings.

Mr. BROTZMAN. How long has it been in Florida since you have built more of these types of institutions: that is, the regular brick and mortar construction to provide more facilities?

Mr. PEPPER. We built several. Perhaps Mr. Rogers might remember when the one was built in West Hollywood. We built several in the past few years. The one in West Hollywood, I suppose within the last 5 years maybe, probably within the last 5 years, it is in Broward County, in Mr. Rogers' district.

We have been adding to our facilities in the last several years but we still do not have anything like enough. Our Governor has proposed to recommend some additional facilities to the legislature which is going to meet in a few days but my opinion is that we are not nearly adequately meeting the challenge of this problem in our State. We do not intend to be neglectful of these people who are certainly deserving of our concern, but this is just another instance of where I think the Federal Government can supplement what is being done in the States and should approach the problem on an overall basis for the country. They should help the States and encourage the States to do more.

Mr. BROTZMAN. Do you think there is going to be a program in the Florida Legislature under the leadership of the Governor in this area?

Mr. PEPPER. I do not know what the Governor's recommendations will be but I am sure that he will have to make some recommendations that will provide more facilities because the patient load is increasing all the time. Our population is increasing. We now have almost 5½ million population. Of course it is just like other facilities, you have to provide more as you have more demands. But whatever the Governor recommends, I am sure that it is not adequately going to meet the challenge of this problem.

Mr. BROTZMAN. You do not know exactly what he is going to recommend, do you?

Mr. PEPPER. I know he is not going to recommend enough. I just know that as a matter of commonsense because the problem is so large, that it takes so much money, and there are so many demands for money I am just morally certain that the Governor is not going to recommend that the legislature appropriate enough money to meet the problem adequately because it would cost more than the legislature feels that it could appropriate, I imagine; more than the Governor feels he can recommend, also.

Mr. BROTZMAN. This is just your feeling though, you have not talked to the Governor?

Mr. PEPPER. No, I have not, but I would venture to say that in his recommendation the Governor would say that this has not anything like met the problem but at least we should make this much progress. That is what he will say, I believe.

Mr. BROTZMAN. Do you think there is any danger that the enactment of such a bill as this would curb the incentive on the part of the people of Florida to solve this problem?

Mr. PEPPER. One the contrary, it would encourage them and tend to push them a little bit to do more than is being done. Like a lot of the other Federal aid programs, it is a stimulus to the States to meet problems that they are not adequately meeting, many of the Federal programs are. We have a Veterans' Committee in the House and I can assure you that this problem is nothing like adequately being met by the Veterans' Administration.

Mr. BROTZMAN. The simple fact is though the money is going to come from the same place?

Mr. PEPPER. I beg your pardon?

Mr. BROTZMAN. The money for this program here or the one in Florida is basically going to come from the same place, and that is part of it is going to come from the people of Florida.

Mr. PEPPER. Well, that is true, there is no doubt about that. You know, it has been my observation over the years that I have been associated with Washington that the Federal Government as a general rule has held up higher standards than are to be found in many, if not in most, of the States. The Federal Government has taken the lead in so many fields, not because it was looking for new territory to invade but because there were problems that were not being adequately met. After all, these are people that are citizens of the United States; citizens of the States in which they live, and also citizens of the United States. They are our people as well as State people that we are talking about.

The Federal Government in so many fields has willingly taken the lead and set high standards and furnished credible examples to the States and at the same time provided funds that the States were not able to provide. Furthermore, in my State, and I am not going to say whether it should or should not be that way, we found it desirable to have it that way, but practically all of the revenue for our State government comes from excise taxes. We do not have a State inheritance tax and we do not have a State income tax, so we do not have anything like as broad a base of taxation as the Federal Government has.

Our ability to raise funds according to our present constitutional structure is nothing like as great as the ability of the Federal Government with a larger tax base that it can rest its appropriations upon. It may well be that we are one of those States that is not particularly geared, as it were, to meet all of the problems that we have, with the burden falling rather unduly on the masses of the people.

Mr. BROTZMAN. The method of taxation in the State of Florida has been determined in Florida, is that not right?

Mr. PEPPER. That is correct.

Mr. BROTZMAN. That is a system that has been picked by the leaders there.

Mr. PEPPER. It may be a matter that many people would not agree with, but it is not going to do these poor mental patients any good to argue about the constitutional deficiencies relating to the tax structure of the State of Florida. They are there, they are suffering. They appeal to our conscience and are the subject of our concern. We are talking about practical ways to help them. The Federal Government can help, and I feel it proper that it should render a greater service to these people than it is now rendering.

Mr. BROTZMAN. I wondered how practical the approach was in the State of Florida to the problem. You mentioned something was being done and I wondered really what you were trying to do to solve the problem there.

Mr. PEPPER. As I said, we are not far away from the national average and the amount that we are contributing is constantly increasing. I do not claim in any sense of the word that we have done all that we should have done; we have not. I think we will do more in the future, and this legislation will encourage us to do still more.

Mr. BROTZMAN. Thank you.

Mr. ROBERTS. Our next witness is the Secretary of Health, Education, and Welfare.

We are very happy to have you today. I believe this is the first time that you have honored our subcommittee with your appearance. You have been before the full committee. We are very happy to have you and have you introduce the gentlemen who are accompanying you, Mr. Secretary, for the record.

STATEMENT OF HON. ANTHONY J. CELEBREZZE, SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY WILBUR J. COHEN, ASSISTANT SECRETARY; BOISFEUILLET JONES, SPECIAL ASSISTANT FOR HEALTH AND MEDICAL AFFAIRS; DR. LUTHER L. TERRY, SURGEON GENERAL, THE PUBLIC HEALTH SERVICE; AND DR. JACK C. HALDEMAN, CHIEF, DIVISION OF HOSPITAL SERVICES, PUBLIC HEALTH SERVICE

Secretary CELEBREZZE. Mr. Chairman and distinguished members of the committee, I have with me Mr. Wilbur J. Cohen, Assistant Secretary, Mr. Boisfeuillet Jones, Special Assistant for Health and Medical Affairs, Dr. Luther L. Terry, Surgeon General of the Public Health Service.

Mr. Chairman, the legislative proposals under consideration by your committee today—H.R. 3688, H.R. 3989, and other similar bills—are directed toward two related and long-neglected health problems; mental illness and mental retardation. The urgency of these problems, and the essential actions required to meet them, were set forth in the President's special message on February 5 of this year.

Nearly a million and a half people receive treatment every year in institutions for the mentally ill and mentally retarded. On any given day the total number of patients in these institutions is about 800,000—including nearly 600,000 mental patients and over 200,000 who are mentally retarded. But these institutional figures do not represent the total number of persons afflicted. Among the mentally retarded, for example, those confined to institutions represent only 4 percent of the 5 to 6 million retarded persons in this country. The others, the remaining 96 percent, are cared for at home.

The cost of caring for these afflicted persons is huge. The expenditure from tax funds alone, apart from private and voluntary expenditures, is approximately $2.4 billion a year for direct outlays. Of this total nearly $2 billion is for mental illness, and over a half a billion dollars is for mental retardation. In addition to their direct outlays for care, the States and localities spend approximately $250 million annually for special education, welfare, rehabilitation, and other services for retarded persons outside of public institutions.

For the most part, however, these huge annual outlays provide only minimal care in grossly inadequate facilities. Three-fourths of the State mental institutions were opened prior to World War I. Many are fire and health hazards. Almost all are understaffed. The average expenditure per patient in State institutions is only $4 a day, and in some States the average is less than $2 a day.

In brief, the facts regarding mental illness and mental retardation reveal national health problems of tragic proportions compounded by years of neglect. In the President's words:

> This neglect must end if our Nation is to live up to its own standards of compassion and dignity and achieve the maximum use of its manpower.

To meet these problems the President outlined two interrelated programs—a national program for mental health and a national program to combat mental retardation. The legislative proposals under consideration today cover several component parts of these national programs.

I will direct my comments today to two specific bills: H.R. 3688—the Community Mental Health Centers Act of 1963 and H.R. 3689—the Mental Retardation Facilities Construction Act of 1963.

These comments also will apply to the provisions of the several identical or related bills that are under consideration by your committee.

The principal purpose of this statement will be to outline the main provisions and the purposes of H.R. 3688 and H.R. 3689 and to indicate their role in the broader programs recommended by the President.

Attached to this statement are more detailed summaries of both bills. While the program objectives of the bills include some new concepts and approaches, the legislative and administrative devices employed are not new in any essential respect. Rather, they employ or adapt concepts and procedures that have proved effective in other Federal grant-in-aid programs.

THE COMMUNITY MENTAL HEALTH CENTERS ACT OF 1963

The key provisions of H.R. 3688 can be very simply and briefly summarized.

First, title I of the bill would authorize a new 5-year program of Federal grants—on terms similar to those employed in existing health facility grant programs—to assist in the construction of facilities needed for the development of comprehensive community mental health programs. Second, this construction grant program would be supplemented by the provisions of title II, authorizing a temporary program of project grants to assist communities in meeting the initial staffing costs for comprehensive centers built with Federal construction grant assistance.

Simple as these two provisions may first appear, they reflect a dramatic advance in our capacity to cope with mental illness, a revolutionary change in approach and emphasis in mental health programs, and a major modification in traditional patterns of meeting the costs of mental illness.

In addition, I might add, these proposals are the outgrowth of an exceptionally thorough and competent study of our national mental health needs, resources, and opportunities. I am referring, of course, to the work of the Joint Commission on Mental Illness and Health, which was initiated pursuant to the provisons of the Mental Health Study Act of 1955.

The care of the mentally ill has been traditionally centered in large State mental hospitals. Until verey recently most of these institutions offered little hope of recovery for their patients. They were pri-

marily institutions for quarantining the mentally ill, not for treating them.

Even today, although advances in medical knowledge have provided new means for treating and curing mental illness, the large State mental hospital is still the focus of most public programs for treating mental illness. While new therapies have considerably improved the prospects for cure and rehabilitation for many patients, and further improvements can be expected, it is clear that huge custodial institutions are not suitable for the treatment of mental illness.

Given what is now known about the treatment of mental illness, the magnitude of the problem, the human, economic, and social loss to the Nation resulting from millions of mentally disabled persons, we cannot continue to support mental health activities in the traditional manner. Rather, if we are to plan for the mental health needs of the Nation, we must embark upon a bold and imaginative new program.

Therefore, the national program for mental health is centered on a wholly new emphasis and approach—care and treatment of most mentally ill persons in their own home communities. Recognizing that our State hospitals will still have a major role to play during a period of transition, however, the program also makes provision—under existing authority—for limited project grants to develop and establish improved programs in existing State institutions.

This major shift in our approach to the treatment of mental illness cannot be effected unless we develop throughout the country a network of adequately staffed community facilities providing a series of preventive, diagnostic, therapeutic and restorative services.

This is what is meant by the "comprehensive community mental health center," a relatively new concept, which offers exciting possibilities for upgrading mental health services. Such a center would be more broadly based than either the traditional outpatient clinic or the usual State institution, combining the best elements of both, and adding others.

We believe these centers should provide the focus for most future mental health services. Close to the patient's home, they would provide preventive and diagnostic services, outpatient and inpatient treatment, and transitional and rehabilitation services. Thus they could offer patients a continuity of care not readily available anywhere at present. As his needs change, the patient in such a center could move quickly from diagnosis to treatment, from inpatient to outpatient status, from sheltered workshop to industry.

To do what obviously must be done in replacing our obsolescent mental health facilities, three basic requirements must be met.

First, we must embark on a substantial and sustained construction program.

Second, we must increase our limited supply of trained personnel to staff these new centers.

Third, we must not only obtain the additional funds required to build these centers, but also develop new sources and methods for financing the costs of community-based mental health services.

To help communities meet the first of these requirements, title I of H.R. 3688 would authorize a categorical program of Federal matching grants patterned after familiar construction grant programs.

Under existing statutory authority for the support of mental health training programs, the administration's program proposes a substan-

tial increase in such Federal assistance to assure that our manpower supply will be expanded to meet the additional needs of community programs.

The third requirement—that of finding new sources of revenue for the construction and operation of community mental health centers—cannot be met through established programs and practices alone.

In part, these community financing requirements can and should be met by redirection of funds from existing sources. Since the development of effective community-based programs will predictably reduce the utilization, and hence the costs, of State operated mental hospitals, it is reasonable to expect the States to share in some manner in the costs of providing community services programs. Furthermore, the kinds of services provided through community centers—with their emphasis on early and intensive treatment, as opposed to long-term custodial care—will make it possible to shift a substantial share of the costs away from governmental budgets. There is no reason why many such services cannot be paid for, in whole or in part, by the patient or his family, or through private health insurance plans.

We are confident, therefore, that most communities will be able to work out sound and effective methods for assuming the costs of operating comprehensive mental health programs. We recognize, however, that during the initial period of operations—before the center and its program are well established and accepted in the community, and before estimates of operating revenues can be validated by actual experience—the uncertainties of program financing may lead many communities to delay the undertaking of new programs. In other cases, financial concerns may lead to the initiation of such limited programs as to jeopardize their value, to or acceptance by the community.

To help provide the budgetary assurance needed to support bold community action, title II of H.R. 3688 proposes short-term Federal project grants to meet part of the initial staffing costs of comprehensive community health centers. Without going into detail on this particular proposal, Mr. Chairman, I should like to underscore several key points.

First, these initial staffing grants will not be made available for all community facilities constructed with Federal aid under the provisions of title I of the bill. Rather, they will be limited to the staffing of comprehensive centers which—alone or in conjunction with affiliated facilities—will provide "at least diagnostic services, inpatient care, outpatient care, and day care for mentally ill persons."

Second, Federal aid will be based on the costs of new or additional staff only. It canont be used for the salaries of existing community mental health personnel.

Third, such Federal aid will be limited to the first 4 years of a center's operation, with progressively decreasing Federal proportions. After this initial period, the Federal Government will not participate in these staffing costs. We believe it is essential—both from the standpoint of Federal budgetary consideration, and in the interests of effecting community acceptance of the basic responsibility for the provision of needed community services—that the States and communities continue to retain this basic health responsibility.

The Federal Government must both continue and extend its present role in financing research and training in mental health. It can also

stimulate and assist States and communities in inaugurating major new construction and service improvement programs. But the dimensions and costs of the improvements required are too great to be met simply by transferring responsibilities from one set of governing bodies to another. All levels of government, as well as private individuals and groups, must share the responsibilities and costs of converting from a 19th century to a 20th century approach to this outstanding national health problem.

THE MENTAL RETARDATION FACILITIES CONSTRUCTION ACT OF 1963

The legislative approach and provisions of H.R. 3689 parallel those in H.R. 3688 in several important respects.

First, they represent two elements of a broad and diversified program. The total program to combat mental retardation calls for action on a broad front—including more research and aimed at prevention, additional research facilities, better care of mothers and children, more vocational rehabilitation of the mildly retarded, additional teachers of handicapped children, special programs for educationally deprived youth, and provision for the construction of facilities in which a variety of badly needed services can be provided.

Second, these and other proposals in the program were developed through an intensive study of needs and resources. In this case the study was conducted by a panel of outstanding physicians, scientists, educators, and other specialists appointed by the President. I understand that the Chairman of the Panel has sent copies of their report to your committee.

Mr. ROBERTS. I have received my copy and I believe the others have.

Secretary CELEBREZZE. Third, while the program proposals are new, the legislative provisions are adaptations from those employed in existing Federal health programs.

Fourth—and most important of all—their goal is to correct a long-standing national neglect of a major health problem. I have already cited some highlight facts regarding the numbers of persons afflicted and the costs of the problem in annual expenditure figures. These figures indicate the dimensions of the problem, but they cannot define its essential nature or its urgency. These can be measured only in terms of the emotional strains and of the many difficult problems—of adjustment, training, schooling and vocation—that accompany every case of mental retardation. We as a nation can no longer leave these problems to the 5 to 6 million who are afflicted and to their immediate families, with only the inadequate help now provided through Federal, State, and local funds.

The mentally retarded person is one in whom there has been a faulty development of intelligence which impairs his ability to learn and to adapt to the demand of society. The failure of intelligence to develop normally may be due to diseases or conditions—occurring before or at the time of birth, or in infancy or childhood—that damage the brain. It may also be due to factors determined by heredity that affect the development of the brain. Often it is accentuated by home or social condition which fail to provide the child with adequate stimulation or opportunities for learning.

The degree of retardation varies greatly among individuals. It can be so severe that the afflicted person must have protective care

throughout his life. But in some individuals the retardation is so limited that many tasks can be learned and a measure of independence in everyday life can be achieved.

Although the provisions of H.R. 3689 cover only two elements of the total national program, these two elements are particularly vital to the success of the program as a whole.

In terms of the ultimate objective of the program—the conquest of mental retardation as a national problem—the key element in the program is research. The need for more research is dictated by the sheer magnitude of the problem and the vast unknowns relating to its causes and prevention. While there have been isolated dramatic advances recently in our knowledge of the causes of some types of mental retardation, they only serve to underscore the remaining gaps in our knowledge. We still must admit partial or complete ignorance of the causes of mental retardation in 75 to 85 percent of the cases.

At this stage in the advancement of science, there is an urgent need for a broadly based program of research in the biological, medical, and behavioral sciences. To meet this need for new research advances, the President's Panel recommended that special priority be given to developing a limited number of highly specialized research centers in strategically located universities and in selected institutions for the retarded. As in the case in the other fields of health, much of the needed research will be conducted in nonspecialized research laboratories and facilities throughout the country. But if we are to achieve the accelerated research program which is demanded by the problem of mental retardation, we will also need key centers for the conduct of highly specialized research and related activities.

To meet this particular need, title I of H.R. 3689 would add a new part B to the health research facilities grant authority of the Public Health Service Act. This new part would authorize a 5-year program for grants to public or other nonprofit institutions to assist in the construction of special centers for research on mental retardation and related aspects of human development. Appropriations aggregating $30 million would be authorized for the 5-year period. Up to 75 percent Federal matching would be available for costs of constructing these specialized facilities. Grants would be awarded by the Surgeon General, with the assistance of appropriate national advisory councils.

The establishment of these comprehensive research centers would offer new hope for the development of effective methods of treatment and prevention of mental retardation.

While anticipating those advances we must help to provide a whole range of badly needed services for those who are now afflicted with mental retardation. Today they number from 5 to 6 million persons. By 1970, there may be as many as 1 million more. This increase is predicated on anticipated general population growth, increased infant survival rates, and the longer lifespan of handicapped persons.

The need for expanded services—and for the facilities to support these services—also stems from the fact that organized service programs for the mentally retarded are relatively new. Prior to 1950

very little attention was directed toward this problem, either by public agencies or by private groups. Until 1954 no State health department offered any specialized programs or services for retarded children or their families. During the last decade, however, a new awareness of need has developed, and many new and expanded service programs can be found in all sections of the country. Beds in residential institutions have increased by about 10 percent in the last 5 years, and a number of diagnostic and consultation clinics have been established. The number of mentally retarded enrolled in special educational classes has been doubled in the past decade.

Encouraging as this growth of services has been, its inadequacy to meet existing needs is revealed by the long waiting lists for admission to residential institutions, the number of communities with no specialized services or facilities at all, and the fact that only 25 percent of our retarded children have access to special education and training programs.

A number of other proposals included in the national program will provide some Federal stimulation and support for State and community service programs. But the growth of these programs will be dependent in large part on the availability of funds for new facility construction and for the improvement of existing buildings.

Facilities for the care of the mentally retarded are not only in short supply, but many are seriously inadequate and of an improvised nature. No other segment of our handicapped population is subjected to care, treatment, and custody in facilities which are so obsolete from the functional and structural point of view. Moreover, the present approach to care of the mentally retarded, in which services must be obtained from separate and scattered institutions, frequently means that essential services are in fact, not available. Finally, in the years to come, as further progress is made in demonstrating potentials and abilities in various groups, additional services will be needed.

In recognition of these needs, title II of H.R. 3689 would authorize a new 5-year program of Federal grants to help meet the costs of constructing public and other nonprofit facilities for the mentally retarded. Among the kinds of facilities authorized would be those especially designed for the diagnosis, treatment, education, training, or custodial care of the mentally retarded, including facilities for training specialized personnel. Special consideration would be given to facilities which will provide comprehensive services for a particular community or communities. This accords with the emphasis in the report of the President's Panel on Coordinated Services relating to the physical, mental, social and educational and vocational needs of retarded persons. Special provision is also made for earmarking some of the funds appropriated for use only in the construction of facilities associated with a college or university.

As will be noted from the summaries of the bills appended to this statement, the provisions of this title relating to allotments, State plan requirements, matching requirements, and other grant conditions and procedures closely parallel those contained in title I of H.R. 3688. As I indicated earlier, both in turn have been adapted—with some modifications—from the statutory provisions governing existing health facility construction grant programs.

CONCLUSION

This concludes my opening statement, Mr. Chairman. I recognize that this highlight review of the background, objectives, and provisions of H.R. 3688 and H.R. 3689 has omitted many details. We shall be very pleased, however, to supply any additional information or supporting materials that your committee may find useful in your consideration of the bills.

For the reasons briefly outlined in this statement, and more fully explained in the President's message, we assign the highest of priorities to these two proposals, and we urge their favorable consideration by your committee.

Thank you, Mr. Chairman.

(The summaries of the bills referred to follow:)

SUMMARY OF H.R. 3688, 88TH CONGRESS

Short title: "Community Mental Health Centers Act of 1963."

TITLE I—CONSTRUCTION OF COMMUNITY MENTAL HEALTH CENTERS

Title I would authorize the Secretary of Health, Education, and Welfare to make project grants for the construction of public and other nonprofit community mental health centers; i.e., facilities providing services for the prevention or diagnosis of mental illness, or care and treatment of mentally ill persons, or rehabilitation of persons recovering from mental illness. To be eligible, the centers must provide at least those essential elements of comprehensive mental health services which are prescribed by the Secretary in accordance with regulations, and would have to provide such services in the community. Applications would be submitted to the Secretary after approval by the State agency designated by the State to administer the State plan.

Appropriations

Appropriations of such sums as the Congress may determine would be authorized for the 5-year period from July 1, 1964, through June 30, 1969.

Allotments

The funds appropriated would be allotted among the States on the basis of population, extent of need for community mental health centers, and the financial need of the respective States, with a minimum of $100,000 for any State. Some flexibility in the allotment structure would be permitted in certain situations. First, where two or more States have a joint interest in the construction of a single mental health center, part of one State's allotment could, with the Secretary's approval, be transferred to the allotment of another State to be used for that purpose. Second, if all of a State's allotment in any year is not needed to meet the costs of pending applications for mental health centers, or if the need for facilities for the mentally retarded in the State is greater than the need for community mental health centers, the State could request the Secretary to approve the transfer of the balance of its allotment for use in financing facilities approved under title II of the Mental Retardation Facilities Construction Act of 1963 (H.R. 3689).

Federal share

A State would be given the alternative of varying—between 45 and 75 percent—the Federal share of the cost of construction of projects within that State in accordance with standards providing equitably for variations among projects or classes of projects on the basis of the economic status of areas and other relevant factors, or of choosing a uniform Federal share—which would not be less than 45 percent and could go as high as 75 percent for some States—for all projects in the State.

State advisory council

A State advisory council, composed of representatives of nongovernment organizations or groups, and of State agencies, concerned with planning, operating, or utilizing community mental health centers or other mental health facilities, as

well as representatives of consumers of the services involved, would consult with the State agency in carrying out the State plan.

State plans

The State plan would be required to set forth a program for construction of community mental health centers based on a statewide inventory of existing facilities and survey of need for facilities, and to provide for construction in the order of relative need for the facilities, insofar as permitted by available financial resources. The State plan would also have to meet several other requirements, including designating a single State agency as the sole agency to administer the plan; providing methods of administration necessary for the proper and efficient operation of the plan; providing minimum standards for the maintenance and operation of centers constructed under the title; and providing for affording applicants an opportunity for hearing before the State agency.

Federal regulations

The Secretary would be required to issue regulations within 6 months after enactment of this title, and after consultation with the Federal Hospital Council—the advisory council for the hospital and medical facilities construction (Hill-Burton) program. (The bill would provide for increasing the membership of the Federal Hospital Council from 8 to 12 members, and would require 1 member to be an authority in matters relating to mental illness.) The regulations so issued would prescribe (1) the kind of community mental health services needed to provide adequate mental health services for persons residing in a State; (2) the general manner in which the State agency shall determine priority of projects based on relative need in different areas, giving special consideration to projects on the basis of the extent to which the centers to be constructed will, alone or in conjunction with other facilities owned or operated by or affiliated or associated with the applicant, provide comprehensive mental health services for mentally ill persons in a particular community or communities, or which will be part of or closely associated with a general hospital; (3) general standards of construction and equipment of different classes of center and in different types of location; and (4) that the State plan shall provide for adequate community mental health centers for people residing in the State, and for adequate centers for serving persons unable to pay therefor.

Other requirements for project approval

Applicants would have to meet several other requirements set forth in the bill, such as providing assurances that adequate financial support will be available for construction of the project and for maintenance and operation of the center when completed, and that in the construction of the centers all laborers and mechanics will be paid not less than the prevailing wages in the locality, and overtime pay in accordance with and subject to the Contract Work Hours Standards Act.

TITLE II—INITIAL STAFFING OF COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTERS

Title II would authorize the Secretary of Health, Education, and Welfare to make grants to assist in meeting the cost of initial staffing of comprehensive community mental health centers.

Appropriations

Appropriations of such sums as may be necessary would be authorized for each fiscal year beginning after June 30, 1965.

Eligibility for grants

To be eligible for grants an applicant must be a public or other nonprofit agency which owns or operates a community mental health center which has received a construction grant under title I of this legislation. Furthermore, the program of services to be provided by the center must include, at least, the following types of service: diagnostic services, inpatient care, outpatient care, and day care. This program of services must be provided by the center—alone or in conjunction with other facilities owned or operated by, or affiliated or associated with the center—principally for persons residing in a particular community or communities in or near which the center is situated.

Duration and amounts of grants

Grants for staffing a community mental health center could be made only for the period beginning with the commencement of operation of such center

and ending 4 years and 3 months later. For the first 15 months of the center's operation, the Federal grant may not exceed 75 percent of the staffing costs of the center; for the following 3 years the Federal participation in such costs may not exceed 60, 45, and 30 percent, respectively.

Federal regulations

The Secretary would be required to consult with the National Mental Health Council in the development of regulations concerning the eligibility of centers and the terms and conditions for approving applications under this title.

SUMMARY OF H.R. 3689, 88TH CONGRESS

Short title: "Mental Retardation Facilities Construction Act of 1963."

TITLE I—GRANTS FOR CONSTRUCTION OF CENTERS FOR RESEARCH ON MENTAL RETARDATION AND RELATED ASPECTS OF HUMAN DEVELOPMENT

A 5-year grant program to assist in the construction of centers for research on mental retardation and related aspects of human development would be authorized in a new Part B to the Health Research Facilities title (title VII) of the Public Health Service Act.

Sums authorized to be appropriated each year for grants would be limited by annual ceilings for the 5-year period from July 1, 1963, to June 30, 1968, as follows: $6 million for the fiscal year ending June 30, 1964, $8 million for the fiscal year ending June 30, 1965, $6 million for the fiscal year ending June 30, 1966, $6 million for the fiscal year ending June 30, 1967, and $4 million for the fiscal year ending June 30, 1968.

In acting on applications for grants, the Surgeon General would be required to take into consideration relative effectiveness of the proposed facility in expanding the Nation's capacity for research and related purposes in the field of mental retardation and related aspects of human development, and such other factors as the Surgeon General, after consultation with the National Advisory Council concerned with the field of research involved, may prescribe by regulation to assure that the facilities severally and together will best serve the advancement of scientific knowledge in the field.

Institutions eligible to apply for grants must be public or other nonprofit institutions which the Surgeon General determines are competent to engage in the type of research for which the facility is to be constructed. The research must be that research related to human development (biological, medical, social, or behavioral) which may assist in finding the causes and means of prevention of mental retardation, or in finding means of ameliorating the effects of mental retardation.

Applicants would have to meet several other requirements set forth in the bill, such as providing reasonable assurances that the facility will be used at least 10 years for the research for which it is constructed, and assurances that in the construction of the facilities all laborers and mechanics will be paid not less than the prevailing wages in the locality, and overtime pay in accordance with and subject to the Contract Work Hours Standards Act.

The Federal share of the project could be up to 75 percent of necessary costs of construction.

TITLE II—GRANTS FOR CONSTRUCTION OF FACILITIES FOR THE MENTALLY RETARDED

Title II of the bill would authorize the Secretary of Health, Education, and Welfare to make project grants for the construction of public and other nonprofit facilities especially designed for the diagnosis, treatment, education, training, or custodial care of the mentally retarded, including sheltered workshops for such individuals and facilities for training specialists.

Applications would be submitted to the Secretary after approval by the State agency designated by the State to administer the State plan.

Appropriations

Appropriations of such sums as the Congress may determine would be authorized for the 5-year period from July 1, 1964, through June 30, 1969; $5 million of the sums appropriated for fiscal year 1965 and $10 million of the sums appropriated for any of the next 4 fiscal years would be available only for facilities

associated with college or university hospitals or other appropriate parts of a college or university.

Allotments

The funds appropriated would be allotted among the States on the basis of population, extent of need for facilities for the mentally retarded, and the financial need of the States, with a minimum of $100,000 for any State. Some flexibility in the allotment structure would be permitted in certain situations. First, where two or more States have a joint interest in the construction of a single facility for the mentally retarded, part of one State's allotment could, with the Secretary's approval, be transferred to the allotment of another State to be used for that purpose. Second, if all of a State's allotment in any year is not needed to met the costs of pending applications for facilities for the mentally retarded, or if the need for mental health centers in the State is greater than the need for facilities for the mentally retarded, the State could request the Secretary to approve the transfer of the balance of its allotment for use in financing facilities approved under title I of the Community Mental Health Centers Act of 1963 (H.R. 3688).

Federal share

A State would be given the alternative of varying—between 45 and 75 percent—the Federal share of the cost of construction of projects within that State in accordance with standards providing equitably for variations among projects or classes of projects on the basis of economic status of areas and other relevant factors, or of choosing a uniform Federal share—which would not be less than 45 percent and could go as high as 75 percent for some States—for all projects in the State.

State advisory council

A State advisory council, composed of representatives of State agencies concerned with planning, operating, or using facilities for the mentally retarded and of nongovernment organizations or groups concerned with education, employment, rehabilitation, welfare, and health, as well as representatives of consumers of the services involved, would consult with the State agency in carrying out the State plan.

State plans

The State plan would be required to set forth a program for construction of facilities for the mentally retarded based on a statewide inventory of existing facilities and a survey of need for facilities, and to provide for construction in the order of relative need for the facilities, insofar as permitted by available financial resources. The plan would also have to meet several other requirements, including designating a single State agency as the sole agency to administer the plan; providing methods of administration necessary for the proper and efficient operation of the plan; providing minimum standards for the maintenance and operation of facilities constructed under the title; and providing for affording applicants an opportunity for hearing before the State agency.

Federal regulations

The Secretary would be required to issue regulations within 6 months after enactment of this title, and after consultation with the Federal Hospital Council—the advisory council for the hospital and medical facilities construction (Hill-Burton) program. (The bill would provide for increasing the membership of the Federal Hospital Council from 8 to 12 members, and would require 1 member to be an authority in matters relating to the mentally retarded.) The regulations so issued would prescribe (1) the kinds of services needed to provide adequate services for mentally retarded persons residing in the State; (2) the general manner in which the State agency shall determine priority of projects based on relative need of different areas and giving special consideration to facilities which will provide comprehensive services for a particular community or communities; (3) general standards of construction and equipment of facilities for different classes of facility and in different types of location; and (4) that the State plan shall provide for adequate facilities for the mentally retarded residing in the State and for adequate facilities for serving persons unable to pay therefor.

Other requirements for project approval

Applicants would have to meet several other requirements set forth in the bill, such as providing assurances that adequate financial support will be available for construction of the project and for maintenance and operation of the facility when completed, and that in the construction of the facilities all laborers and mechanics will be paid not less than the prevailing wages in the locality, and overtime pay in accordance with and subject to the Contract Work Hours Standards Act.

Mr. ROBERTS. Thank you, Mr. Secretary. I think you make a very strong case for these bills. I would like, however, at the outset for us to get for the record the total for the construction of the mental health facilities and then the construction of the mental retardation research centers.

Secretary CELEBREZZE. The cost factor for construction of mental retardation research centers is $30 million. The projected cost of the mental retardation facilities is approximately $150 million. Direct program expenses for mental retardation would be the $1,730,000; so that the total program cost as represented by H.R. 3689 for mental retardation over a 5-year period would amount to $181,730,000.

In the mental health program, the community mental health centers, the program calls for a total construction appropriation of $330 million. Initial staffing of mental health centers calls for $204 million; direct program expenses calls for $2,965,000; for a total program of $536,965,000—over a 5-year period.

Mr. HARRIS. Will you include that table in the record?

Secretary CELEBREZZE. I would be happy to.

Mr. HARRIS. It would be easier to refer to.

Secretary CELEBREZZE. Yes; I will furnish it to the record.

Mr. ROBERTS. That will be placed in the record, without objection.

(The document referred to follows:)

Estimated cost of mental retardation and mental health programs for fiscal years 1964 through 1969

[In thousands of dollars]

	Mental retardation		Mental health	
	Appropriation	Expenditure	Appropriation	Expenditure
Centers for mental retardation research	30,000	26,800		
Mental retardation facilities	150,000	71,000		
Direct program expenses mental retardation	1,730	1,575		
Community mental health centers			330,000	177,500
Initial staffing of mental health centers			204,000	189,000
Direct program expenses			2,965	2,760
Total	181,730	99,375	536,965	369,260

Mr. ROBERTS. I think, Mr. Secretary, before we go into this new program that we ought to have some outline of what the Federal Government is doing in the field of mental health and retardation under its existing authority. Now let me set those out for you where I would like for you to have an outline. For example, in research, the training of personnel, in construction of facilities and in community services.

(The material referred to follows:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Obligations for mental retardation by category and agency for fiscal years 1955, 1963, and 1964

Category and agency	1955	1963 estimate	1964 estimate [1]
Research:			
Office of Education		$517,400	$1,081,000
Vocational Rehabilitation Administration	$48,700	1,100,000	2,735,000
Public Health Service	267,000	20,357,000	31,460,000
Welfare Administration	48,892	106,101	866,101
Total, research	364,592	22,080,501	36,142,101
Training of personnel:			
Office of Education		1,000,000	1,000,000
Vocational Rehabilitation Administration		125,000	500,000
Public Health Service		2,256,000	4,274,000
Welfare Administration		596,046	809,046
Total, training of personnel		3,950,046	6,583,046
Services:			
Vocational Rehabilitation Administration	230,000	3,550,000	5,400,000
Public Health Service	50,000	947,000	1,555,000
Welfare Administration	15,000	989,853	989,853
Total, services	295,000	5,486,853	7,944,853
Administration:			
Office of Education		61,250	129,000
Vocational Rehabilitation Administration			47,000
Welfare Administration	5,000	126,000	202,000
Total, administration	5,000	187,250	378,000
Income assistance:			
Social Security Administration		63,800,000	75,300,000
Welfare Administration	11,000,000	33,000,000	36,000,000
Total, income assistance	11,000,000	96,800,000	111,300,000
Grand total, Health, Education, and Welfare	11,664,592	128,504,650	162,348,000
From appropriated funds	11,664,592	64,704,650	87,048,000
From trust funds		(63,800,000)	(75,300,000)

[1] Existing legislation.

SUMMARY OF PUBLIC HEALTH SERVICE MENTAL HEALTH PROGRAMS, CURRENT AND PROPOSED LEGISLATIVE AUTHORITIES

The Community Mental Health Centers Act of 1963, as proposed in H.R. 3688, would provide Federal assistance for the construction and initial operation of community mental health centers. As a backdrop against which the need for this specific legislation can be more appropriately considered, a highlight review of the historical development of the Public Health Service mental health program, and its current programs is outlined below. Historical detail in terms of legislative and appropriation history is attached (ap. A and ap. B, respectively).

I. KEY LEGISLATIVE DEVELOPMENTS

In terms of national significance, there have been three keystone acts in the field of mental health and illness: The National Mental Health Act of 1946, the Health Amendments Act of 1956, and the Mental Health Study Act of 1955.

The act of 1946 established the National Institute of Mental Health and authorized the broad programs of research, training, and technical assistance which have characterized the mental health effort of the Public Health Service up to present time.

With one exception—the authorization of mental health project grants under title V of the Health Amendments Act of 1956—the Public Health Service is operating its programs under authorities contained in the initial basic act of 1946. That one exception, however, has been highly significant; it provided the basis for continuing emphasis, through demonstration and project grants, on the prompt and effective translation of research findings to their practical applica-

tion to the care, treatment and rehabilitation of the mentally ill, and to the development and establishment of improved methods of institutional operation and administration.

Finally, the Mental Health Study Act of 1955 provided the basis for the historic study conducted by the Joint Commission on Mental Illness and Health. The final report of the Joint Commission was transmitted to the Congress in the spring of 1961 and provided the background to the development of the President's proposed national mental health program which was submitted to the Congress in his special message early this year.

II. HIGHLIGHT REVIEW—PROGRAM DEVELOPMENT

A. Background

The National Institute of Mental Health is the Federal Government's principal instrumentality for the support and conduct of research, training and technical assistance programs in the field of mental illness and health. The Director of the Institute is responsible to the Surgeon General as the focal point of leadership and coordination of the total mental health program of the Public Health Service.

Since the establishment of the NIMH in 1948, there has been a basic transition in the character of the national effort in the field of mental health. Institute programs have evolved from a simple dimension of program effort oriented toward a beginning program of psychiatric research and mental health training to a complex, diversified system of Federal support of mental health activities on a broad national base.

In recognition of mental illness as one of the Nation's most serious health problems, program developments over the years have drawn a complex family of diverse disciplines into the mental health field—the biological, the clinical, the social and behavioral sciences. There has been a marked intensification of mental health activities. There has been an emergence of improved technology, large scale collaborative efforts, both in research and in the application of research knowledge, and a marked acceleration of program effort along specific disease or problem oriented lines in response to public pressure as reflected in congressional mandates, for example, alcoholism, drug addiction, psychopharmacology, delinquency and mental retardation.

Against this backdrop of program growth and development, the NIMH has evolved a program structure that embraces substantially all aspects of mental health activity—from basic research to disease control and community programs. These programs have been administered as a unified whole in order to assure maximum effectiveness in terms of an integrated, coordinated total mental health effort.

B. Analysis of current programs

(a) Research, training, and community services—NIMH Programs

Over the years, the major program effort of the Institute has been accomplished through grants and related contracts. In 1962, for example, 85 percent of the total appropriation was for the support, through grants, of research, training, and community and technical assistance activities in non-Federal settings—universities, research and training institutions, State and local mental health institutions and agencies. Since 1962 represents the most recently completed fiscal year, it provides an appropriate baseline for the presentation of an overview of the Institute's programs. With this in mind, and directing the presentation to the extramural program area which represents 85 percent of the total program effort, a series of three tables has been developed setting forth, for each of the three major functional areas (research, training and community services), the following:

Table 1.—An overview by major types of support programs;
Table 2.—An overview by State; and
Table 3.—An overview by problem area.
The tables follow:

TABLE 1.—*NIMH extramural program allocations: Fiscal year 1962* [1]

[In thousands]

	Fiscal year 1962			Fiscal year 1962	
	Amount	Percent		Amount	Percent
Research:			Training—Continued		
Research grants	$29,680	33	Research fellowships	$4,225	5
Regular [2]	20,979	(23)	Predoctoral	1,662	(2)
Small	860	(1)	Postdoctoral	772	(1)
Psychopharmacology	5,774	(6)	Special	488	(1)
Special areas	2,067	(2)	Career	1,303	(1)
Demonstrations and contracts	589	1	Community services:		
Psychopharmacology	589	(1)	Title V	10,064	11
Training:			State grants-in-aid	6,634	7
Training grants	39,375	43	Demonstrations and contracts	496	
Psychiatry	13,329	(15)	Research utilization demonstrations	319	[3]
Psychology	5,522	(6)	Technical assistant projects	144	[3]
Social work	5,937	(7)	Biometrics research contracts	33	[3]
Nursing	4,465	(5)			
Biological sciences	1,871	(2)	Grand total	91,062	100
Social sciences	801	(1)			
Public health	746	(1)			
Pilots and special	1,268	(1)			
General practitioner	5,436	(6)			

[1] Data for this and all subsequent tables exclude intramural programs and costs for review and approval and other administrative activities.
[2] Includes $2,000,000 for basic projects in areas of psychopharmacological research.
[3] Denotes less than 1 percent.

TABLE 2.—*NIMH extramural program expenditures: By States, fiscal year 1962*

[In thousands]

State and foreign country	Training						Community Services						Total	
	Research		Training		Fellowships		Title V		Grants-in-aid		Demonstrations and contracts			
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
Alabama	----------	-------	$176	(1)	$5	(1)	$68	1	$125	2	$5	(1)	$378	(1)
Alaska	----------	-------	----------	----------	----------	----------	----------	----------	52	1	----------	----------	52	(1)
Arizona	$34	(1)	86	(1)	7	(1)	26	(1)	46	1	----------	----------	199	(1)
Arkansas	71	(1)	197	1	18	(1)	61	1	59	1	----------	----------	405	(1)
California	3,900	13	4,284	11	597	14	1,314	13	472	7	107	10	10,674	12
Colorado	394	1	710	2	29	1	240	2	47	1	3	(1)	1,424	2
Connecticut	1,112	4	1,061	3	213	5	333	3	74	1	----------	----------	2,794	3
Delaware	23	(1)	----------	----------	2	(1)	----------	----------	67	1	----------	----------	92	(1)
District of Columbia	433	1	1,273	3	31	1	375	4	67	1	91	8	2,270	2
Florida	269	1	683	2	84	2	93	1	158	2	9	1	1,295	1
Georgia	84	(1)	464	1	10	(1)	128	1	145	2	23	2	855	1
Hawaii	90	(1)	122	(1)	----------	----------	3	(1)	67	1	----------	----------	282	(1)
Idaho	----------	----------	----------	----------	----------	----------	73	1	67	1	4	(1)	144	(1)
Illinois	1,993	7	2,275	6	246	6	375	4	303	5	139	13	5,331	6
Indiana	600	2	414	1	76	2	----------	----------	161	2	----------	----------	1,251	1
Iowa	127	(1)	346	1	12	(1)	64	1	88	1	----------	----------	637	1
Kansas	339	1	648	2	75	2	175	2	68	1	----------	----------	1,304	1
Kentucky	167	1	355	1	17	(1)	26	(1)	112	2	20	2	697	1
Louisiana	152	1	687	2	3	(1)	31	(1)	118	2	26	2	1,017	1
Maine	166	1	16	(1)	----------	----------	10	(1)	67	1	4	(1)	263	(1)
Maryland	989	3	1,028	3	218	5	129	1	98	1	105	10	2,567	3
Massachusetts	3,987	13	3,678	9	450	11	623	6	156	2	60	6	8,954	10
Michigan	1,575	5	1,519	4	122	3	166	2	246	4	----------	----------	3,627	4
Minnesota	310	1	801	2	69	2	228	2	114	2	7	1	1,530	2
Mississippi	28	(1)	114	(1)	11	(1)	54	1	93	1	8	1	307	(1)
Missouri	572	2	1,370	3	95	2	181	2	141	2	----------	----------	2,360	3
Montana	57	(1)	15	(1)	----------	----------	140	2	67	1	----------	----------	279	(1)
Nebraska	49	(1)	361	1	8	(1)	164	2	58	1	7	1	646	1
Nevada	29	(1)	----------	----------	----------	----------	46	(1)	48	1	----------	----------	123	(1)
New Hampshire	8	(1)	38	(1)	----------	----------	----------	----------	64	1	5	(1)	115	(1)
New Jersey	820	3	350	1	43	1	103	1	184	3	8	1	1,509	2
New Mexico	17	(1)	11	(1)	----------	----------	81	1	67	1	----------	----------	175	(1)
New York	5,021	17	6,047	15	597	14	2,925	29	515	8	105	10	15,210	17
North Carolina	697	2	1,329	3	127	3	148	1	171	3	2	(1)	2,474	3
North Dakota	20	(1)	39	(1)	13	(1)	5	(1)	67	1	10	1	154	(1)
Ohio	932	3	1,197	3	127	3	409	4	304	5	66	6	3,035	3
Oklahoma	136	(1)	428	1	30	1	53	1	79	1	----------	----------	726	1
Oregon	281	1	338	1	57	1	28	(1)	66	1	----------	----------	770	1
Pennsylvania	1,490	5	2,504	6	242	6	436	4	362	5	109	10	5,142	6
Rhode Island	145	(1)	174	(1)	74	2	34	(1)	66	1	29	3	521	1

See footnote at end of table, p. 58.

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TABLE 2.—*NIMH extramural program expenditures: By States, fiscal year 1962*—Continued

[In thousands]

State and foreign country	Training						Community Services						Total	
	Research		Training		Fellowships		Title V		Grants-in-aid		Demonstrations and contracts			
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
South Carolina			$105	(1)			$126	1	$94	1	$8	1	$333	(1)
South Dakota	$11	(1)	18	(1)	$8	(1)	71	1	65	1			173	(1)
Tennessee	120	(1)	740	2	31	1	140	1	133	2	6	1	1,170	1
Texas	389	1	1,054	3	21	(1)	28	(1)	308	5	56	5	1,856	2
Utah	99	(1)	532	1	50	1			25	(1)			707	1
Vermont	55	(1)	87	(1)			75	1	67	1	5	(1)	289	(1)
Virginia	139	(1)	372	1	4	(1)			136	2	35	3	685	1
Washington	270	1	488	1	34	1	2	(1)	83	1	23	2	900	1
West Virginia	10	(1)	61	(1)					67	1			137	(1)
Wisconsin	624	2	500	1	66	2	114	1	129	2			1,432	2
Wyoming	6	(1)					118	1	31	(1)			155	(1)
Puerto Rico	56	(1)	280	1					99	1			436	(1)
Guam									40	1			40	(1)
Virgin Islands									31	(1)			31	(1)
Total domestic	28,895	97	39,375	100	3,923	93	10,023	100	6,634	100	1,085	100	89,935	99
Australia	11	(1)			9	(1)							20	(1)
Brazil														
Canada	298	1			40	1	41	(1)					379	(1)
Denmark	42	(1)											42	(1)
Finland	37	(1)											37	(1)
France	108	(1)			24	1							132	(1)
Germany					8	(1)							8	(1)
India					6	(1)							6	(1)
Israel	29	(1)											29	(1)
Japan					7	(1)							7	(1)
Kenya	17	(1)											17	(1)
Lebanon	8	(1)											8	(1)
Mexico	1	(1)			18	(1)							19	(1)
Netherlands	7	(1)			8	(1)							15	(1)
Norway	45	(1)			5	(1)							50	(1)
Sweden	46	(1)			13	(1)							58	(1)
Switzerland	12	(1)			41	1							53	(1)
United Kingdom	123	(1)			124	3							246	(1)
Total foreign	785	3			302	7	41	(1)					1,128	1
Grand total	29,680	100	39,375	100	4,225	100	10,064	100	6,634	100	1,085	100	91,062	100

[1] Denotes less than 1 percent.

TABLE 3.—*NIMH extramural program expenditures: By problem areas,[1] fiscal year 1962*

[In thousands]

Problem areas	Training						Community services						Total	
	Research		Training		Fellowships		Title V		Grants-in-aid		Demonstrations and contracts			
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
Child personality development	$7,896	27	----------	----------	$800	19	$4,836	48	----------	----------	$4	(2)	$13,537	15
Schi ophrenia	7,570	26	----------	----------	504	12	1,913	19	----------	----------	30	5	10,037	11
Psychopharmacology	7,736	26	$1,698	4	433	10	----------	----------	----------	----------	589	54	10,456	11
Mental retardation	1,803	6	352	1	109	3	897	9	----------	----------	66	6	3,226	4
Juvenile delinquency	863	3	484	1	25	1	3,550	35	----------	----------	15	1	4,937	5
School mental health	1,248	4	1,075	3	83	2	1,168	12	----------	----------	29	3	3,603	4
Alcoholism	1,605	5	76	(2)	24	1	530	5	----------	----------	112	10	2,348	3
Aging	1,357	5	257	1	25	1	227	2	----------	----------	3	(2)	1,869	2
Drug addiction	641	2	----------	----------	18	(2)	191	2	----------	----------	79	7	930	1
Industrial mental health	216	1	----------	----------	9	(2)	101	1	----------	----------	----------	----------	326	(2)
Accident prevention	294	1	----------	----------	----------	----------	30	(2)	----------	----------	----------	----------	324	(2)
Total	29,680	----------	39,375	----------	4,225	----------	10,064	----------	($6,634)	----------	1,085	----------	[3] 84,429	(2)

[1] While percentages reflect those portions of the various programs so identified, they are not necessarily mutually exclusive, nor do they in totality subsume the entire support for any one program.

[2] Denotes less than 1 percent.

[3] Total does not include grants-in-aid, portions of which are used for services in these problem areas but data are not available.

1. *Research.*—From its inception in 1948 until the end of fiscal year 1962, the National Institute of Mental Health supported over 2,900 distinct research projects through its program of research grants. These projects—ranging in duration from 1 year to 14—account for nearly 6,200 annual grants and a total of nearly $122 million in awards. This history of the Institute has been marked by a steady growth and diversification of research effort—reaching a level in fiscal year 1962 of 1,343 grants and $30,158,896 in awards for studies in a variety of specific problem areas.

The growth of the NIMH research program has been accompanied by the initiation of a number of administratively distinct grant programs to meet special needs in the mental health field. Among the major substantive concerns of the Institute have been the areas of mental retardation, child health and development, juvenile delinquency, schizophrenia, alcoholism, aging, drug addiction, and psychopharmacology.

In the area of mental retardation, the total expenditure of research funds between 1948 and 1962 was nearly $8 million; the level of support in 1962 was over $2 million. Among the major areas included here are studies of etiology of mental retardation; the diagnosis and treatment of the retarded; the psychological and social adjustment of the retarded and their families; and the care, management and training of the retarded.

Effort in the area of schizophrenia has also been heavy. From the inception of the NIMH research grant program in 1948 until the end of fiscal year 1962, 1,209 awards totaling $32,047,114 were made for projects in the area of schizophrenia; this represents roughly one-fourth of the total research grant effort to date. In 1962, over 220 projects, totaling nearly $8 million were devoted to studies of schizophrenia. Here too, the emphasis of the research varies over a broad area—including, for example, studies of brain and body biochemistry; social and cultural factors; epidemiological studies; and analyses of treatment methods.

Research on psychopharmacological treatment of mental illness has grown from a very small proportion of the program to approximately one-quarter of the grant program in the past few years. From 1948 until the end of fiscal year 1962, 1,223 awards totaling $29,590,866 were made for research on the use of drugs for the treatment of mental illness. In 1962, 281 grants totaling $7,798,112 were awarded for this area of research.

National Institutes of Mental Health has responded to the increased public interest and concern about the problem of juvenile delinquency by increased research grant support through the years. A total of 105 research grants has been awarded for the total sum of $6,108,822 between 1948 and 1962. In fiscal year 1962, 26 grants totaling $1,054,044 were awarded for juvenile delinquency studies.

Other special program areas which NIMH has supported include problems of the aging, alcoholism and drug addiction. Two hundred and twenty-seven grants totaling $6,546,235 were awarded for studies of aging from the years 1948 through 1962. In 1962, 37 grants totaling $1,357,467 were devoted to studies of aging. Between 1948 and 1962, 202 grants totaling $5,186,412 were awarded for studies of alcoholism, while in 1962, 43 grants totaling $1,627,053 were devoted to this psychiatric and social problem. One hundred and thirty-seven research grants totaling $2,710,982 have been awarded for studies of drug addiction between the years 1948 and 1962. In fiscal year 1962, 23 grants totaling $641,414 were supported for studies of drug addiction.

It should be noted that a number of projects supported by NIMH are overlapping in their areas of emphasis. A single study may be relevant, for example, to both the field of psychopharmacology and schizophrenia, or to both mental retardation and juvenile delinquency. As a result, the figures noted above should not be interpreted as representing wholly discrete parts of the program, but rather areas of overlapping, interrelated effort.

An important segment of the total program has been devoted to basic research in the behavioral sciences. As part of this effort, scientists in the biological, psychological, and social sciences are being supported in their attempts to identify baseline data regarding human behavior. Such data are of considerable importance in the planning, execution and interpretation of clinical studies in mental health and illness.

All of the research described above has been supported through the NIMH extra mural research programs other than the title V program. The Institute's total effort includes also a large intramural research program covering a broad spectrum of basic and clinical studies in the mental health field. In 1962, the NIMH intramural research activities totaled $9,180,000.

2. *Training.* Since its establishment in 1948, the Institute has directed a major proportion of its total effort to the problem of mental health manpower. Initially, the primary concern was with the major professional mental health fields—the so-called four-core groups of psychiatry, clinical psychology, psychiatric nursing, and psychiatric social work—those shortage areas that deal with the care and treatment of the mentally ill. The Institute supports graduate training in all these areas and has continued to invest a major share of its training efforts in the production of such personnel.

A second concern was the problem of mental health research manpower—to add to the scientific manpower pool and to seek some of the answers to the cause, the etiology of mental illness, and ultimately its prevention. To accomplish this the Institute supports programs for research training in psychiatry, psychology, social work, and nursing, as well as programs in the biological and social sciences of relevance to mental health.

Now, as the needs in the field continue to grow and as efforts to improve mental health have become more extensive, a wide variety and an ever-increasing number of various kinds of personnel have become important to the further progress—occupational and recreational therapists, the legal profession, the clergy, and of course the psychiatric aid and mental health attendant. In sum, the seriousness and extent of the mental health problem is such that the broadest possible spectrum of manpower must be utilized to meet this problem. The Institute's training program is dedicated to this total effort.

The growth of the training program is exemplified in the contrast between the $1,140,079 awarded in 1948 for a total of 62 grants and the $39,374,975 awarded in 1962 for a total of 1,145 grants. Over this entire period of time the Institute supported almost 1,500 distinct training projects, whose awards have totaled approximately $185 million.

These awards have gone to training centers of all kinds, although over 80 percent has been awarded to colleges and universities, of which approximately one-half has gone to medical schools. For example, of the $39.4 million awarded in 1962, $32,049,000 went to colleges and universities, including $15,594,000 to medical schools. Hospitals and other institutions received $4,154,000, clinics received $1,145,000, and various State and local agencies, professional associations, and independent community service organizations received a total of $2,027,000, in 1962.

The growth in the program has been accompanied by a corresponding increase in the numbers of trainees supported. In 1948 a total of 219 graduate trainees received stipends. In 1962, this total had increased to 4,570. In 1962, this included 1,152 stipends for residency training in psychiatry, plus an additional 373 such stipends in the special general practitioners program. Also included were 976 stipends in psychology, 1,143 stipends in social work, and 451 stipends in nursing. Almost 500 additional stipends were awarded in various areas such as research training in the biological and social sciences, pilot projects and stipends in schools of public health. The total award for all graduate stipends in 1962 was almost $17.5 million.

In addition, a total of 494 research fellowship awards were made in 1962. This compares with 19 awards made in 1948, the initial year of the fellowship program.

As of 1962, every major medical school department of psychiatry is receiving some support through a training grant from the National Institute of Mental Health. Of those other schools with appropriate mental health specializations, all the major graduate departments of psychology, graduate schools of social work, and graduate schools of nursing also receive NIMH training grants. In most cases these include traineeships. University departments in the biological and social sciences with programs of mental health relevance also receive support. Other training centers, including many of the major psychiatric training hospitals, child guidance clinics, and private, nonprofit psychiatric treatment centers, as well as clinical psychology internship centers, provide training facilities and traineeships supported by NIMH training funds. Grants are also provided to almost 100 schools of nursing with basic collegiate programs, for strengthening the mental health content of the undergraduate nursing curriculum.

The total operation of this training program is a major influence on the field of mental health today. The evidence is clear that over the past 15 years the growth of the individual mental health specialties in the basic professions of medicine, psychology, social work, and nursing has been more rapid than the growth of most of the other specialties in these generic professions.

Psychiatry, clinical psychology and psychiatric social work have each grown more rapidly than their total respective fields. Psychiatry has been one of the

most rapidly growing medical specialties over the decade from 1950 to 1960, increasing almost 2½ times in that period from 5,500 to 13,000, while the total number of physicians increased less than 25 percent. In 1950, psychiatrists represented approximately 3 percent of the 194,000 active physicians. This figure increased so that by 1960, psychiatrists represented approximately 6 percent of the 231,500 active physicians. Psychiatric social work also increased almost 2½ times in the same decade, from 3,000 to 7,200, while the total social welfare personnel increased about 40 percent from 74,000 to 105,000. Clinical psychology is today the largest subspecialty in psychology and has grown vigorously in the past 15 years.

In toto, the number of persons with recognized graduate training in the four core mental health professions increased almost 2½ times between 1950 and 1960, while the grand total in all health professions increased about 30 percent over that same period of time.

3. *Community mental health services—Technical assistance.*—A staff of expert consultants work actively with the representatives of public and private mental health organizations to communicate research findings and to advise and assist in their prompt and effective application in the treatment of mental illness nationally. Collectively these consultants serve as a bridge between the research laboratories and the mental health practitioners—those who work directly with mental patients and those who are engaged in the administration of clinics, mental hospitals, general hospitals, day centers, and the host of community facilities with a concern for the care of the mentally ill. New knowledge from research into clinical practices or mental health services administration is critically analyzed with the most promising new information translated into mental health treatment practices for further evaluation in clinical settings through special studies and demonstrations. States are encouraged to adapt new treatment techniques in expanding the community mental health services currently provided into a comprehensive system of mental health care. Some of the new or improved services are designed to meet the special needs of individual population groups such as the aged, alcoholic, and juvenile delinquent.

This work began in 1948. A total of $381,000 was allotted to support these activities in fiscal year 1950. The fiscal year 1962 budget was $1,336,000.

Several special techniques were developed to disseminate new information in regard to the conduct of mental health services and to demonstrate the application of clinical techniques developed from research findings. Demonstrations are primarily implemented in areas where the needs for new and improved treatment procedures have not been met. The demonstrations focus on the translation of new knowledge into treatment practices or the implementation of recently developed treatment practices to new settings. In fiscal year 1958 $65,000 was allotted for these demonstrations. The amount allotted for this activity in fiscal year 1962 is $319,000. During the intervening period 12 demonstrations have been conducted or are in progress.

Intensive workshops called technical assistance projects were started in 1955 to disseminate new information to State mental health representatives on the application of modern principles and methods to administer mental health services programs. These technical assistance projects are planned with representatives of the State mental health authorities and are financed by the National Institute of Mental Health. Since 1955 a total of 135 technical assistance projects have been held in 46 States at a cost of $540,000. Thirty-three technical assistance projects were held in 1962.

Grants to States.—The National Institute of Mental Health has administered the mental health grant-in-aid to States since 1948. This program is administered under authority of section 314(c) of the Public Health Service Act. Grants which States must match dollar for dollar are made to the agency in each State designated as the "Mental health authority." Funds are made available to assist States in prevention and control of mental illness through establishing, maintaining, and expanding community mental health services.

In fiscal year 1948 a minimum grant of $20,000 was made to each State with the States expending an aggregate of $1,653,454 of grant-in-aid funds. The State community mental health programs expanded and additional funds were appropriated to stimulate further activity on the part of the States in community mental health. The minimum grant to each State in fiscal year 1955 was reduced slightly to $17,750 but the total amount expended by States increased to $2,339,627. Further increases in grant appropriations enabled the minimum grant to be raised to $65,000 in fiscal year 1962 and the total of grant funds expended by the States reached $6,633,839.

The States primarily utilize the grant funds to develop and assist in the operation of mental health services including clinics. These programs provide a wide variety of mental health services to a full range of mental health patients including the mentally retarded.

Mental health project grants.—From its inception in 1958 until the end of fiscal year 1962, the NIMH supported 400 distinct projects through its program—mental health project grants. These projects—ranging in duration from 1 year to 7—account for over 400 annual grants and a total of over $25 million in awards. The history of this program has been marked by a steady growth and diversification of effort—reaching a level in fiscal year 1962 of 248 grants and $10,108,959 in awards for studies in a variety of specific problem areas.

Among the major substantive concerns of the Institute have been the areas of mental retardation, child health and development, juvenile delinquency, schizophrenia, alcoholism, aging, drug addiction, and psychopharmacology.

In the area of mental retardation, the total expenditure of mental health project grant funds between 1958 and 1962 was nearly $5 million; the level of support in 1962 was over $2 million. Among the major areas included here are studies of the diagnosis and treatment of the retarded; the psychological and social adjustment of the retarded and their families; and the care, management, and training of the retarded.

Effort in the area of schizophrenia has also been heavy. From the inception of the NIMH mental health project grant program in 1958 until the end of fiscal year 1962, 263 awards totaling $8,786,485 were made for projects in the area of schizophrenia. In 1962, over 50 projects, totaling nearly $2 million were devoted to studies of schizophrenia. Here, too, the emphasis of the program ranges over a broad area—including, for example, social and cultural factors; epidemiological studies; and analyses of treatment methods.

NIMH has responded to the increased public interest and concern about the problem of juvenile delinquency by increased mental health project grant support through the years. A total of 241 research grants has been awarded for the total sum of $5,766,610 between 1958 and 1962. In fiscal year 1962, 45 grants totaling $3,358,178 were awarded for juvenile delinquency studies.

Other special program areas which NIMH has supported include problems of the aging, alcoholism, and drug addiction. Twenty-six grants totaling $652,886 were awarded for studies of aging from the years 1957 through 1962. In 1962, six grants totaling $227,338 were devoted to studies of aging. Between 1957 and 1962, 30 grants totaling $1,100,311 were awarded for studies of alcoholism, while in 1962, 15 grants totaling $530,350 were devoted to this psychiatric and social problem. In fiscal year 1962, six grants totaling $191,383 were supported for studies of drug addiction.

It should be noted that a number of projects supported by NIMH are overlapping in their areas of emphasis. A single study may be relevant, for example, to both the fields of psychopharmacology and schizophrenia, or to both mental retardation and juvenile delinquincy. As a result, the figures noted above should not be interpreted as representing wholly discrete parts of the program, but rather areas of overlapping, interrelated effort.

(b) Construction: Hill-Burton program

Historically, the Hill-Burton program, under the Hospital Survey and Construction Act, has been directed toward assisting the States in the construction of adequate hospital and medical service facilities through matching grants to public or private, nonprofit applicants. There is no specific legislative provision for the construction of the various types of mental health facilities; however, the authority does allow for the construction of specialty-type facilities such as chronic disease facilities including mental illness.

As provided by law, the specific projects to be supported are based on priorities as to relative need as determined by the States and based on approval by the State agency. In point of fact, the States have identified these relative needs with the demand and need for general hospital facilities throughout the country. This demand and need has been so great that the States have been unable to direct Hill-Burton funds into the mental health category.

In the period, 1947–62, the total Federal expenditure under the Hill-Burton program was approximately $1.8 billion. Of this amount, only about 3 percent or $59.6 million has been used for the construction of beds and facilities for the care of the mentally ill.

In terms of numbers of approved projects there were only 2.3 percent in the mental health category—146 mental hospital projects out of a total of 6,236 approved Hill-Burton projects.

In sum, then, the Hill-Burton program has been oriented primarily to general hospital facilities with only minimal support to mental health facilities; and, in large measure, most of the construction support provided has been confined to psychiatric wards in general hospitals.

III. PROPOSED NEW PROGRAMS

A. Background

By direction of the President in December 1961, the Secretary of Health, Education, and Welfare, in consultation with the Secretary of Labor and the Administrator of Veterans' Affairs, initiated a study to determine recommendations for a broadened national program in the field of mental health and illness. The findings and recommendations of this study group were reported to the President in December 1962.

The impetus of the President's request for such a study was the historic final report of the Joint Commission on Mental Illness and Health—the culmination of 5 years of the most intensive and comprehensive study of mental illness in the history of this country. To implement its program recommendations, the Joint Commission proposed that the Nation increase its total mental health outlay to a level of $3 billion by 1970, with the increase to come principally from the Federal Government.

The President, in his unprecedented special message of February 5, 1963, has now proposed a national mental health program of far-reaching dimensions—a program with the intermediate goal of reducing the resident population in public mental hospitals by some 50 percent in a decade or two and the ultimate goal of eliminating the traditional custodial mental hospital, as we know it today, from the American scene; a program designed to return mental health care to the mainstream of American medicine. The heart of this program is the concept of the community mental health center—a new concept representing a wholly new emphasis and approach to the prevention of mental illness and to the care, treatment, and rehabilitation of the mentally ill, an approach that will make it possible for most of the mentally ill to be successfully and promptly treated in their own communities and returned to a useful place in society.

In marked contrast to the Joint Commission recommendation that such an expanded program be financed principally by the Federal Government, the President's program proposes that responsibility be shared by governments at every level—Federal, State, and local—and by the private sector. Under the impetus and stimulus of this program, the total national outlay would indeed meet the goal of the Joint Commission of $3 billion by 1970—but its financing would be shared by all levels of government and by the private sector. Under this program, the total national outlay would increase from its current (1962) level of $2.2 billion to an annual level of $3.2 billion by 1970. The Federal share of this increase would be approximately 30 percent; the State and local share, 63 percent; the private sector, 7 percent. It is to be expected that the private sector share will progressively increase as the community programs develop. It is also predicted that, ultimately, the availability of community mental health centers throughout the country will leave such a marked impact on the resident patient population in public mental hospitals as to make possible a significant shift of State and county expenditures from such hospitals to community use. A comparative analysis of these projections is set forth below:

Comparative analysis of mental health outlays Federal, State and local, private sector, including projected impact of H.R. 3688

[Figures in millions]

	1962	1963	1964	1965	1966	1967	1968	1969	Accumulated total 1964–69
Federal	$794	$829	$880	$937	$988	$1,023	$1,058	$1,092	$5,97
Veterans Administration	621	620	620	620	620	620	620	620	3,720
Care and research	321	320	320	320	320	320	320	320	1,920
Compensation and pensions	300	300	300	300	300	300	300	300	1,800
Labor (training)			4	10	12	14	16	18	74
Defense (care)	31	32	33	34	35	36	37	38	213
Bureau of Prisons (care)	2	2	2	2	2	2	2	2	12
Department of Health, Education, and Welfare	140	175	221	271	319	351	383	414	1,959
St. Elizabeths Hospital	23	23	23	23	24	24	24	24	142
Lexington and Fort Worth Hospitals	8	8	8	8	8	9	9	9	51
National Institutes of Medical Health	109	144	190	240	287	318	350	381	1,766
Research	50	56	67	81	98	112	127	140	625
Training	41	57	77	97	115	130	147	164	730
Community services	17	28	31	34	34	35	35	35	204
Hospital improvement grants			12	24	36	36	36	36	180
All other activities	1	3	3	4	4	5	5	6	27
H.R. 3688				35	67	104	143	188	537
Construction				35	50	65	80	100	330
Initial staffing					17	38	62	87	204
Direct program expenditure						1	1	1	3
State and local	1,170	1,193	1,207	1,237	1,286	1,382	1,551	1,803	8,466
Public mental hospitals	1,011	1,031	1,041	1,041	1,041	1,041	1,031	1,011	6,206
Community services [1]	87	87	87	109	152	245	419	687	1,699
Research	16	16	17	17	18	18	19	20	109
Training	56	59	62	70	75	78	82	85	452
Private sector	249	250	250	253	261	281	294	322	1,661
Private psychiatry	160	160	160	160	160	160	160	160	960
Proprietary and nonprofit voluntary hospitals	80	80	80	80	85	90	95	100	530
Community services [1]				2	5	20	28	51	106
Training	9	10	10	11	11	11	11	11	65
Grand total	2,213	2,272	2,337	2,427	2,535	2,686	2,903	3,217	16,105

[1] Projections from 1965 to 1969 reflect impact (non-Federal share) of H.R. 3688.

C. Need for new legislation

The heart and major thrust of the President's national action program is the proposed grant program embodied in H.R. 3688 for the construction and initial staffing of community mental health centers. Existing legislative authorities under the Hill-Burton program are not adequate to implement the proposed program. They do not now provide specific categorical coverage for the field of mental health and illness and experience has clearly shown that the limited general coverage now available under Hill-Burton has been inadequate even for conventional mental health facilities. Further, the placing of additional funds in the regular Hill-Burton program would not accomplish the specific purposes set forth in H.R. 3688.

In sum, then, existing legislative authorities are not adequate for the implementation of the community mental health centers construction and initial staffing proposals set forth in H.R. 3688. Specific legislation is therefore needed and in view of the positive advantages that would accrue in terms of visibility and direct program emphasis, such legislation has been developed as a specific categorical proposal with respect to mental health and illness—H.R. 3688.

D. Summary

The foregoing highlights of mental health program development in the Public Health Service provide a necessary backdrop, both in terms of historical development and current program content, to a consideration of the President's proposed national mental health program—particularly that part of the President's program requiring legislative consideration, namely H.R. 3688—the Community Mental Health Centers Act of 1963.

Based, in part, on the recommendations of the final report of the Joint Commission and, in part, on recommendations of the President's interdepartmental study group, the President in his special message proposed "a national mental health program to assist in the inauguration of a wholly new emphasis and approach to care for the mentally ill. This approach relies primarily upon the new knowledge and new drugs acquired and developed in recent years which make it possible for most of the mentally ill to be successfully and quickly treated in their own communities and returned to a useful place in society." Essentially the President's program consists of the following major points:

1. The provision of Federal assistance through planning grants for the development of comprehensive mental health programs by the States.
2. The support of expanded research in order to "push back the frontiers of knowledge in basic and applied research into the mental processes, in therapy, and in other phases of research with a bearing upon mental illness."
3. The extension of efforts to increase the supply of and improve the utilization of trained manpower.
4. The provision of special grants for demonstration projects to assist State mental hospitals to improve the quality of care, and to provide in-service training for personnel manning these institutions. This will permit the hospitals to perform a valuable transitional role, through the strengthening of their therapeutic services, by becoming open institutions serving their local communities.
5. The development of comprehensive community mental health centers through the provision of Federal support on a sharing basis for construction and early year operation (H.R. 3688).

All of the foregoing recommendations can be carried out within existing legislative authorities with the exception of the final proposal which is proposed for implementation under H.R. 3688. As indicated earlier, current construction authorities under the Hill-Burton program do not provide specific authority even for conventional mental health facilities, and, of course, provide no authority for the wholly new types of construction envisioned in the community mental health centers proposal. In the light of this fact, and the need to provide visibility and specific emphasis to and impetus for the prompt development of community mental health centers, the specific mental health legislation represented by H.R. 3688 would appear to be both desirable and necessary to effectively implement the President's recommendation in this critical area.

That the proposed program will pay off in humanitarian terms is clearly not debatable. There are some 17 million of our population with some form of mental or emotional problem; nearly 516,000 of these are in public mental institutions. Most of them are confined and crowded within an antiquated chain of State hospitals. In 1961 only 29 percent of these hospitals were approved by the Joint Commission on Accreditation of Hospitals; over one-third are more than 75 years

old; 18 percent of their beds were rated as nonacceptable on the basis of fire and health hazards. The average amount expended in them for patient care is only $4 a day. In spite of these conditions, these institutions cost the taxpayer over $1 billion in 1962.

That the program will pay off, in economic as well as humanitarian terms, can also be confidently predicted. The investments of the past have already paid off to the extent of the reversal beginning in 1956, of a 9 year upward trend (1946–55) in the resident patient population in public mental hospitals. The steady decline in resident patient population of only 1.1 percent per year during the period 1955–62 has already resulted in an accumulated saving of $700 million in maintenance costs exclusive of capital outlay—an amount in excess of the total Federal appropriations to the NIMH since its inception in 1948.

At the end of 1962, there were still some 516,000 resident patients in public mental hospitals. A reduction of 50 percent in this population—one of the goals of the President's program—would result in estimated savings in hospital maintenance costs of even greater proportions. If this 50 percent of our current resident patients were further assumed to obtain gainful employment upon release, at the average earnings for 1962 of $5,024, the national product would be increased by $1.296 billion—a significant return on the Federal, State, and local, and private investment represented by the proposals contemplated in H.R. 3688.

The foregoing represent the highlights of the humanitarian and economic impact of the investment proposed by H.R. 3688. We are now on the verge of the greatest breakthrough in the history of mental health in this counrty. Our state of readiness is due in large part to the wisdom and financial support provided by the Congress over the past decade and a half which have enabled us to tool up through research, trained manpower, and the stimulation of public interest throughout the Nation.

The implementation of this legislation is critically needed; it is feasible and timely. It offers a dramatic opportunity for historic progress against mental illness together with potential economic gains of an equally historic proportion. It will provide a type of facility which by its very nature will restore mental health care to the mainstream of American medicine. Finally, its passage will ultimately affect the welfare of millions of American citizens.

Appendix A

Legislative and Related History—PHS Mental Health Program

1929: Public Law 672, 70th Congress—To establish two U.S. narcotic farms for the confinement and treatment of persons addicted to the use of habit-forming narcotic drugs, and for other purposes.

The act created a Narcotics Division in the Public Health Service to administer this program.

1930: Public Law 357, 71st Congress—Establishment of the Division of Mental Hygiene, Bureau of Medical Services, Public Health Service, by transfer of the authorities, powers and functions of the Narcotics Division. Provided broader scope and enlarged responsibility including narcotic addiction activities, supervision, and furnishing of medical and psychiatric services to Federal prisons, and for the study and inventory of the causes, prevalence, and means for the prevention and treatment of nervous and mental diseases.

1946: Public Law 487, 79th Congress—The National Mental Health Act, enacted July 3, 1946.

Provided for improvement of the mental health of the people of the United States through the conducting of researches, investigations, experiments, and demonstrations relating to the cause, diagnosis, and treatment of psychiatric disorders; assisting and fostering such research activities by public and private agencies, and promoting the coordination of all such researches and activities and the useful application of their results; training personnel in matters relating to mental health; and developing, and assisting States in the use of the most effective methods of prevention, diagnosis, and treatment of psychiatric disorders.

The act authorized the establishment of the National Institute of Mental Health to administer this program.

1946: Public Law 725, 79th Congress—Hospital Survey and Construction Act (Hill-Burton).

Provided assistance to the States to inventory existing hospitals, survey the need for hospital construction, and to assist in the construction of public and other nonprofit hospitals.

1949: In April 1949, the National Institute of Mental Health was established as one of the Institutes of the NIH and the Division of Mental Hygiene was abolished. The Lexington and Fort Worth neuropsychiatric hospitals (originally established as narcotics farms in the act of 1929) were transferred to the Division of Hospitals, Bureau of Medical Services, PHS, with provisions for cooperative arrangement for use of such hospital facilities for mental health research and training purposes.

1949: The Surgeon General, by General Circular No. 43, provided that the Director of the National Institute of Mental Health shall be responsible in a staff capacity to the Surgeon General as the focal point of leadership and coordination for the total mental health program of the Public Health Service.

1955: Public Law 182, 84th Congress—the Mental Health Study Act of 1955. Provided for an objective, thorough, and nationwide analysis and reevaluation of the human and economic problems of mental illness. Authorized the Surgeon General to make grants for such a study of the entire field of mental illness and such grants were made to the Joint Commission on Mental Illness and Health begining in 1956.

1956: Public Law 911, 84th Congress—Title V of the Health Amendments Act of 1956.

Provided authority for mental health project grants to State mental hospitals and other organizations for "* * * investigations, experiments, demonstrations, studies, and research projects with respect to the development of improved methods of diagnosing mental illness, and of care, treatment, and rehabilitation of the mentally ill, including grants to State agencies responsible for administration of State institutions for care, or care and treatment, of mentally ill persons for developing and establishing improved methods of operation and administration of such institutions."

1961: The final report (the culmination of 5 years of study) of the Joint Commission on Mental Illness and Health was submitted to the Congress, the Surgeon General, and the Governors of the several States—as required by law under the Mental Health Study Act of 1955.

1961: The President requested the Secretary of the Department of Health, Education, and Welfare, together with the Secretary of Labor and the Administrator of Veterans' Affairs to undertake an analysis of the final report of the Joint Commission and suggest possible courses of action. The findings and recommendations of this study group were reported to the President in December of 1962.

1963: The President transmitted his special message on mental health and mental retardation to the Congress recommending a national mental health program to be implemented, in part, through existing legislation and, in part, through proposed legislation (specifically with respect to mental health; H.R. 3688).

Appendix B

Appropriation History

The highlights of the appropriation history for mental health activities in the Public Health Service for the major functional areas of the PHS mental health effort—research, training, and community services—are set forth in the following table. It will be noted that appropriation "allocations" are included for the Service's two neuropsychiatric hospitals located at Lexington, Ky., and Fort Worth, Tex. (originally identified in the legislative history as the two "narcotic farms"); these hospitals are administered by the Bureau of Medical Services, PHS and the amounts represent extrapolations from the "Hospitals and medical care" appropriation. It will also be noted that the tabulation excludes Hill-Burton funds since the appropriations for that program represent general hospital construction grant financing and therefore are not earmarked for the categorical area of mental health and illness; on the other hand, a separate highlight review of the Hill-Burton program has been prepared to show the extent to which these funds have been used over the years for the construction of mental hospital and other related facilities.

Appropriation history of Public Health Service mental health programs by major functional area for selected fiscal years

[In thousands of dollars]

	Research [1]		Training [2]		Community services [3]		All other [4] activities, direct operation	Total, NIMH programs		PHS nueropsychiatric hospital,[6] direct operation	Grand total, all PHS programs
	Grants	Direct operation	Grants	Direct operation	Grants	Direct operation		Grants	Direct operation		
1948	374	185	1,263	120	1,653	223	280	3,290	808	2,167	6,265
1951	1,179	720	3,605	212	3,550	419	315	8,334	1,666	2,993	12,993
1954	2,587	1,869	4,363	128	2,325	397	426	9,275	2,820	4,966	17,061
1957	[4] 11,426	5,161	12,647	301	4,000	1,037	625	28,073	7,124	6,000	41,197
1960	[4] 19,355	8,133	28,202	775	9,127	1,638	860	56,684	11,406	6,000	74,090
1963	42,085	13,211	55,313	1,612	24,871	3,355	3,152	122,269	21,330	7,510	151,109
1964, President's budget	53,565	13,696	74,582	2,126	38,140	4,535	3,452	166,287	23,809	7,650	197,746

[1] Legal basis: Public Law 487 (currently reflected in secs. 217, 301, 302, 303, 304, 431, 433 of the Public Health Service Act).

[2] Legal basis: Public Law 487 (currently reflected in secs. 301, 431, 433 of the Public Health Service Act).

[3] Legal basis: Public Law 487 and Public Law 911 (currently reflected in secs. 217, 301, 302, 303, 311, 312, 314, 431, 433 of the Public Health Service Act).

[4] Grants during the period 1956–61 were made to the Joint Commission on Mental Illness and Health under authority of Public Law 182 (currently reflected in sec. 304 of Public Health Service Act).

[5] Legal basis: Public Law 487 (currently reflected in secs. 301, 311, 312, 431, 433 of the Public Health Service Act).

[6] Legal basis: Public Law 672 (currently reflected in secs. 301, 302, 341–347 of the Public Health Service Act).

Secretary CELEBREZZE. The administration's total program in mental retardation, as proposed in the 1964 budget, calls for approximately $204 million. This compares with about $128 million that we are spending in the present fiscal year—so that the 1964 budget calls for an increase of some $76 million in the mental retardation field.

Our current program of $128 million includes money which is spent by the Children's Bureau, for example. It also includes money which is spent by the National Institutes of Health. Funds are included for the Bureau of Family Services for its mental retardation programs.

So today we have a program involving a Federal expenditure of $128 million for a variety of mental retardation programs—research, services, education, care, and so forth with respect to care, alone, the Federal Government today spends relatively little as compared to State and local capital and operating expenditures for institutional care of some $300 million. The States and local communities, in addition to that $300 million, spend $250 million in services; that is, special education, welfare, and rehabilitation. In summary, then, the States and local communities are spending approximately $550 million as against the Federal expenditure this year of $128 million in the field of mental retardation.

In the mental health program the figures——

Mr. HARRIS. Let's stop right there then. What you have just said, is for mental retardation under existing law.

Secretary CELEBREZZE. Yes; I was comparing the expenditure of Federal Government as against the expenditure at State and local levels.

Mr. HARRIS. Yes, I recognize that, but what new authorization do you need, to do what you cannot do under existing authorization?

Secretary CELEBREZZE. Unless we get the new——

Mr. HARRIS. Unless you get the new authorization.

Secretary CELEBREZZE. Yes. The new emphasis must of necessity be on research. As I stated earlier, until about 1954 we didn't pay too much attention to this problem. The cause of mental retardation is an unknown source in 75 to 85 percent of the cases. That means that we have to establish comprehensive research centers.

Mr. HARRIS. I appreciate that. I think I recognize the full need for research, but do you have any authorization for mental retardation research now?

Secretary CELEBREZZE. No; I am trying to give the background.

Mr. HARRIS. I was just trying to shortcut it. I did not want to repeat or ask you to repeat what you have already said.

Secretary CELEBREZZE. The importance of the present bill is that it would authorize $30 million for construction grants which would permit us, with State matching funds, to construct 10 research centers so that we can find the answers to some of the mental retardation problems. In addition of course under title II it would cooperate in expanding community mental retardation facilities which are badly needed and for which there is no current authorization.

Mr. HARRIS. Let's stay with research first and then we will go over to that. Let's take one at a time before we pass over it so fast.

Secretary CELEBREZZE. The construction cost of mental retardation research centers in this bill is $30 million.

Mr. HARRIS. Do you have authorization for research under the present law?

Secretary CELEBREZZE. We have authorization for research but we do not have specific authorization for construction of research facilities in this particular category of mental retardation.

Mr. HARRIS. That is what I wanted to find out. Now all of your present research is going on where?

Secretary CELEBREZZE. All of our present research is going on under the NIH program in the National Institute of Neurological Diseases and Blindness and the National Institute of Mental Health; newly established the National Institute of Child Health and Human Development will also support research in this field. However, with respect to the specific construction authority which we are now requesting, there is no specific provision now for the construction of this particular category.

Mr. ROBERTS. That is all research?

Secretary CELEBREZZE. This is all research that we are doing now which totals some $23 million out of our total outlay in 1963 of roughly $128 million for all aspects of our mental retardation effort.

Mr. HARRIS. I did not intend to get into this, Mr. Chairman, because I imagine you or somebody else will do it, but what I am trying to do, Mr. Secretary, is to get this record straight as to what you propose to do here. In other words, what authority do you need that you don't have now, what are you doing now in this area, and would the additional authority be overlapping and an extension of what you are presently doing? You are going to have to answer these questions and we might as well find out now.

Now is all of this research costing $128 million going on now?

Secretary CELEBREZZE. The $128 million is the total program which we spend now on a Federal level in the mental retardation area including the $23 million for research.

Mr. HARRIS. All right. Does the Federal Government spend that itself in research or does it allocate part of it to non-Federal institutions?

Secretary CELEBREZZE. A great deal of this is allocated. As a matter of fact, I would say 95 percent of it is allocated through grants to institutions for research. I may have misled you, Congressman. The total cost of research is not the $128 million, that is the Department's total 1963 program for mental retardation. Now I can furnish for the record a complete breakdown for you on this.

(The material referred to appears on p. 78.)

Mr. HARRIS. I think it would be helpful if you would do that.

Secretary CELEBREZZE. All right.

Mr. ROBERTS. May I ask also, Mr. Chairman, of the full committee, that the Secretary break it down in the categories that I mentioned of research, training of personnel, construction of facilities, and in community services, which would be helpful to the committee. Under the research category I think we would like to have an account of the allocations that were made to other institutions.

Secretary CELEBREZZE. I didn't hear your last part of that.

Mr. ROBERTS. The allocations that you mentioned when you say 95 percent will be made up of that.

Mr. HARRIS. I am sure the other members will adopt this approach. I don't want to take the time to do it but I did want to get a definite

breakdown as to what you are proposing here that you can't do now. That is the purpose. If you will give us that information it would be helpful.

Secretary CELEBREZZE. Basically the things we cannot do now are the new items we are calling for in this bill, which is construction authority for research centers and for the basic mental retardation facilities.

Mr. HARRIS. I am sure you and your staff must know that but you come here and tell us you are spending $128 million in this program and then you ask for $30 million more in the field of research and $150 million more for community centers, I believe it is, isn't it?

Secretary CELEBREZZE. Community retardation facilities.

Mr. HARRIS. What I am trying to find out is what you are doing now with the $128 million that does not cover what you propose to do here?

Secretary CELEBREZZE. I will refer that to my specialist, Mr. Cohen.

Mr. COHEN. Mr. Chairman, the $128 million is the figure for fiscal year 1963 that encompasses all of the activities of the Department of Health, Education, and Welfare in the field of mental retardation.

Mr. HARRIS. All right. Tell us what these encompass.

Mr. COHEN. The first aspect, which deals with prevention and treatment, including research, training and services of the Public Health Service, totals $23 million, made up of two components.

Mr. HARRIS. Prevention of what?

Mr. COHEN. Prevention of mental retardation, research and training in the prevention of mental retardation.

Mr. HARRIS. That encompasses how much money?

Mr. COHEN. That encompasses roughly $23 million and consists of expenditures of two Institutes in 1963, the National Institute of Mental Health, $7,288,000, and the National Institute of Neurological Diseases and Blindness, $15,839,000.

Mr. HARRIS. Is that all the authorization you have for that program?

Mr. COHEN. No, that is the expenditure figure for 1963. In 1964 it is increased, and there is no specific authorization limit on those two items.

Now the next component of our expenditures on prevention and treatment involved the Office of Education, which is not involved in this particular bill but which in 1963 involved a total expenditure of $1,578,000 made up of expenditures for the training of personnel for the teaching of mentally retarded children, $1 million; the cooperative research program, which involves learning research for the teaching of the mentally retarded of $517,000; and the salaries and expenses of the exceptional children's program in the Office of Education of $61,000; making a total of $1,578,000.

The Welfare Administration, including the Children's Bureau, and the Bureau of Family Services, has a total of $1,791,000. That component is not involved in this legislation either, the Maternal and Children's Services and other activities. There is, as you know, a separate bill authorizing expansion of those appropriations which goes to the Ways and Means Committee and is pending before that committee.

Then in the field of vocational rehabilitation there is $4,775,000 being expended in 1963. This total is made up of $3,550,000 for grants

to the State vocational rehabilitation agencies for the basic support of those programs in dealing with the rehabilitation of the mildly mentally retarded, and $1,225,000 for grants to States and localities and nonprofit institutions for research and training of personnel in helping the mentally retarded.

That concludes the breakdown of the prevention and treatment component of the total program. The largest single element of other expenditures for the mentally retarded is $33 million in 1963 for payments under the public assistance program for aid to the permanently and totally disabled under title XIV of the Social Security Act and $63,800,000 to the mentally retarded under the social security system of old age survivors and disability insurance. That gives us a grand total of $128,504,000. As the Secretary said, we need statutory authorization to do the two things that are in this bill, the construction of the 10 special research centers and the authorization for the construction of mental retardation facilities.

Mr. HARRIS. Then the $23 million that you mentioned back there at the outset in the research field of mentally retarded children has altogether different objectives than what is sought here?

Mr. COHEN. It actually totals $23,560,000 for 1963. This is the program under existing legislation. That might be called our basic research program under the Public Health Service for the causes and cures of mentally retarded children.

Mr. HARRIS. Is that program carried on in this area?

Mr. COHEN. $7 million of that is in the National Institutes of Mental Health.

Mr. HARRIS. Where is that?

Mr. COHEN. Pardon, sir?

Mr. HARRIS. Is that out in Bethesda?

Mr. COHEN. Yes, sir. The other $15,900,000 is in another institute, the National Institute of Neurological Diseases and Blindness. A small additional amount, about $450,000, is in the Bureau of State Services of the Public Health Service.

Mr. HARRIS. Where is that research center located?

Mr. COHEN. The $15 million, that is at Bethesda also.

Mr. HARRIS. In other words, all of the research that you now have underway in the field of mental retardation is being carried on at Bethesda?

Mr. COHEN. The Institutes are located at Bethesda, but the great majority of their research effort, as the Secretary says, is through grants to universities and project directors who are working out in the States and communities.

Mr. HARRIS. Give us an example of the kind of grant that is being given to an institution somewhere.

Dr. TERRY. One of the best examples, Mr. Harris, is the perinatal study which is being conducted at the present time by the National Institute of Neurological Diseases and Blindness. It consists of a study devoted toward following some 50,000 women from the time they become pregnant, through the pregnancy, and through the early life, infancy, of the child. The objective is to detect those factors which will tell us why some of these children will be mentally retarded and to find out what is the difference between those women during their pregnancies and the thing that happened to the child at and

shortly after birth, what is different in those who are mentally retarded and those children which are not mentally retarded.

Mr. HARRIS. Who is carrying on that work?

Dr. TERRY. This is directed through the National Institute of Neurological Diseases and Blindness, but it involves some 15 institutions outside which are supported with grants from this project. Mr. Harris, I think it is probably one of the most significant research studies going on in this country today in terms of getting some basic information which we cannot get in other ways.

Mr. HARRIS. Does this new program for research centers propose to do away with that research program or in any way interfere with that kind of research?

Dr. TERRY. It would be expected to do neither. This study has been underway something in excess of 2 years. It is expected that it will take another 2 years or so to complete it and to bring the required 50,000 women and children and babies under study. It is presently planned to follow these children until they are 6 to 8 years of age.

Now the proposals in this legislation would not affect that at all, Mr. Harris. This study is supported through specific appropriations to the National Institute of Neurological Diseases and Blindness under our existing legislative authority for the support of intramural and extramural research and other activities.

Mr. HARRIS. It is anticipated that the $30 million requested here together with additional sums contributed by the States, will provide adequate facilities to meet the needs of the future insofar as we can tell now?

Dr. TERRY. The $30 million which is requested for construction grants, for the aid in the construction of centers for mental retardation research, is expected to meet our needs over the next several years at least, Mr. Harris.

Mr. HARRIS. As far as you can see in advance?

Dr. TERRY. Yes, sir. I would say this is projected on the basis of a 5- to 7-year planning. I think it would be completely ridiculous for me to attempt to project beyond that. If we are accurate up to that time or reasonably accurate we will have done an exceptionally good job.

Mr. HARRIS. That is all, Mr. Chairman. I am sure you will develop the other questions.

Thank you very much.

Mr. ROBERTS. Certainly, Mr. Chairman.

Now when we get into the shifting of the roles through the community so that the people who are mentally defective will be taken care of on the community level, is it your thinking, Mr. Secretary, that some of the money that has been paid by the States for custodial care might possibly be lessened and would be channeled into a new direction?

Secretary CELEBREZZE. Yes, sir. Mr. Chairman, in the area of mental illness, as the custodial care diminishes from large institutions, that part of the costs of care can be gradually transferred over to the community centers, but we also must be realistic in that local communities cannot absorb the initial costs. It will take a period of transition. That is why, under the bill (H.R. 3688), we provide for a 4-year period of Federal participation in the initial staffing costs of these centers ranging from up to 75 percent the first year and reduc-

ing down to 30 percent the fourth year. These grants, then, are on a declining basis. The Federal share drops 15 percent a year, from 75 to 60, to 45 to 30 percent. That gives the sponsors of community mental health centers an opportunity to adjust their financing within this 4-year period, ultimately to adjust to the full impact. If you were to throw this full impact at them in the initial year, in my opinion at least and based on the years of being a local public official, they would not be able to absorb it. Now in 4 years time, once the community mental health centers become established, the large State institutional facilities should start to diminish their patient load, and once this happens it is reasonable to expect they can shift part of their funds over to community use.

Moreover, as I said in my opening statement, part of the cost can be paid by the families and part of the cost can be paid under insurance programs. These three factors taken together will, in our opinion, make it possible for the communities, at the end of the 4-year period, to absorb the total subsequent cost of these centers.

Mr. ROBERTS. Then after the 4-year period has run its course, the Federal Government would propose to step out and leave it up to the State?

Secretary CELEBREZZE. That is correct. However, turning now to the mental retardation research centers, the Federal Government could still participate in these latter centers by making money available for the purposes of research just as we now make research grant money available to other institutions. We would not grant money for the operation of the research center, but it would still be eligible for grant moneys that we may have for research and training grant support from the NIH to the same extent as other research facilities, but only to that extent.

Mr. ROBERTS. How would you proceed with staffing of the community mental health service? Would you proceed to do it through the State health departments and local sources or how would you go about it?

Secretary CELEBREZZE. Well, of course under the terms of the bill the State has to come up with a plan both for construction and the actual staffing of the research facility. That is why we emphasize in the bill itself close association with universities and private groups that have been engaged in this field. Through our training grant programs we have and will continue to give assistance in the broad manpower field, but we do have a problem. That is the problem which we are trying to resolve under House bill 12 which is Mr. Harris' bill under the Health Education Act to meet the problem of getting more doctors and getting more psychiatrists out into the field. However, at the present time, we do feel that it will be possible to attract personnel to adequately staff these research facilities. Our existing training grant programs are currently adding to the research manpower pool and should help in this regard.

We do have a long-range staffing problem and I think that is the basic reason, Mr. Chairman, that we have limited our proposal, at this time, to only 10 mental retardation research centers for the whole country. As to this overall staffing question, I am hopeful that the Congress in its wisdom will pass House bill 12 in order to provide a long range program to meet adequately the manpower needs of the country in the future years.

Mr. ROBERTS. Well, I was going to ask the question, where were you going to get this personnel under present conditions?

Secretary CELEBREZZE. I think that the best answer that I can give is that, in part, some will become available as a result of our existing training grant programs and, in part, some will be recruited from other sources. The competition is so great today, and on the other hand the problem is of such a magnitude——

Mr. HARRIS. Will the gentleman yield?

Mr. ROBERTS. Yes.

Mr. HARRIS. You said you hope to obtain part of it out of H.R. 12, the medical and dental health training program.

Secretary CELEBREZZE. Yes.

Mr. HARRIS. Well, you will have to train them.

Secretary CELEBREZZE. Yes, indeed.

Mr. HARRIS. Incidentally, do you not agree that that program is more in the field of public health than in the field of education? Than in the broad category of education?

Secretary CELEBREZZE. Well, the two are so closely related, in other words, in public health in most instances you have to be a doctor, you have to be a scientist, and we have to turn out doctors and scientists through a program of education but because they belong to the medical profession we say the program as proposed in House bill 12 should be under the jurisdiction of the Public Health Service.

Mr. HARRIS. And it should remain that way, should it not?

Secretary CELEBREZZE. Yes.

Mr. HARRIS. Have you so notified the Committee on Education and Labor?

Secretary CELEBREZZE. Our recommendation has been to that effect.

Mr. HARRIS. We are getting a little bit off the subject here but I think it is important to help work out any problem that might have a semblance of a jurisdictional question involved. I think it is highly important.

Secretary CELEBREZZE. We have so advised the committee.

Mr. ROBERTS. Mr. Rhodes.

Mr. RHODES. Mr. Secretary, I would like to ask if you think that added inducement or incentive is needed to encourage talented students to study and train for service as phychiatrists. It is not a very attractive field. In institutions and hospitals the pay is not adequate. In private practice high fees must be charged because much time is given to a patient. Many talented persons won't enter this field.

Secretary CELEBREZZE. That is why again under our other legislation we are requesting special consideration for people who can be trained and induced to go into this field and train for this particular purpose. I think now that in the last few years under the best guidance of some of our Federal programs we have been obtaining more and more people who through education and training had been going into this area. It is up to us to make it available for them either through special loan features or special inducements, by forgiveness of part of their loan to go into these particular areas which we think are critical. That is also covered partly under House bill 12, Mr. Harris' bill.

Now you have two situations. You would not have a problem of attracting people to the research centers because of the nature of the

work in the research centers. However, you would have it in these other facilities, which are partly for custodial care, partly other.

Mr. RHODES. I want to commend you Mr. Secretary for your interest and leadership in combating what I think is one of the most serious problems which confronts our people and our country today. There are several aspects of the problem which I believe deserve consideration and attention. One is the heavy financial burden of catastrophic illnesses on individual families.

Most State mental hospitals have inadequate facilities and personnel. Yet the cost for a patient runs from about $4 to $10 a day. It is a burden that adversely affects the welfare of many families which are required to pay these hospital bills.

I suggest, Mr. Secretary, that if figures are available that you put into the record what the daily rates are for patients in various State and Federal mental hospitals. I also suggest that you include information on the number of fully paid and free patients.

Secretary CELEBREZZE. The cost as to the parents?

Mr. RHODES. The cost to the families.

Secretary CELEBREZZE. The cost to the individual family?

Mr. RHODES. Yes, that is right, for the patient. It seems to me that the cost for many families is just out of reach. About two-fifths of the families in this country live on incomes of less than $4,000 a year. This is little more than it cost for a patient in some of our public institutions.

Secretary CELEBREZZE. I am sure we can obtain the figures as to the State institutions and we will furnish those for the record.

(The material referred to follows:)

BURDEN OF CATASTROPHIC ILLNESS

A measure of the economic impact of mental illness on the patients themselves and their families is the accumulated loss of income suffered by the patients resident in mental hospitals as of the end of 1960 over the total period of time they have been hospitalized. These patients have experienced an accumulated loss of 4,367,976 man-years in the labor force. This is conservatively estimated to be the equivalent of $10,900 million in wages or $23,000 per patient. This computation assumes that $2,500 per year is the average equivalent value of a man-year in the labor force during this entire period of hospitalization.

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FEDERAL, STATE, AND LOCAL GOVERNMENT EXPENDITURES FOR THE CARE OF THE MENTALLY ILL, FISCAL YEAR ENDING JUNE 30, 1962 [1]

Government, agency, and amount spent for care of the mentally ill

	Thousands
Federal:	
Veterans' Administration:	
Inpatient care	$314,303
Outpatient care	6,706
Compensation	256,216
Pensions	43,573
Total [2]	620,838
Department of Health, Education, and Welfare:	
St. Elizabeths Hospital	22,542
U.S. Public Health Service hospitals	7,995
Grants to States	6,634
Total [3]	37,171
Department of Defense:	
Inpatient care	25,000
Outpatient care	5,500
Total [4]	30,500
Justice Department: Bureau of Prisons, total	1,689
Total Federal expenditures	690,198
State and local:	
Public mental hospitals, excluding District of Columbia	1,010,616
Community mental health services [5]	87,189
Total	1,097,805
Total Federal, State, and local expenditures	1,788,003

[1] Some States may have other fiscal year ending.

[2] In previous years the term "neuropsychiatric," as used for the estimate of inpatient costs, compensation, and pensions encompassed psychiatric and neurological patients. However, in the 1962 expenditures data the neurological cases are excluded, and only those costs that pertain to veterans having psychoses or other psychiatric conditions are included. Comparable data for 1961 are given as follows:

Veterans' Administration:	
Inpatient care	$302,550
Outpatient care	6,562
Compensation	277,079
Pensions	46,651
Total	632,842

[3] Includes all expenditures for District of Columbia, territories, and possessions. It encompasses the complete mental health formula grant program. These data have been estimated.

[4] These data are estimated.

[5] These are estimates since in some instances State, local, and private expenditures were not readily available.

Mr. RHODES. I would like also if you could show in the record the added cost for a patient because of legal red tape that burden the families which have a problem of mental illness. I don't know what can be done to lighten that burden not only on admittance of a patient but also on readmittance.

Secretary CELEBREZZE. I think that you are interested in total cost but we do not have data on the total costs to the family. The other thing you have to take into consideration is what the cost is to the Nation as a whole.

Since we are on figures now I thought it would be interesting for the committee to know that while it is difficult for us to estimate the

total loss to the public which is due to mental illness, at the end of 1962 there were 515,948 resident patients in public mental hospitals. If we assumed that half of these people would be employed if they were not mental patients, were not mentally ill, they would have an average earning based on 1962 average earnings of about $5,024 and the national product would be increased by $1.3 billion. Since each dollar of national product generates 20 cents in Federal taxes and 4 cents in State taxes, we can assume that the tax losses to the Federal and State governments are about $259 million and $52 million, respectively. You see how much we could do with that additional money.

Mr. RHODES. I believe, too, that some consideration needs to be given to the problem which many patients have after they are released from a mental hospital. It is impossible for many of them to find gainful employment. The answer is not in the legislation before us but it is a question that must be faced to help the victims of mental illness.

Another question which I think should be considered is the matter of sterilization, both in prevention of mental illness and also in reducing the increasing cost this illness brings to society. I know this is a controversial issue but I do think it is something that is worth consideration and attention.

Secretary CELEBREZZE. You mean our attitude or my attitude on sterilization?

Mr. RHODES. How is that?

Secretary CELEBREZZE. Are you asking me to furnish for the record my attitude?

Mr. RHODES. No; I am making a statement. I think it is something that deserves a lot of attention and study not only in reducing the cost but also in preventing mental illness.

Mr. HARRIS. Mr. Secretary, he is expresing a private opinion and he is not asking you for your opinion. I doubt the wisdom of volunteering.

Mr. ROBERTS. The Chair would like to confine the hearing to the bill. The gentleman from Minnesota.

Mr. NELSEN. Mr. Secretary, I think you mentioned the $1,578,000 for training of personnel. How are these persons trained and where?

Mr. COHEN. Is that the figure I mentioned? Do you say $1,578,000?

M. NELSEN. Yes. I wonder how you proceed with the training of personnel in this field of mental illness?

Mr. COHEN. That particular figure Mr. Congressman, dealt with the expenditures under the Office of Education for training teachers of mentally retarded children.

Mr. NELSEN. Well, where are they trained, what facilities do you use? Various States?

Mr. COHEN. The expenditures for this teaching program largely find their way into the State universities where they are teaching teachers who will go out and work with teachers in the elementary and secondary schools.

Mr. NELSEN. Is this money allocated to the university for the purpose of training these persons?

Mr. COHEN. Yes, sir, it is. That is correct, under this particular grant authority.

Mr. NELSEN. Now in the figure of $4,775,000 for vocational rehabilitation, how is that money allocated and do you have any information as to where it goes, to what States, to what schools, could we get that information?

Mr. COHEN. Yes, I could put that in the record. The expenditures for the grants are pursuant to a specific grant formula in the Vocational Rehabilitation Act and the research and training ones are specifically on the basis of projects as authorized in the act. We can put more detail on that in the record.

(The information referred to follows:)

VOCATIONAL REHABILITATION ADMINISTRATION, MENTAL RETARDATION PROGRAM, FISCAL YEAR 1963

[In thousands]

Program:	*Amount*
Grants to States for vocational rehabilitation	$3,550
Research and training:	
Research and demonstrations	1,100
Training	125
Total, research and training	1,225
Total, vocational rehabilitation administration	4,775

GRANTS TO STATES

Funds are granted the States on a formula basis to provide rehabilitation services to the disabled and for extension and improvement projects. The States provide services in relation to many categories of disability, including mental retardation. The funds are not accounted for by disability category, however. The amount of $3,550,000 is the estimated amount of Federal funds involved in rehabilitating national total of 5,400 mentally retarded persons in the 1963 fiscal year.

RESEARCH AND TRAINING

Research and demonstrations

The amount of $1,100,000 is budgeted in fiscal year 1963 to support 41 projects in the field of mental retardation. Under this program grant funds are made available to States and to public and private nonprofit agencies to pay part of the cost of projects for research, demonstrations, and the establishment of special facilities and services which promise to contribute to the solution of rehabilitation problems common to all or several States.

Training and traineeships

It is estimated that about $125,000 of the amounts granted under this program in 1963 will be used to train persons in various fields such as speech and hearing, occupational therapy, psychology, counseling, etc., especially to work with mental retardates in the rehabilitation program. Under the program of training and traineeships, teaching grants and traineeship grants are made to educational institutions, grants are made to State vocational rehabilitation agencies for inservice training, contracts are made with educational institutions and agencies for short-term training, and research fellowships are awarded. The major purposes are to increase the supply of personnel in professional fields involved in rehabilitation, to improve the quality of training, and to further train personnel serving disabled individuals. The mentally retarded compose one of the major disability groups served by personnel trained under this program.

Estimated obligations as of June 30, 1963, for projects in category mental retardation research and demonstrations grants

State and grantee	
Alabama:	
RD–842: University of Alabama, University	$18,600
1059: Alabama Institute for Deaf and Blind, Talladega	5,000
Arkansas: 698d: Morrilton Public Schools Training Center for the Mentally Retarded	21,800
California:	
902–P: Aid Retarded Children, Inc., San Francisco	35,000
980d: Hope for Retarded Children, San Jose	37,700
Florida:	
989–P: MacDonald Training Center, Tampa	64,600
1204: Lee County Association for Retarded Children, Fort Myers	31,000
Georgia:	
531–D: Greater Atlanta Chapter for Retarded Children, Atlanta	18,300
836: Georgia Division of Vocational Rehabilitation, Atlanta	40,700
Illinois:	
1075–P: Champaign Community Unit 4 Schools	46,900
1207–D: Lt. Joseph P. Kennedy, Jr. School, Palos Park	26,900
1216–P: Jewish Vocational Service, Chicago	68,000
Indiana: 436–D: Delaware County Council for Retarded Children	4,400
Iowa: 854–D: Wall Street Mission, Sioux City	10,000
Maryland: 373–D: Maryland Society for Mentally Retarded Children, Baltimore	13,700
Massachusetts:	
484–D: Vocational Adjustment Center, Boston	18,800
832: Marsalin Institute, Brookline	3,500
Michigan: 981–P: Kent County Board of Education	24,500
Minnesota:	
681: Minneapolis Public Schools	29,500
735–D: Lake Region Sheltered Workshop, Fergus Falls	28,200
Mississippi:	
606–D: Harrison County Association for Retarded Children	21,100
621–D: Hinds County Association for Retarded Children	20,000
Nebraska: 480–D: Occupational Training Center for the Mentally Retarded	17,000
New Jersey:	
425: Edward R. Johnstone Training & Research Center, Bordentown	48,900
1189–P: Occupational Center of Essex County	59,000
New York:	
568: Association for the Help of Retarded Children	56,200
1036: Human Resources Foundation	66,700
North Dakota:	
1122–D: Vocational Training Center, Fargo	24,000
1203–D: Opportunity Training Center, Inc., Grand Forks	29,200
Pennsylvania: 993–P: The Devereaux Foundation, Devon	52,900
Puerto Rico: 1158–P: Department of Education	43,500
Rhode Island: 444–D: Parents' Council for Retarded Children of Rhode Island	7,000
South Dakota: 719–D: South Dakota Association for Retarded Children	6,500
Tennessee: 956–D: Tennessee Association for Retarded Children, Nashville	83,300
Texas: 489–D: San Antonio Council for Retarded Children	12,500
Virginia: 678–D: Richmond Goodwill Industries	17,600
Washington:	
308–D: Goodwill Industries of Tacoma	27,600
603: University of Washington, Seattle	8,900
West Virginia: 773–D: Cabell Co. Sheltered Workshop, Huntington	14,200
Wisconsin:	
404: Jewish Vocational Service, Milwaukee	18,000
1067: United Association for Retarded Children, Inc., Milwaukee	18,800
Total grants: 41	1,200,000

Mr. NELSEN. Now in the amounts that go to the States, to be allocated under social security, do you have a formula that you use for that?

Mr. COHEN. Yes. There are two aspects, sir, of the inquiry you have made. The one, relating public assistance payments to needy individuals, is on a matching grant basis; that is, the Federal Government gives a certain proportion to each State based on its per capita income based on earnings of individuals and the amount that it pays. The grant formula is determined by statute. The second aspect—the $63,800,000 from the social insurance program—is met entirely through the contributory payroll taxes under the old-age and survivors and disability insurance program. These funds do not come out of general revenues, but from the OASI trust fund financed through the earmarked payroll contributory tax program.

Mr. NELSEN. I wonder if figures would be developed as to average bed stay of mental patients; do you have any study on that?

Mr. COHEN. Yes.

Mr. NELSEN. Could you make that available?

Mr. COHEN. Yes.

(The material referred to follows:)

First admissions to public mental hospitals currently have a median duration of stay of about 3 months during their first episode of hospitalization. For schizophrenic first admissions which constitute about 25 percent of all first admissions to State mental hospitals the median duration of hospitalization is about 5 months during their first episode of hospitalization. As a result of repeated episodes of hospitalization required by patients and prior trends of admission to and separation from these hospitals, a situation has developed where the median duration of stay of all patients residing in such hospitals as of the end of 1960 was 8.9 years. The median duration of stay of schizophrenic resident patients which constitute 50 percent of all resident patients in these hospitals is 10.4 years.

Mr. NELSEN. Then there is another question that comes up when we talk about this and that is the tendency on the part of States, for example, to sort of back away from their responsibility when the Federal Government steps in.

Now in Minnesota we have had a very active program on a mental health program and now I notice some of the testimony today where the State tax basis was referred to as not providing adequate funds to do more than is presently being done. Now it would seem little unfair where States are really meeting their obligations and other States are not and so the Federal Government steps in. Now is it possible that we retard the States' activities when there is a crutch to lean on from the Federal Government?

Secretary CELEBREZZE. My experience has been to the contrary. In programs in which the local communities and local States receive some degree of assistance—and as you recall under the provisions of the bill these moneys that the Federal Government is giving cannot be used for expenditures which the State now has—there is an inducement for them to support their programs. The difficulty is that, for example in the case of the research facilities, that the States themselves cannot go forward unaided at this time in establishing new facilities because of the financial conditions as they now exist in most States. I find that when the Federal Government comes in, the States and the local communities will do much more. I think that is true in the cities under the urban renewal program; that is true in

your highway program; it is true in your pollution programs. When the Federal Government came in and provided the money for these purposes, the local communities stepped up their programs.

Mr. NELSEN. Thank you. Now under the provisions of this bill where the Federal Government will step in, is it 70 percent matching or 75?

Secretary CELEBREZZE. Up to 75 percent.

Mr. NELSEN. And the next year it is 60. Is it? And then it tapers off on a 5-year program?

Secretary CELEBREZZE. That is only for operating purposes, once the community mental health centers are constructed.

Mr. NELSEN. I see. Now the dollar figure that you gave us, what is it, $181 million on mental retardation?

Secretary CELEBREZZE. Yes.

Mr. NELSEN. $536,965,000 in the mental health area. Is that the estimated cost for the 5-year program?

Secretary CELEBREZZE. Yes. We can give you the breakdown for the period if you want us to. We will furnish it for the record so you will have it.

Mr. NELSEN. As I understand it you propose some 10 sort of pilot plants; is that what you suggested?

Secretary CELEBREZZE. In the mental retardation program (H.R. 3689) we propose 10 research centers and then we also propose the mental retardation facilities program for which we estimate within the course of the 5 years that we could build up the money available, together with matching State funds, about 150 throughout the country attached to universities and in local communities. In the mental health program (H.R. 3688) it is our estimate that we can, within the life of the program, establish perhaps about 422 units across the country.

Now in the mental retardation research centers, these would run approximately $4 million per unit so we allocated $30 million under this bill; that is 75 percent of the cost. The other 25 percent or $10 million will come from local matching contributions.

Mr. NELSEN. Some time back, several months ago, a neighbor of mine stopped at my home and they have a little boy that is mentally retarded. Their great concern was of the fact that there was no place where this young boy could receive some education which he had the capability of receiving. Had they put him into the regular public school not equipped to provide proper training actually it would hurt his chances of advancement.

Now in a case like this the family is not interested in sending this child off to some distant point for training. The thought occurred to me that throughout our country because of our school reorganization program we have vacated countless very good country schoolhouses with playgrounds and facilities, with heating plants, with running water. If some program could be worked out where the county welfare agencies, the county commissioners would get a lease on this particular school it is entitled to it, the parents would be most happy to bring their child to school.

Now it would seem to me that we might be overlooking something easily within our grasp financially and otherwise and accommodating to the problem. Have you any idea relative to this suggestion?

Secretary CELEBREZZE. Yes, I think that in the past there were two problems. Prior to 1950 those who had a mentally retarded child were more apt to keep the child away from the public. Fortunately, we have now made considerable progress in bringing the problem out into the open. The parents are seeking help, and there are many of them I assure you. If you have known any parents of a mentally retarded child you know their great concern for that child as they go from one doctor to another. But the basic problem again has been lack of adequate facilities and professional staff or teachers to teach these children, and that is what we are trying to build up under our bills that we have presented to the Congress.

As we establish these community facilities bringing the children in and letting them stay close to home where their parents can visit them. That is the purpose of these community centers.

Mr. NELSEN. You again have about 10 per State and it would still be a long way from home. My idea is we have for example houses that you put up for auction for a dollar, just to get rid of them?

Secretary CELEBREZZE. The 10 applies to the proposed 10 research centers. In addition to these, we will have approximately 150 mental retardation facilities dispersed throughout the country.

Mr. NELSEN. I though you said there would be 400 in the 50 States?

Secretary CELEBREZZE. The 422 is the number of community mental health centers.

Mr. NELSEN. I see, this is mental health.

Secretary CELEBREZZE. Yes. We are referring to mental retardation right now.

Mr. NELSEN. Thank you Mr. Secretary.

Mr. ROBERTS. The gentleman from Florida.

I think before we leave that particular part of the record we should try to get it straight. Mr. Nelsen, would you let us know what you had in mind when you asked him about the unit cost of these mental health services?

Secretary CELEBREZZE. On the average, the unit cost of the community mental health centers will be approximately $1,300,000. That is for the 422 community mental health centers that we are speaking about.

The unit cost of the research centers under the mental retardation program will run approximately $4 million and the mental retardation facilities will run approximately $1,700,000 per unit, divided on the average 60 percent Federal and 40 percent local. So it would run approximately $950,000 Federal money and $650,000 local money.

Mr. NELSEN. Another question. The total cost of this is included in the President's budget, is it not?

Secretary CELEBREZZE. Only that part of the President's total program that can be implemented under existing legislation is included in the 1964 President's budget.

Mr. NELSEN. Thank you very much.

Mr. ROBERTS. The gentleman from Florida.

Mr. ROGERS of Florida. Mr. Secretary, I believe you said there were between 5 and 6 million affected in this country with mental diseases, mental retardation?

Secretary CELEBREZZE. That figure pertains to mental retardation.

Mr. ROGERS of Florida. Is there any reason to separate the two facilities as you have in this bill?

Secretary CELEBREZZE. Yes, because it requires completely different philosophies, Congressman Rogers.

In mental illness there is an impairment of effective intellectual and emotional functioning. In the case of mental retardation there is an intellectual deficit which can be the result of hereditary factors, or of prenatal injury, or it can be a result of other causes which are little understood today. We do know that if given the proper training at a certain age a mildly retarded young man has a capacity to become to a degree self-sustaining. I think it would be a tragic error to mix the two groups together. Perhaps the doctors can define it much better than I can. In the case of mental retardation the need is to develop limited capacity, whereas with mental illness the mental capacity may be present but something went wrong with those capacities.

Mr. ROGERS of Florida. Now how many approximately do you estimate are afflicted with just mental illness as separated from mental retardation?

Secretary CELEBREZZE. Mental illness runs, I am informed, about 17 million.

Mr. ROGERS of Florida. Seventeen million?

Secretary CELEBREZZE. In the United States.

Mr. ROGERS of Florida. How many of those are institutionalized? Are those the figures you gave us?

Secretary CELEBREZZE. About 600,000 are institutionalized in public institutions.

Mr. ROGERS of Florida. Yes. How many would you say can be taken care of in veterans' facilities of the 17 million?

Secretary CELEBREZZE.. Do I understand the question correctly, Congressman, how many of these 17 million mental patients can be handled by the veterans' facilities?

Mr. ROGERS of Florida. Yes. In other words, what percentage of this would you estimate would perhaps—I don't know, maybe you could figure it out how many would be veterans, maybe we have some estimate or maybe not, but at least what facilities do we have to take care of veterans from this illness?

Secretary CELEBREZZE. The Veterans' Administration provides psychiatric services to veterans, and we will furnish data on the number of persons served for the record.

Mr. ROGERS of Florida. If you could, because I think this should have some relation.

(The material referred to follows:)

During 1962 approximately 124,000 persons were under care of the Veterans' Administration inpatient psychiatric services and 76,000 were served by the VA outpatient psychiatric services. Thus approximately 200,000 or 1.2 percent of the estimated 17 million mentally ill in the United States were provided services by the VA.

Mr. ROGERS of Florida. Do you have a liaison between your Department and the Veterans' Affairs?

Secretary CELEBREZZE. Only to the extent of our vocational rehabilitation program that works with them in the program they have and also within part of our research work with the Veterans' Administration.

Mr. ROGERS of Florida. To what extent do you coordinate research work in the mental health field, Veterans' Administration?

Secretary CELEBREZZE. I have Dr. Felix here who is a consultant to the Veterans' Administration.

Dr. FELIX. I am Dr. Robert H. Felix, Director of the National Institute of Mental Health, Public Health Service.

Mr. ROGERS of Florida. To what extent do you coordinate your work with the Veterans' Administration work in the field of mental illness or mental health?

Dr. FELIX. I am a consultant to the Veterans' Administration, Department of Neurology and Psychiatry. A representative of the Veterans' Administration is an ex officio member of the National Advisory Mental Health Council, which is an advisory group to the Institute set up by law. In addition to these formal arrangements there are a great number of informal contacts back and forth all of the time using members of their staff as consultants and on special programs in our Institute and members of our staff act as special consultants to them in their programs both here and also elsewhere.

At the present time, for instance, we are working collaboratively on the study of the effectiveness of various tranquilizing drugs, in which they are working on certain aspects of the problem, we on others, and we are pooling our resources, both material, financial, and staff.

Mr. ROGERS of Florida. So you feel there is close coordination?

Dr. FELIX. Both close and cordial coordination, Mr. Chairman.

Mr. ROGERS of Florida. I noticed we were talking about problems from earlier and I know the plans are to build a large mental institution for veterans in Florida which would help alleviate the problem of some there. I wonder if that had been gone over and considered in presenting this particular legislation, the amount that the veterans themselves do for a portion of the appropriation.

Secretary CELEBREZZE. In preparing our proposed legislation, Congressman Rogers, representatives of the Veterans' Administration participated in our studies and program planning.

Mr. ROGERS of Florida. I see. And you will furnish us, then, with this; what they are doing and can take care of?

Secretary CELEBREZZE. We will furnish that for you for the record if it is available.

Mr. ROGERS of Florida. Now, as I understand it, for community mental health centers this legislation envisions 150 such centers?

Secretary CELEBREZZE. No; there would be 422 mental health centers. The figures of 150 applies to the mental retardation facilities.

Mr. ROGERS of Florida. I see.

Mr. HARRIS. I am hoping we can get the record clear on this. Now do you mean 150 mental retardation centers or $150 million for mental retardation?

Secretary CELEBREZZE. No; he is talking about mental health centers.

Mr. ROGERS of Florida. I know it.

Secretary CELEBREZZE. Under the mental health program there would be 422 community mental health centers provided.

Mr. HARRIS. That is under H.R. 3688?

Secretary CELEBREZZE. Yes. However, under H.R. 3689, the mental retardation program, there will be approximately 150 retardation facilities.

Mr. ROGERS of Florida. But you are also constructing 10 what?

Secretary CELEBREZZE. In addition, we are constructing 10 research centers for mental retardation.

Mr. ROGERS of Florida. So that is the total construction program that is envisioned by these two pieces of legislation?

Secretary CELEBREZZE. That is right.

Mr. HARRIS. I will pursue that further.

You testified a moment ago that $150 million would be authorized for the construction of facilities for the mentally retarded over the 5-year program?

Secretary CELEBREZZE. Yes. We are not talking about dollars and cents. His question was on how many units we are going to build.

Mr. HARRIS. I know, but I am talking about dollars and cents now.

Secretary CELEBREZZE. All right.

Mr. HARRIS. Is $150 million correct?

Secretary CELEBREZZE. Yes, $150 million is correct.

Mr. HARRIS. Then can we say that you anticipate a million dollars for each on an average?

Secretary CELEBREZZE. No; actually they run more than that—approximately $1.6 million per unit of which the Federal share would be $950,000, or approximately $1 million.

Mr. BROTZMAN. Would the gentleman yield?

Secretary CELEBREZZE. I can give you those.

Mr. BROTZMAN. May I make one statement? I am very confused about the interrelationships of these programs. I would hope there is a more graphic way to present this. I don't know if I am speaking for the other members of the subcommittee or not but as I listen to some of the questions I think we are all suffering from the same problem, Mr. Secretary.

Now I wonder if there is not a more graphic way of presentation. What I had intended to do, but the hour being as late as it is, I was going to ask for the document from which your expert is testifying which might help me to ask intelligent questions about these particular matters. First, as to the costs of the various programs, what part is broken down between operations and construction as has been asked? Secondly, if I understood some of your statements correctly I would assume part of the $128 million that we were discussing would not be in the budget under anticipated appropriations for new legislation as you answered.

Secretary CELEBREZZE. None of it.

Mr. COHEN. That is all 1963 existing programs, sir.

Mr. BROTZMAN. All right. I was partially correct in my surmise.

This would be budgeted in the 1963 budget as distinguished from the $556 million which would fall under the anticipated appropriations for new legislation, is that correct?

Secretary CELEBREZZE. That is correct. The new legislation would become operative in the 1965 budget and would spread over the 5-year period, 1965–69.

Mr. BROTZMAN. Going back without your answering the specific question, I hope I am in part able to——

Mr. COHEN. Why don't we give you this document that I read from, which not only gives the 1963 but as well the 1964, which I did not go into the details of. It is all spelled out and we will give each member

of the committee one and then you can see what is both the present program and as well what is the new program.

Mr. BROTZMAN. I think that is very helpful and that poses one more problem.

I submit this to the chairman. We need those to be able to intelligently ask you questions, or at least I can speak for myself. I know I have to have that information.

Secretary CELEBREZZE. Congressman, we sent what we referred to as an 801 to the committee which gives the costs of the program as defined by the bill. That is submitted.

Mr. BROTZMAN. Yes, sir; I heard you say you sent something and I am certainly not saying you didn't send it but I frankly have never seen it. I don't know if it has been available to me or not. I have not at this juncture seen that document. So in order to get down to the basic facts that I think we need to consider, I am going to go back and try to find it. I also believe we need those before us to be able to talk over and to ask you proper questions.

Mr. HARRIS. Will you identify this Document 801?

Mr. COHEN. The 801 document is the cost estimates required by Public Law 801 which we sent to the committee in connection with the legislation. We can easily make additional copies available with this.

Mr. ROBERTS. Let the Chair suggest that the copies of the 801 be made available to the committee and in the period between now and 2 o'clock the committee will review these documents and see if we can get the record straightened out this afternoon.

Is that agreeable?

Mr. HARRIS. I think so, but I won't be here this afternoon because I have another committee meeting. I want to pursue this just a minute.

I think I understand the first part of the H.R. 3689 program relative to mental retardation centers for research. I think I understand now what that is. It is nailed down. You propose to nail it down in the authorization here. However, I am not sure that I have gotten a clear picture of your grants for construction of mental retardation centers.

Now, as I understand it, you propose an authorization for the period of 5 years of a total of $150 million?

Secretary CELEBREZZE. That is right.

Mr. HARRIS. That is true?

Secretary CELEBREZZE. Yes.

Mr. HARRIS. That is to be matched on an average of 60 percent by the Federal Government and 40 percent by the States?

Secretary CELEBREZZE. Well, we take the average; yes.

Mr. HARRIS. That is anticipated?

Secretary CELEBREZZE. Yes.

Mr. HARRIS. Approximately that?

Secretary CELEBREZZE. Yes.

Mr. HARRIS. Now with that you propose to construct approximately 150 facilities throughout the Nation?

Secretary CELEBREZZE. That is right, average cost per unit of approximately $1,600,000 with the Federal share approximately $950,000.

Mr. HARRIS. Each?

Secretary CELEBREZZE. Yes.

Mr. HARRIS. Now do you have that broken down in your budget as to the annual requirements? In other words, 1965 is the first year. Beginning 1965 you have a 5-year program. Is this anticipated to be $30 million a year?

Secretary CELEBREZZE. No; starting in 1965 with $10 million; 1966, $20 million; 1967, $30 million; 1968, $40 million; and then $50 million in the last year.

Mr. HARRIS. That makes a total of $160 million.

Mr. COHEN. No; it is $150 million.

Mr. HARRIS. You are right, $150 million. That is true. Ending in 1970.

Mr. ROBERTS. Is that correct, ending in fiscal year 1970?

Secretary CELEBREZZE. 1969 would be the last budgetary period.

Mr. HARRIS. Beginning in fiscal year 1965 for a period of 5 years.

I think we need to develop this, Mr. Chairman, and I would like to take a few minutes on that.

Under the Hill-Burton program we have authorization for certain categories. One of those categories is for mental health.

Secretary CELEBREZZE. Yes.

Mr. HARRIS. What is that authorization, Dr. Terry?

Dr. TERRY. Dr. Haldeman who is Chief of our Division of Hospital Facilities, the Hill-Burton program, can give you the exact details.

Dr. HALDEMAN. Mental health facilities are made available in part C of the Hill-Burton program which provides for construction of hospitals, however, only about 3 percent of the funds under the Hill-Burton program have gone into mental health facilities.

Mr. HARRIS. That is not what I am asking. How many dollars are authorized for the category of mental health under the Hill-Burton program?

Dr. HALDEMAN. There is no specific category of mental health under the Hill-Burton program. It is contained under the——

Mr. HARRIS. Now we had four categories under the Hill-Burton program as we added to it. One is diseases.

Dr. HALDEMAN. That is right, sir. One is nursing homes, one is rehabilitation centers and the fourth is diagnostic and treatment centers.

Mr. HARRIS. Now which one of those categories are you using for mental retardation?

Dr. HALDEMAN. Mental retardation might be covered under more than one. It might come under the nursing home or if it is a rehabilitation center it would come under the rehabilitation category.

Mr. HARRIS. Under the nursing home category you would take normally those who are old and senile. That could not be considered retardation could it?

Dr. HALDEMAN. I believe we have approved several projects for the mentally retarded under the nursing home category.

Mr. HARRIS. Will you supply for the record the projects that you have approved under the Hill-Burton program, part B, is it not?

Dr. HALDEMAN. Part B.

Mr. HARRIS. Part B, applications for facilities for the mentally retarded.

Dr. HALDEMAN. I would be glad to, sir. Actually there are 37 projects we have approved involving Federal funds in the amount of about $12 million.

(The material referred to follows:)

Projects for the mentally retarded, approved under the Hill-Burton program as of Dec. 31, 1962

Location	Name of facility	Type of project	Total cost	Federal share	Status of project
Arkansas: Conway	Arkansas Children's Colony	D-T center	$248,362	$26,597	In operation.
		Rehabilitation	298,371	198,914	Do.
		Nursing home	265,866	177,244	Do.
Connecticut: Bridgeport	Kennedy Center	Rehabilitation	371,202	100,000	Under construction.
Delaware: Stockley	Hospital for the Mentally Retarded	do	285,200	140,000	Do.
Georgia: Gracewood	Gracewood Evaluation Center	do	666,000	333,000	Do.
Idaho: Nampa	Nampa State School	Mental hospital	1,328,297	478,297	Initially approved.
Illinois: Chicago	Misercordia Home	Nursing home	730,388	123,627	In operation.
Iowa: Iowa City	University Hospital	Rehabilitation	620,000	295,767	Under construction.
Kansas: Parsons	Parsons State Hospital and Training Center	do	785,704	392,852	Do.
Louisiana:					
Albany	Retarded Children's Home	Mental hospital	2,000,000	1,000,000	Initially approved.
		do	3,241,000	1,617,000	Under construction.
		Rehabilitation	600,000	300,000	Do.
Pineville	State Colony and Training School	Nursing home	776,235	388,117	In operation.
Mississippi: Ellisville	Ellisville State School	Rehabilitation	881,160	587,440	Under construction.
Missouri: Columbia	Woodhaven Christian Home	do	2,246,020	446,142	Do.
New Hampshire: Laconia	Laconia State School	Nursing home	111,000	37,500	Initially approved.
		Rehabilitation	52,000	26,000	Do.
New Jersey: Haddonfield	Bancroft School	do	547,298	175,274	Under construction.
New Mexico: Los Lunas	Los Lunas Hospital and Training School	Nursing home	264,000	132,000	Do.
		D-T center	266,600	133,300	Do.
		Rehabilitation	280,000	140,000	Do.
Ohio:					
Columbus	Columbus State School	Rehabilitation	690,000	230,000	In operation.
Tiffin	Betty Jane Center	do	579,294	193,098	Do.
Oklahoma: Sand Springs	Hisson Memorial Center	Mental hospital	1,418,127	600,000	Under construction.
Rhode Island: Exeter	Ladd School	Rehabilitation	675,699	112,956	Do.
		Nursing home	1,385,178	300,000	In operation.
South Carolina: Clinton	Whitten Village	Mental hospital	1,010,000	505,000	Under construction.
Texas:					
Abilene	Abilene State School	Rehabilitation	130,852	64,191	In operation.
		Nursing home	800,000	400,000	Under construction.
Denton	Denton State School	Rehabilitation	246,804	121,250	In operation.
		Nursing home	1,254,086	625,000	Do.
		do	924,870	469,500	Do.
		do	1,890,000	945,000	Under construction.
San Antonio	Incarnate Word College Rehabilitation Center	Rehabilitation	130,492	64,050	In operation.
Virginia: Arlington	George Mason Center	do	234,146	128,205	Do.
Wisconsin: Madison	Central Wisconsin Colony and Training School	do	2,654,716	360,000	Under construction.
Total, 37 projects			30,888,967	12,358,321	

Mr. HARRIS. All right. Now, what we do not want to get, Mr. Secretary, is a program which overlaps existing authority. I want to get it nailed down specifically because we are later going to have to meet the problem. We have already been meeting some of these problems and they have given us some concern.

So what I want to do is to be sure we put each authorization where it belongs. If part of this program is now covered by the Hill-Burton program, inadequate as it might be, all of it ought to be put here where it belongs.

Secretary CELEBREZZE. We will clarify that for the record.

Mr. HARRIS. I think Mr. Cohen probably will give some thought to this. We don't want a program under which you do exactly the same thing that you do under another one and duplicate the other program in another way. I believe it would be better to get all the program under one roof.

Mr. ROGERS of Florida. I think it would be helpful, I know it would be to me, to have this same type of approach made on every program where there is an overlap. For instance, on NIH, we have a research staff for this and tie in all of this research and let us know exactly what we do have. Our community facilities bill, I think there might even be an overlap there as I recall the bill on some of these centers. I think it would be helpful to the committee if we could have that information as to where the overlap exists.

Secretary CELEBREZZE. So that there is no misunderstanding, then what the committee wants is all the existing programs which touch on mental health and mental retardation.

Mr. ROGERS of Florida. And building of these facilities, yes.

Dr. TERRY. Mr. Chairman, I would like to explain that we have already taken that under consideration and the construction of facilities here is allocated to the Federal Hospital Council for review, for instance in both the mental retardation and mental health facilities. Furthermore there is a provision in the bill which increases the number of members of that Council with specific representation from these areas of mental health and mental retardation. Now this has to do with the construction of the care facilities. On the research side, the bill provides for the research facilities to be administered through our research facilities construction program at the NIH.

So there is already in the plans and in the stipulation of these bills provisions to be sure that these are administered hand in glove with existing authority.

Basically it does not represent and will not represent an overlap.

Mr. ROGERS of Florida. Just for my own knowledge, and I think the committee, we want to go into it ourselves to clear our minds of possibility of authorization and so on.

Dr. TERRY. Surely.

Mr. ROBERTS. I think that we are fairly well satisfied with the explanation on 3689, but some of the members have expressed a desire to come back this afternoon and to get further clarification of H.R. 3688. With that in mind, the Chair would recess the hearings until 2 this afternoon.

Mr. Secretary, I know you are quite busy and if you are not available just make the staff available to us this afternoon.

That will be satisfactory to the committee.

Secretary CELEBREZZE. Thank you.

(Whereupon at 12:20 p.m., a recess was taken until 2 p.m., of the same day.)

AFTERNOON SESSION

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

I think in view of the questions and some of the answers this morning it might be best for us to clarify certain points that have been in the record in the administration and that we start with a presentation on the mental health bill and, Mr. Jones, if you would go through that and review for us or offer for the record, with comment, the portions of 801 you have been kind enough to supply us with, I think it would be very helpful.

So if you would direct your presentation to the mental health bill, and then have Secretary Cohen present the mental retardation program, I think we can get this record in good order.

STATEMENTS OF BOISFEUILLET JONES, WILBUR J. COHEN, AND DR. LUTHER L. TERRY—Resumed

Mr. JONES. Thank you, Mr. Chairman.

First, the Secretary asked to be excused, as you offered to excuse him, and asked that the staff continue with the hearing as you may direct.

Supplementing the Secretary's opening statement, Mr. Chairman, I think it would be well at this time, if it is satisfactory to you, to have in the record three tables which describe and break down the costs for the proposed community mental health centers, the mental retardation facilities, and the related programs.

Mr. ROGERS of Florida. Aren't we going to take one bill at a time?

Mr. ROBERTS. That is correct. But the way the charts are made up I think what you have to do is put the whole thing in the record and then refer to the mental health part of it as he goes along in his testimony and then let Mr. Cohen do the same thing on mental retardation.

I say that, because you will note on the first page, the first statement is estimated cost of mental retardation and mental health programs for fiscal years 1964 through 1969, and although they are set out separately I think we will have to let the gentlemen separate them as they go throughout their testimony but we will without objection admit the entire 801 statements of these three, is that correct?

Mr. JONES. That is correct, Mr. Chairman.

(The material referred to follows:)

Estimated cost of mental retardation and mental health programs for fiscal years 1964 through 1969

[In thousands of dollars]

	Mental retardation		Mental health	
	Appropriations	Expenditures	Appropriations	Expenditures
Centers for mental retardation research	30,000	26,800	----------	----------
Mental retardation facilities	150,000	71,000	----------	----------
Direct program expenses, mental retardation	1,730	1,575	----------	----------
Community mental health centers	----------	----------	330,000	177,500
Initial staffing of mental health centers	----------	----------	204,000	189,000
Direct program expenses	----------	----------	2,965	2,760
Total	181,730	99,375	536,965	369,260

COMMUNITY MENTAL HEALTH CENTERS ACT OF 1963

Estimated cost of program for fiscal years 1965 through 1969 (the life of the bill)

[In thousands of dollars]

Item	1964	1965	1966	1967	1968	1969
Appropriation requirements:						
Grants for—						
Construction of community mental health centers		$35,000	$50,000	$65,000	$80,000	[1] $100,000
Initial staffing of facilities			17,000	38,000	62,000	[1] 87,000
Direct program expenses		130	310	665	910	[1] 950
Total		35,130	67,310	103,665	142,910	[1] 187,950
Expenditures:						
Grants for—						
Construction of community mental health centers		3,500	12,000	34,000	53,000	75,000
Initial staffing of facilities			15,000	35,000	57,000	82,000
Direct program expenses		115	280	615	850	900
Total		3,615	27,280	69,615	110,850	157,900

	Appropriation	Expenditures
Recapitulation:		
Construction of community mental health centers	$330,000	$177,500
Initial staffing of facilities	204,000	189,000
Direct program expenses	2,965	2,760
Total	536,965	369,260

[1] Assumed appropriation amounts—not included on form 801.

NOTE.—Appropriation amounts are based on the form 801 approved by the Bureau of the Budget. Expenditures for construction of facilities were computed on the basis of experience in the hospital construction program (Hill-Burton program) which shows that 10 percent of the funds appropriated in a given fiscal year will be expended in that year; 20 percent of such funds will be expended in the 2d year; 50 percent in the 3d year; and 20 percent in the 4th year.

Cost details for Mental Retardation Facilities Construction Act, 1964–69

[In thousands of dollars]

Item	1964	1965	1966	1967	1968	1969
Appropriation requirements:						
Grants for construction of:						
Centers for research	$6,000	$8,000	$6,000	$6,000	$4,000	
Facilities		10,000	20,000	30,000	40,000	[1] $50,000
Direct program expenses	50	150	250	360	460	460
Total	6,050	18,150	26,250	36,360	44,460	50,460
Expenditures:						
Grants for construction of:						
Centers for research	300	1,900	5,300	7,000	6,300	6,000
Facilities		1,000	4,000	12,000	22,000	32,000
Direct program expenses	40	130	225	330	420	430
Total	340	3,030	9,525	19,330	28,720	38,430

[1] Assumed appropriation amounts—not included on form 801.

NOTE.—Appropriation amounts are based on the form 801 approved by the Bureau of the Budget. Expenditures for construction of facilities were computed on the basis of experience in the hospital construction program (Hill-Burton program) which shows that 10 percent of the funds appropriated in a given fiscal year will be expended in that year; 20 percent of such funds will be expended in the second year; 50 percent in the third year; and 20 percent in the fourth year.

Approximately the same formula was used in computing expenditures for research centers.

Mr. JONES. The first table before you contains the estimated cost of both the mental retardation and mental health programs. For mental health, Mr. Rogers, you refer only to the lower half of this table.

The second table refers only to community mental health centers and related operating costs. I think we can now proceed with a consideration of these tables.

What is contemplated in the mental health program, Mr. Chairman, is an effort to transfer the care of the mentally ill from custodial institutions operated almost exclusively by the States, to community facilities and services whereby those who have mental and emotional problems, can be served in their communities in a way comparable to the services provided for those who are physically ill.

What is contemplated then, in the first title of this bill is a grant-in-aid program to States to permit Federal participation in the construction of local mental health facilities. These facilities are to provide a continuum of services for the mentally ill, which would include activities related to prevention, counseling services, diagnosis of mental illness, treatment, both in inpatient operations, primarily in general hospitals that have inpatient psychiatric units, and in outpatient treatment through related clinics, day care programs for those who can go home in the evening but need to be under supervision during the day, night care for those who are able to work or to carry on normal activities during the day but need to be under supervision and treatment and care at night, and to provide for rehabilitation activities such as sheltered workshops, the training from which would lead to employment on a full-time basis in productive capacities.

There would be available an emergency walk-in service so that those who are struck with acute conditions will have immediate access to care through these comprehensive community mental health centers.

Now, it is contemplated that these centers, to be comprehensive in nature, would provide for most of these services. Some of these services now exist in communities in the form of a psychiatric unit in a general hospital.

To make this a more comprehensive community mental health center would require only the addition of an outpatient clinic, the addition of day and night care, the addition of diagnostic services, the addition of a sheltered workshop, rehabilitation unit; any one or all of these activities to be included under one coordinated program for the community serving a geographic area which is generally defined.

The program would permit the building under a State plan of any one, two, three, or four of the facilities to meet these needs.

In other words, each project in and of itself would not necessarily include all the services. It would be supplementary to services that already exist to form a comprehensive program in a community.

The bill provides that a State will prepare a comprehensive plan for mental health care in the State, will survey the needs, will survey the facilities, and will make provision for priorities.

Projects then would be presented to the State agency and a single State agency would administer the program as determined by the State. We would assume that many States would choose to have the program administered by the same agency that administers the Hill-Burton program, because the general provisions for a statewide plan track precisely with the original provisions under the Hill-Burton

program which preceded the award of construction grants by a statewide plan.

The money that would be available then would be utilized for local projects as approved by the States. The difference in this program and the Hill-Burton program, would be in two regards: Whereas psychiatric facilities hospitals can be built under the Hill-Burton program, the experience of the past 15 or so years has been that priority has been given community by community, State by State, to general hospital bed construction rather than to psychiatric facilities.

This occurred for two reasons: One is that the program was designed to give priority to those areas that were short of general hospital facilities.

The second is that insofar as communities have been concerned, the need for general beds took priority anyway over the need for psychiatric facilities.

This bill, then, is designed to provide a stimulus to the State to give special attention to the need for psychiatric facilities, to move the care of the mentally ill into the community and out of these large State mental institutions.

The fact that this money would be specifically authorized only for community mental health facilities would mean that these would be given first and only consideration, and the program would move ahead as a stimulus to communities and the State.

There is one other feature of this bill which requires special legislation, and that is that the matching formula for the program is more advantageous than the existing matching formula under the Hill-Burton program.

Whereas the Hill-Burton program provides for matching from approximately 35 to 65 percent, this particular bill will provide Federal matching from 45 to 75 percent. This is to provide an additional stimulus to communities and States to develop these facilities. This is the program of facility grants-in-aid.

It uses the pattern of Hill-Burton. It uses the techniques and the administrative mechanisms of the Hill-Burton program. The programs will be coordinated in the Department through the Federal Hospital Council which is the statutory advisory council for the Hill-Burton program.

The bill provides that this council will be expanded from 8 to 12 members to take into account additional members especially versed in problems of mental illness.

I think the question of possible overlapping or duplication need not necessarily be a consideration in relation to this particular proposal.

Now, Mr. Chairman, I will stop at that point to see if there are questions on the construction aspects of the program as presented.

Mr. ROBERTS. I think this, it might be well for you to move over to the recapitulation column on page 2 and take the $330 million and show how it is to be programed by year, by each year in the program, and then explain to us the meaning of initial staffing of facilities, and the meaning of the direct program expenses.

Then, I think that will give us a pretty good picture of the financing involved.

Mr. JONES. Well, then, if I am to present the financing of additional staffing, I think I had better speak to the second part of the bill, since there are two titles, two features of the bill.

Mr. ROBERTS. All right.

Mr. JONES. The second part of the bill has to do with the initial staffing of comprehensive community mental health centers.

Since the basic purpose of this legislation is to provide for comprehensive care of the mentally ill in the community, special emphasis is given here to encourage the development of such centers which provide at least the minimum of the range of services to qualify as a comprehensive center.

This is as contrasted with a community that starts its program by building one or two or three parts of a facility with the expectation that in another 3 or 4 years it would add to this to develop a comprehensive program.

If a project that receives a grant under title I of this program for building a comprehensive mental health center, includes at least four of the services related to a comprehensive center, and these minimum services would be diagnostic services, inpatient care, outpatient care and day and night care, if these services are available, then under the definition in the bill related to title II, this project then would qualify for a grant-in-aid for support of the staffing costs for the first 4 years of the operation of this comprehensive center.

Now, the staffing costs would be related only to those people who were employed in addition to those who were related to such a center prior to the approval of the project, the new construction.

The reason for this, Mr. Chairman, is that communities undertaking a comprehensive mental health program, and these would be primarily for the first time, do not really understand the services that can be rendered, have had little, if any, experience in the care of the mentally ill, or have had such experience in isolated units, often operating under varying auspices, so that when the comprehensive, continuum of services becomes available, it would seem important, as an additional stimulus, to move this program ahead rapidly, to assist in staffing this center for a definite and short period of time in decreasing amounts.

Therefore, the bill proposes that the new staff brought into service at the center will be eligible for Federal assistance up to 75 percent for the first 15 months of operation.

Mr. ROBERTS. Thank you very much for your presentation. I think you are doing a splendid job but the thing is before I pass on, these people to be trained would receive, you say, some Federal assistance.

Would they work and receive training?

Mr. JONES. This would be, the staffing of the center for service to the mentally ill. They would be psychiatric social workers, they would be clinical psychologists, and under State-operated or voluntary hospital auspices that oversaw one of these centers, it might be a psychiatrist who is full time on the staff. It would be psychiatric nurses, it would be the staff that provides the basic service comparable to the staff of the hospital.

Mr. ROBERTS. Then at the end of the 4-year period you propose under this bill the Federal Government steps out of the picture.

Mr. JONES. That is right.

Mr. ROBERTS. So far as any staffing is concerned?

Mr. JONES. That is correct.

Mr. ROBERTS. That becomes then a local responsibility?

Mr. JONES. That is right, and it is expected that during this period of 4 years, with the decreasing participation by the Federal Government, 75 to 60, to 45 to 30 percent, in the ensuing 4 years, the cost of operating the center, will be picked up by the traditional financing patterns of the care of physically ill in the community.

In other words, the individuals who would be served at the center, would pay the costs of their care just as they pay a hospital bill. They will be there only a limited period of time, because experience shows that under treatment provided by a center of this kind, treatment will result in a very short stay, relatively, as contrasted with a very long stay when the patient is sent initially to a large State mental institution.

So the costs will be cut considerably. The care will be intensive and related to the needs of the patient, and the patient can pay for this himself as he does a hospital bill.

Now, it is our purpose to promote through the Department by direction of the President, as indicated in his health message, the inclusion of mental illness through this kind of pattern in voluntary health coverage programs, voluntary insurance programs for hospitalization, and other medical care.

Also those who are subject to care from public funds will be given the care in these service centers and will compensate for that care just as is done now for physical illness in general hospitals.

These are charges of the State or the county. Those who are medically indigent, who are cared for by third parties, by the State, by local government, by insurance programs, or who pay their own bills.

So what we are really advocating, Mr. Chairman, is in a sense removing the care of the mentally ill from complete, almost complete, responsibility of the State through tax funds and direct operations in these isolated large State mental institutions, and putting this care back in the community to be financed and supported and operated through the traditional patterns of medical care to which we have become accustomed in this country. This means providing for the mentally ill in precisely the same pattern that we provide for the physically ill.

But we think that some grant-in-aid support of the kind envisioned in this proposal will be important to encourage and to stimulate communities to develop the comprehensive center that will make possible caring for the emotionally disturbed, the mentally ill, and to assist in preventing mental illness through training of ministers, of social workers, of teachers, of police officers, of juvenile court representatives in the community in order that mental health will be promoted.

That is the concept of the operating support for a limited period of years.

Now, if you would like, Mr. Chairman, I can give you the figures on both of these programs.

Mr. ROBERTS. The figures, I think are before us, and will be made part of the record.

Mr. JONES. Yes.

Mr. ROBERTS. I think that is clear enough.

Now, as to direct program expenses. What will that come to?

Mr. JONES. That is the relatively small cost for administration of the program by the Federal Government, Mr. Chairman. The staffing

is in the Public Health Service to provide the backup, administrative support to administer the program.

Mr. ROBERTS. Do you have any estimates as to how many personnel would be involved in this administrative burden?

Mr. JONES. It is on a table that we will submit for the record, Mr. Chairman.

Mr. ROBERTS. It is your belief that this type program will change the pattern of these services from the present one or two or more State institutions to several community-type facilities?

Mr. JONES. That is quite correct; yes, sir.

Mr. ROBERTS. Have you gone into the proposition of whether or not there may be some reluctance on the part of patients or their families in going to a facility in the community as against going to a State institution?

Mr. JONES. I think the opposite is true, Mr. Chairman. I think the American public now has a much more enlightende attitude toward mental illness than was true even 10 years ago. I think this has come about primarily because medical science has found ways to treat mental illness with dramatic success.

The tranquilizing drugs have made quite an impact on the management of mental illness, and I think people are increasingly coming to the viewpoint that mental illness is an illnes, and not a result of a scourge or condemnation for which the individual is responsible.

I think we have a much more enlightened attitude. The President's message embracing these programs, was intended to make it abundantly clear that there is a problem that we, as a nation, have failed to recognize and failed to respond to that must receive national attention and receive it quickly and in great volume to catch up with the laxity of the past years.

Mr. ROBERTS. In the Secretary's presentation this morning we have around 17 million people affected.

Mr. JONES. Who are suffering some form of emotional disturbance from mild all the way to very severe mental illness. This doesn't mean they are all in hospitals or all need to be. But the point is that many of these unless they have access to the kind of guidance, counseling, advice or care that they need when the first evidences of emotional disturbance, whether it is a child who cant' get along well in his classroom, who with guidance and care could be guided properly, and forestall a much more serious illness, or a seriously disturbed adult. This is what the 17 million figure means.

There are that many people who do have emotional disturbances who would respond or need to respond to proper professional care.

Mr. ROBERTS. Can you give us some guidelines as to the type of patient who would be received in this institution?

Mr. JONES. In a comprehensive community?

Mr. ROBERTS. Yes; just in a general way.

Mr. JONES. It may well be a 16-year-old youngster who has been at odds with the law, and who has been at odds with the law because of some inability to adjust to the society around him.

A resentment, an emotional disturbance, which could be handled with proper care of a trained, not necessarily a psychiatrist, but a trained counselor or a trained clinical psychologist. This individual would be responsive to treatment in such a center. He would be diag-

nosed when he first came in by a team of people especially versed in identifying the nature of the problem that the individual had.

Then in consultation with the mother or the father or the teacher or whatever environmental condition may be partly or completely responsible for a problem there, the youngster would be saved, would not become a criminal in later years, and would then be a beneficiary as would society, of the availability of this kind of service in this community.

Mr. ROBERTS. Would these services be available for cases of alcoholism?

Mr. JONES. They would. Alcoholism is, as my professional friends tell me, a very difficult problem to deal with. There is a basic underlying psychiatric problem related to alcoholism, and certainly there would be an effort through these centers to deal with this problem.

Mr. ROBERTS. What about the case of the nonservice connected veteran, would he have this service?

Mr. JONES. Yes, I would expect that the service would be available to him.

Mr. Rogers brought up the question of the Veterans' Administration activity in mental illness.

I think, Mr. Chairman, that about half of the beds in VA hospitals are devoted to the mentally ill.

Mr. ROBERTS. Very difficult to claim even for the service-connected veteran, I know from my experience as do these two gentlemen.

Mr. JONES. The Veterans' Administration has done a very, very good job of bringing treatment to those who are brought into their hospitals. In fact, they have pointed the way to much of what is now known in the way of treatment of the mentally ill. I think it would be important, though, to recognize, as the Veterans' Administration I am told does, that to provide adequately for those who are in their hospitals they must also provide, as some of their hospitals are now doing, for a continuum of services, other than just the inpatient institutional care of the kind, that is envisioned in this bill.

Mr. ROBERTS. Thank you very much.

Mr. Nelsen?

Mr. NELSEN. I wondered about the old saying that there is nothing so permanent as something temporary.

Now, this program is supposed to phase out. Do you anticipate any difficulty looking out ahead when it begins to phase out, and the pressure coming on again to get the Federal Government back in on the original basis?

Do you anticipate the phaseout would be easily accomplished, or what is your feeling about that?

Mr. JONES. It is never very easy, Mr. Nelsen, to give up help once given. But the very limited nature here of a 4-year program, with the grants predicated on a diminishing percentage, I think the phaseout is, and the pattern that is proposed, would give about as much assurance for a complete phasing out as almost anything we could devise.

I would say that it would not be a difficult problem at all to phase out these programs.

Mr. NELSEN. Another point that was mentioned this morning in the testimony, that the veterans' hospitals were inadequate to meet the need, well now, of course, there is Federal support there. It would

seem to me that perhaps we had failed in some respect there, and why should we assume that this program would meet the need when another Federal program has failed to meet it in some areas.

Mr. JONES. On the contrary, Mr. Nelsen, the Veterans' Administration has done a very good job relatively in meeting the needs as they existed at the time they had gotten into the care of the mentally ill.

With the techniques they are now applying to the treatment of the mentally ill, their results are quite remarkable.

The question is not so much whether they have done well with what they have, which is primarily an inpatient service in a hospital. What we are saying now is that medical science has advanced in terms of mental health to the point that treatment can now be given outside of a hospital and prevent the inpatient service as a requirement.

The amount of time that would be required in a hospital could be greatly reduced if there were a facility that could adequately serve the patient other than as an inpatient in a hospital, and at considerably less expense, both as to the actual cost and the time involved.

Mr. NELSEN. I have no further question. I wish to thank the gentleman for his very good testimony. Thank you.

Mr. ROBERTS. Mr. Rogers?

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

Now, in setting up these centers of which you say there would be about 400 as I recall?

Mr. JONES. Well, may I clarify that point just a minute, Mr. Rogers.

No two of these centers will be exactly alike. They will be patterned to the needs of the community, to the existing facilities of the community.

What we are saying is that a comprehensive center of the kind we envision would cost an amout of money which, when added to the average of 40 percent provided locally would result in about 422 such centers.

Now, we have some that are more costly than the average, and we may have many projects that are far less costly.

My guess is that even though we project 422, as an average number that could be taken care of under this program, the actual number of individual projects would be somewhat larger than this.

So that is something I wanted to make clear, that these are not precise patterns that are situated community by community but are molded and modeled to the needs and wishes of the community.

Mr. ROGERS of Florida. Now this, of course, envisions a 5-year program and you anticipate it will probably be plus or minus 400-some-odd at the end of the 5 years, is that correct?

Mr. JONES. Correct.

Mr. ROGERS of Florida. Now, how many personnel do you require to handle this?

Mr. JONES. I can give you for the record, Mr. Chairman, a breakdown of the staffing pattern for it.

Mr. ROGERS of Florida. I think we need that.

Mr. JONES. I could either read it to you or give it to you for the record. It probably will be easier to provide you with the pattern of a typical comprehensive community mental health center. I can do that likewise for the costs involved.

(The material referred to follows:)

Staffing pattern of a community mental health center [1]

	Outpatient clinic	Day and night care	Emergency services	Acute inpatient service	Research and evaluation	Total number [2]	Amount
Psychiatrists	5	2	2	1		10	$190,000
Psychologists	4	2	1	1		8	93,800
Social workers	4	2	1	1		8	67,280
Nurses	2	10	1	6		19	133,570
Health educators	2					2	19,960
Occupational therapists		3		1		4	30,760
Rehabilitation counselors		2				2	19,960
Recreation therapists		2		1		3	23,070
Clerical	8	5		3	2	18	75,870
Aids		20		12		32	134,880
Research analysts					2	2	23,450
Total						108	812,600

[1] Based on 100,000 population.
[2] In addition, approximately 55 persons would be employed in supportive activities such as housekeeping, food service, laundry, and logistical service activities, at a cost of $220,000 per year.

Mr. ROGERS of Florida. I think that would be necessary for the committee.

Now, generally without going into great details, how many really trained personnel must there be in a center, would you say? I realize I am not concerned too much with specifics but generally.

Mr. JONES. The table which I will submit for the record, Mr. Chairman, will show that there will be approximately 108 professional or subprofessional personnel required for a comprehensive center serving approximately 100,000 people. These would be——

Mr. ROGERS of Florida. This is not the retardation, this is your mental health. All right.

Mr. JONES. This is the comprehensive community mental health center.

Mr. ROGERS of Florida. Now, for 100,000 population, would be required about 108 trained personnel?

Mr. JONES. That is correct.

Mr. ROGERS of Florida. How many would you say would have to be doctors out of that, what do you envision?

Mr. JONES. Of this number only 10 would be psychiatrists.

Mr. ROGERS of Florida. Doctors or psychiatrists?

Mr. JONES. That is correct.

I think it is important, Mr. Rogers, at this point to recognize that there are practicing physicians in communities who have emotionally disturbed patients who could treat those patients adequately if they had the facilities and the supporting personnel just as they do now in hospitals in the community.

Not having these facilities, the only recourse the practitioner has is to send the patient off to one of these large mental institutions.

So that I think what we are coming to as a pattern whereby most of these 17 million would be cared for other than by psychiatrists and that the psychiatrists would be called upon just as a neurosurgeon or some other specialist is called upon for the more acute, the more difficult, but the psychiatrist would be available to the general practitioner, to the internist, to the pediatrician, all of whom have this problem.

Mr. ROGERS of Florida. How many nurses would you envision now?

Mr. JONES. Nineteen nurses would be envisioned for this center.

Mr. ROGERS of Florida. Would these centers normally be built in communities less than 100,000 or is it your idea that you would not put a center of this type in communities of less than 100,000.

Mr. JONES. This would depend on the pattern of community health service, Mr. Rogers.

For example, if a community of 40,000 people had a general hospital that serves a much larger geographical area than just the town itself, it may well be that a rather comprehensive center would be built in relation to this hospital and operated as a part of the total community health care service.

So that there is no precise answer.

Mr. ROGERS of Florida. Yes.

Mr. JONES. I would hope, of course, as the program developed there would be such centers modeled to the needs of the people in a contiguous geographical region available to most of our population. Obviously the larger metropolitan areas would be considerably involved, but the rural areas would have access through this kind of regional pattern to the same sort of service.

Mr. ROGERS of Florida. Well, frankly what concerns me and is on my mind about this, where are we going to get the personnel? I realize we have got H.R. 12 which this committee has reported out to aid some problem. But if we were to place, for instance, 400 of these at the end of 5 years with 10 psychiatrists in each of those, that is 4,000 psychiatrists at the end of a 5-year period.

Mr. JONES. But some of these psychiatrists, Mr. Rogers, are already practicing in the communities.

Mr. ROGERS of Florida. Yes.

Mr. JONES. Some are practicing in State mental institutions and the program envisions that the patient load of a State institution will be cut by half, probably within 10 years, if this program is really mounted, and many of these personnel can be moved into community services.

Mr. ROGERS of Florida. I can see that can happen maybe in 10 or 15 years but it seems to me it would be difficult within the 5 years.

Mr. JONES. Well, you see it takes a while to develop these facilities.

Mr. ROGERS of Florida. Yes.

Mr. JONES. Meanwhile we have provided through authorization that you have already made effective, an additional emphasis to the training of psychiatrists, to the training of psychiatric nursing.

Mr. ROGERS of Florida. That will probably take what, 7 or 8 years to start those people, won't it?

Mr. JONES. Not necessarily. The trend in the last 10 years has been up in terms of the number of psychiatrists as related to other physicians. I think it has gone from 4 to 6 percent. I can put this in the record if you would like.

(The material referred to follows:)

MENTAL HEALTH MANPOWER

The major professional mental health fields are the four core groups of psychiatric nursing, psychiatry, psychology, and social work. As the needs in mental health become more comprehensive and as the efforts to improve mental health become more extensive, however, an increasing number of professional groups are becoming more important to services and research in mental health. Such professions as occupational therapy, teaching, the clergy, and research

scientists in the biological and social sciences are all making contributions. In addition, other workers such as psychiatric aides and nurse attendants provide all-important services.

The documentation of a shortage of trained mental health manpower in the four core professions has already been made by the Joint Commission in its monograph on "Mental Health Manpower Trends." It should be noted that the present mental health manpower shortage masks the fact that over the past 15 years the growth in the mental health professions has been relatively rapid. Psychiatry, clinical psychology, and psychiatric social work have each grown more rapidly than their total respective fields. Psychiatry has been one of the most rapidly growing medical specialties over the decade from 1950 to 1960, increasing almost 2½ times in that period while the total number of physicians increased less than 25 percent. In 1950, psychiatrists represented approximately 3 percent of all active physicians. This figure increased so that by 1960, psychiatrists represented approximately 6 percent of all active physicians. Psychiatric social work also increased almost 2½ times in the same decade, while the total social welfare personnel increased about 40 percent. Clinical psychology is today the largest subspecialty in psychology and has grown vigorously in the past 15 years.

In toto, the number of persons with recognized graduate training in the four core mental health professions increased almost 2½ times between 1950 and 1960, while the grand total in all health professions increased about 30 percent over that same period of time.

In the light of known information on mental health manpower, and taking into account certain assumptions as to output from training centers, it is possible to estimate the supply of mental health manpower for the years 1965 and 1970. These 2 years are convenient points for illustrating expected trends in supply and in utilization.

THE MAJOR PROFESSIONAL GROUPS

Supply

Table 1 shows total numbers in the four major professional groups in 1960 and projections for 1965 and 1970. In each of the four core fields it is important to recognize that the mental health professionals represent only a proportion of the total generic field. As of 1961, in medicine, approximately 11 percent of all residencies were in psychiatry. In psychology, approximately one-third of all Ph. D.'s were in clinical psychology. In social work, about 25 percent of all graduate students specialized in psychiatric social work. In both psychology and social work, however, relevance to mental health has extended beyond these subspecialties so that it is fair to say that almost half the psychologists and almost 40 percent of the social workers are working in areas of relevance to mental health. In nursing, within a grand total of 500,000 active professional nurses, about 3 percent or 15,000 can be identified with psychiatric nursing.

In medicine and in nursing, therefore, there is considerable potential for increasing the mental health components by modest increases in the proportions in psychiatry and in psychiatric nursing. And even in psychology and social work there is some opportunity to increase the mental health components by increased availability of training in these areas of specialization.

TABLE 1.—*1960 estimates for mental health personnel and projections for 1965 and 1970*

Field	Estimated total number		
	1960	1965	1970
Psychiatry	13,000	17,800	23,504
Clinical psychology	9,000	13,505	20,560
Psychiatric social work	7,200	11,294	16,557
Psychiatric nursing	15,000	17,021	25,885
Total	44,200	59,620	86,506

Utilization

The deployment of the mental health personnel at the present time is not known exactly because of a number of complicating factors. Comprehensive manpower information by type of setting is only now in the process of development. Furthermore, many professional personnel have multiple positions and work part time in two or more settings. This is especially true of psychiatrists and psychologists. Nonetheless, present utilization and estimates of future deployment indicate that the staffing of the community mental health centers will be possible if supply increases as expected in table 1.

OTHER PROFESSIONAL GROUPS

While the four core professions represent the major resource for professional manpower, other professionals, including teachers, lawyers, policy, the clergy, and research personnel in the biological, behavioral, and social sciences will play an important role in the future improvement of the Nation's mental health.

The research personnel in the biological, behavioral, and social sciences are already making important contributions to mental health. In 1961, approximately 200 individuals in these fields (excluding psychology) were receiving Federal stipends for graduate and postgraduate training relevant to mental health. Here again, as with the mental health specialties, these are individuals within larger professional identifications; psychopharmacologists, biochemists, anthropologists, and sociologists, all concentrating on research of relevance to mental health. This pool must be increased. With further Federal support a total of 500 could be in training in 1965 and 1,000 by 1970.

In addition, there is need for occupational therapists, recreational therapists, and rehabilitation counselors. According to 1960 data, there were approximately 10,000 persons in toto in these categories, of which less than half were employed in mental health settings. The requirements for the community mental health centers alone by 1970 may well equal the present total number of persons in these settings.

SUBPROFESSIONAL AND TECHNICAL PERSONNEL

The largest single group of subprofessional persons is that of the psychiatric aids. Taking into account all needs, the present pool of 100,000 aids should be increased to 180,000 by 1970. Equally important to an increase in numbers is an improvement in quality of both presently employed and future aids. While no firm data are available, it is known that only a very small proportion of the presently employed aids have had any effective training. Some form of short-term intensive training is needed.

In summary, it is clear that there are two major components of the manpower supply and utilization in the future. On the one hand, there is the already documented need for increased numbers in the four core mental health professions. With an increase in Federal support for graduate training in these fields it should be possible to raise the 1960 level of 44,200 to 59,600 in 1965 and to 86,500 in 1970.

The other major component includes other professional groups and subprofessional and technical personnel working in the field of mental health. Additional expenditures will be needed to provide the manpower in these groups. A large proportion, if not all, of the cost of training will need to come from Federal funds.

The total funding required to provide adequate personnel is itself a measure of the magnitude of the job. It is pertinent to reemphasize that the relatively rapid increase in manpower in the decade between 1950 and 1960 has not met the even more rapidly increasing demand. While it is anticipated that the rate of growth outlined by the projections for 1965 and 1970 will close the gap, these are based on feasible estimates of supply and not based on anticipated demand alone. Indeed, it is not unlikely that demand for services in the field of mental health and illness will continue to outstrip the supply of personnel as these very services become more readily available and as the public gains even greater acceptance of the importance of mental health.

Mr. ROGERS of Florida. We are going to be asked questions like this.

Mr. JONES. Yes.

Mr. ROGERS of Florida. They are going to want to know. You tell us we have got to have more doctors, we don't have enough now in H.R. 12 when we take that to the floor. When we take this bill to the floor they will say now you are asking us to build facilities that will require more physicians than we can possibly supply because H.R. 12 will barely keep us up with with what we need presently.

Mr. JONES. One of the answers to this question, Mr. Rogers, and I don't want to minimize the problem.

Mr. ROGERS of Florida. I would like to have the answer.

Mr. JONES. Because we have a general shortage of health personnel across the board, but mental health is one of our—is our greatest health problem. There is no reason why at least some additional ratio of our health personnel should not be devoted to a health condition which is our No. 1 problem.

So even——

Mr. ROGERS of Florida. I have no objection to that.

Mr. JONES. Yes, Doctor.

Dr. TERRY. May I say something there, Mr. Rogers?

I think when you talk about H.R. 12 you realize, of course, we are talking about a very narrow category of professional personnel. In H.R. 12 that will not become effective in terms of increasing the turnout for several years.

More important to this program is the fact that in the National Institute of Mental Health for many years we have been training both professional and technical personnel. I just consulted with Dr. Felix and he said that they had participated in the training of personnel of one category or another over the 15-plus years of the National Institute of Mental Health, something like 18,000 persons.

Mr. ROGERS of Florida. These are not doctors?

Dr. TERRY. Some are doctors, some are psychologists, some are nurses, some are technicians, various categories of personnel, including general practitioners, who have been taken for a year's special training in psychiatry, not to become psychiatrists but to become better general physicians and to realize when they need a psychiatrist. So that I think one of the things is that in this field, we literally have a takeoff point in terms of the training job the Federal Government has supported in recent years toward the building up and implementing of this program.

Mr. ROGERS of Florida. That is encouraging. I think it would be helpful for us to have those facts, perhaps a chart where you show what has been done, how many psychiatrists we do have in the country in relation to the problem, whether we have a shortage, an overage, what the prospects are, because this is of real concern to me.

I just wonder where we are going to get them all if we build these facilities and I don't see much point in building them unless we have an adequate staffing, because it seems to me that the staffing is more important than going around building buildings.

I know you have in this bill, as I recall, you have appropriations for training, too.

Mr. JONES. Not in this bill, but we do under existing authorities.

Mr. ROGERS of Florida. Not in that bill. Just staffing?

Mr. JONES. Just the operating staff for a comprehensive center.

Mr. ROGERS of Florida. I see.

That is phased out at the end of 5 years as I recall.

Mr. JONES. Four years; yes, sir.

Mr. ROGERS of Florida. Four.

Dr. TERRY. Mr. Rogers, in speaking of psychiatrists alone, if I may just give you this, in 1950 psychiatrists represented approximately 3 percent of all of the active physicians.

In 1960, they represented approximately 6 percent, in other words, double in terms of the ratio percentage in 10 years time.

It is anticipated that if this rate continues to increase in the manner it has in the past decade, that by 1970 we will have 21,000 psychiatrists in this country, and they will constitute approximately 8 percent of all of the active physicians.

This is the sort of thing that I am talking about, that we have been working on over a period of years, and this is true of other professional and subprofessional personnel in the field of mental health.

So that we have moved, and we are ready to move and we expect to continue because we have this authorization and we have gotten the generous support of Congress in terms of supporting this sort of training over many years.

Mr. ROGERS of Florida. Now, as psychiatry has increased has there been a decrease in any other phase of medical training?

Dr. TERRY. You mean any other specialty?

Mr. ROGERS of Florida. In other words, have we gotten psychiatrists interested in this field, where they have as a result, drawn away from other medical fields or has it just been an increase in training of doctors?

Dr. TERRY. I think the pattern you see is this, that over the period of the last two decades, there has been an increasing tendency to specialization in all lines of specialty.

Mr. ROGERS of Florida. Yes.

Dr. TERRY. And psychiatry is one of those.

Obviously in terms of the overall quantity available they must be taken from some place.

Mr. ROGERS of Florida. Yes.

Dr. TERRY. But in general, the decrease we have seen has been among the general practitioners rather than among any other specialty group.

Mr. ROGERS of Florida. Really this has become a problem now, hasn't it, on the fact we are having such a decrease in our——

Dr. TERRY. Frankly, I think the medical schools and medical profession are going to have to devote a great deal more attention in the coming years to the question of training fine general practitioners in order that we might meet this need, because I think this is one of our real serious shortage areas at the present time.

Mr. ROGERS of Florida. Just a question or two more and then I will be finished here.

Would it be possible for a single project now to receive a greater percentage of its construction costs than under the formula provided in this bill by making applications under other Federal programs like Hill-Burton?

Mr. JONES. No, sir.

Mr. ROGERS of Florida. This is not contemplated?

Mr. JONES. This provides for a better matching advantage to projects approved in the mental health center.

Mr. ROGERS of Florida. Yes.

Now, what happens to your staffing grant of matching funds if the project is only constructed in the last year?

Mr. JONES. The bill provides, Mr. Rogers, that only projects that have been constructed as a comprehensive mental health, community mental health centers under the terms of this bill will be eligible for an operating grant.

Mr. ROGERS of Florida. So they would still be eligible as long as they are constructed within a time period——

Mr. JONES. No, sir, only if it is constructed with money from this program. If it is already under construction without participating in this particular program, it will not be eligible for an operating grant.

Dr. TERRY. He is talking of an example where it is completed as a comprehensive center in 1968 or 1969.

Mr. ROGERS of Florida. It is covered for the next 4 years?

Mr. JONES. Oh, yes.

Mr. ROGERS of Florida. Is there any reason why you picked the amount of up to 75 percent as Federal contribution, why not 50–50?

Mr. JONES. On the construction?

Mr. ROGERS of Florida. Yes.

Mr. JONES. Because, Mr. Rogers, under the existing 50–50 program, we felt that the stimulation to communities that have been reluctant through the years to give special recognition to mental health would not be sufficient.

Therefore, we felt that as a matter of principle, there should be matching, but we felt that, with a 75-percent ceiling on matching rather than a 65-percent ceiling on matching, there would be a greater impetus to get on with this job which they need so badly to do quickly.

Mr. ROGERS of Florida. Yes.

Does Hill-Burton go up to 75?

Mr. JONES. No, sir, it goes to 66⅔ percent.

Mr. ROGERS of Florida. Yes.

Mr. JONES. What we have done in this proposal is to give added stimulus to the community mental health center by raising the floor from one-third to 45 percent, and raising the ceiling from 66⅔ to 75 percent. Under the same formula that is used for Hill-Burton.

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

Mr. ROBERTS. Thank you, Mr. Rogers.

Thank you very much, Mr. Jones. I congratulate you on a very good presentation.

Mr. JONES. Thank you, sir.

Mr. ROBERTS. Now, this morning after talking with several members of the committee, we decided that this particular part was the part that was really in greater need of clarification, but I would like for you, Mr. Secretary, to go ahead and make your presentation on mental retardation pretty much as Mr. Jones has on the mental health and then I think we will have the picture before us.

Mr. COHEN. Mr. Chairman, what I thought I might do as I go along is prepare for your use a rather orderly record by putting the appropriate material in the record so that you will have it as you go through.

Mr. ROBERTS. Without objection.

Mr. COHEN. First, of course, the Mental Retardation Facilities Construction Act of 1963, H.R. 3689, consists of two parts similar to the

fact that there are two parts in the community comprehensive mental health program, but the two parts have striking differences.

The first part deals with the mental retardation research centers, and the second part deals with the mental retardation facilities.

In discussing these two parts I would like first to insert in the record that portion of the President's message that covers just this mental retardation aspect which will give you the background.

Mr. ROBERTS. Without objection.

(The material referred to follows:)

EXCERPTS FROM THE PRESIDENT'S SPECIAL MESSAGE TO THE CONGRESS OF FEBRUARY 5, 1963, ON MENTAL ILLNESS AND MENTAL RETARDATION RELEVANT TO CONSTRUCTION OF MENTAL RETARDATION RESEARCH CENTERS AND MENTAL RETARDATION FACILITIES

Our single greatest challenge in this area is still the discovery of the causes and treatment of mental retardation. To do this we must expand our resources for the pursuit and application of scientific knowledge related to this problem. This will require the training of medical, behavioral, and other professional specialists to staff a growing effort. The new National Institute of Child Health and Human Development which was authorized by the 87th Congress is already embarked on this task.

To provide an additional focus for research into the complex mysteries of mental retardation, I recommend legislation to authorize the establishment of centers for research in human development, including the training of scientific personnel. Funds for 3 such centers are included in the 1964 budget; ultimately 10 centers for clinical, laboratory, behavioral, and social science research should be established. The importance of these problems justifies the talents of our best minds. No single discipline or science holds the answer. These centers must therefore, be established on an interdisciplinary basis.

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Because care of the mentally retarded has traditionally been isolated from centers of medical and nursing education, it is particularly important to develop facilities which will increase the role of highly qualified universities in the improvement and provision of services and the training of specialized personnel. Among the various types of facilities for which grants would be authorized, the legislation I am proposing will permit grants of Federal funds for the construction of facilities for (1) inpatient clinical units as an integral part of university-associated hospitals in which specialists on mental retardation would serve; (2) outpatient diagnostic, evaluation, and treatment clinics associated with such hospitals, including facilities for special trainng; and (3) satellite clinics in outlying cities and counties for provision of services to the retarded through existing State and local community programs, including those financed by the Children's Bureau, in which universities will participate. Grants of $5 million a year will be provided for these purposes within the total authorizations for facilities in 1965 and this will be increased to $10 million in subsequent years.

Such clinical and teaching facilities will provide superior care for the retarded and will also augment teaching and training facilities for specialists in mental retardation, including physicians, nurses, psychologists, social workers, and speech and other therapists. Funds for operation of such facilities would come from State, local and private sources. Other existing or proposed programs of the Children's Bureau, of the Public Health Service, of the Office of Education, and of the Department of Labor can provide additional resources for demonstration purposes and for training personnel.

Mr. COHEN. Secondly, I would like to insert in the record the letter of February 11, 1963, from the Secretary of Health, Education, and Welfare outlining the provisions of the bill.

Mr. ROBERTS. Without objection.

(The material referred to appears on p. 25.)

Mr. COHEN. Third, I believe that it would be desirable to include in the record the document from which I testified this morning which presents—it is entitled "The Mental Retardation Program of the U.S. Department of Health, Education, and Welfare, Fiscal Year 1964"—which presents the entire program of the Department in this field and contains in the back the figures for fiscal 1963 on existing programs, the proposed activities for 1964 under existing authority, and the proposed new legislation and the total which consists of not only the legislation that we are talking about before this committee, of course, but other legislation pending in a number of other committees so that you have the whole picture of what the Department is doing in this area.

Mr. ROBERTS. Without objection.

(The information referred to follows:)

MENTAL RETARDATION PROGRAM OF THE U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, FISCAL YEAR 1964

(Prepared by the Secretary's Committee on Mental Retardation, U.S. Department of Health, Education, and Welfare)

SECRETARY'S COMMITTEE ON MENTAL RETARDATION

MEMBERSHIP

Office of the Secretary:
- Mr. Luther W. Stringham, Chairman.
- Mr. Wallace K. Babington, Staff Assistant to the Committee.
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- Dr. William H. Stewart.

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- Dr. Joseph Bobbitt.
- Dr. Clifford Cole.
- Dr. Jack C. Haldeman.
- Dr. Donald Harting.
- Dr. Richard L. Masland.
- Mr. Allen Pond.

Office of Education: Dr. Romaine P. Mackie.

Vocational Rehabilitation Administration: Dr. Morton A. Seidenfeld.

Welfare Administration:
- Mr. Charles E. Hawkins.
- Mr. Rudolf Hormuth.
- Dr. Arthur J. Lesser.
- Mrs. Mary M. Steers.

Food and Drug Administration: Dr. Irwin Siegel.

SUMMARY

The program to combat mental retardation, which the U.S. Department of Health, Education, and Welfare has proposed to the Congress, totals $204,723,000 for fiscal year 1964.

The recommended program for fiscal year 1964 is an increase of $76,219,000 over the total of $128,504,000 for mental retardation activities estimated for fiscal year 1963.

The program extensions and improvements proposed for fiscal year 1964 are in accord with the President's special messages to Congress on mental illness and mental retardation (Feb. 5, 1963) and on education (Jan. 29, 1963). They also are responsive to recommendations contained in the report of the President's Panel on Mental Retardation.

Activities already underway and the additions proposed for fiscal year 1964 break down as follows:

	Fiscal year 1963	Fiscal year 1964
Programs under present authority:		
Research, training, services, and other activities relating to prevention and treatment	$31,704,000	$51,048,000
Public assistance and social security payments to persons disabled because of mental retardation	96,800,000	111,300,000
Activities for which new legislation is proposed		42,375,000
Grand total	128,504,000	204,723,000

CURRENT ACTIVITIES OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

During fiscal year 1963 funds for mental retardation activities of the Department of Health, Education, and Welfare will total an estimated $128,504,000. These activities may be grouped under five main categories: (1) research and studies; (2) professional preparation; (3) services; (4) construction of facilities; and (5) income maintenance. A listing of the programs approved by Congress in prior years and presently underway follows:

Research and studies

Intramural and extramural support programs of the National Institute of Mental Health and the National Institute of Neurological Diseases and Blindness of the Public Health Service.

The Office of Education programs of studies, surveys, and cooperative research.

Special project grants under the maternal and child health program of the Children's Bureau, Welfare Administration.

Research and demonstration projects of the Vocational Rehabilitation Administration.

Professional preparation

Vocational Rehabilitation Administration grants to educational institutions for training of personnel for all phases of rehabilitation.

Teaching and training programs of the Public Health Service, including the grant programs of the National Institutes of Health and the Bureau of State Services.

Office of Education training grants to colleges and universities and State educational agencies for leadership positions in education of the mentally retarded.

Services

Consultation by the Office of Education to State and local school systems, educational personnel, and voluntary groups.

Collection and dissemination by the Office of Education of comprehensive basic statistics and reports concerning the education of exceptional children, including the mentally retarded.

Consultation and technical services of Children's Bureau staff to State and local communities under the maternal and child health and the child welfare services programs.

Consultation and technical services to State rehabilitation agencies under the Vocational Rehabilitation Administration programs.

Consultation and technical assistance to State and local agencies provided by program representatives of the regional offices of the Department of Health, Education, and Welfare.

Activities relating to the application of knowledge to problems of mental retardation through the neurological and sensory disease service program of the Bureau of State Services, Public Health Service.

Construction

Facilities for the mentally retarded under the hospital and medical facilities construction program of the Bureau of State Services, Public Health Service.

Income maintenance

Payments to mentally retarded persons under the public assistance program of aid to the permanently and totally disabled of the Welfare Administration.

Payments by the Social Security Administration from the old-age and sur-

vivors insurance trust fund in behalf of persons whose disability commenced before age 18 and continued thereafter.

EXPANDED AND NEW ACTIVITIES PROPOSED FOR FISCAL YEAR 1964 UNDER EXISTING AUTHORITY

A number of extensions and improvements in programs relating to mental retardation authorized under existing legislation are included in the President's budget for fiscal year 1964. Increases from $31.7 million in fiscal year 1963 to $51 million in fiscal year 1964 are proposed for research, training, services, and other activities relating to prevention and treatment. The additional funds for next year would permit an expansion of programs in fiscal year 1964 as follows:

1. The Public Health Service, through the National Institutes of Health, would support a wide range of research explorations; evaluate new methods of cases finding, diagnosis ,care, and rehabilitation; explore preventive measures; support, in institutional settings, projects for the care of the mentally retarded and aimed at testing and utilizing research findings; increase the numbers of postdoctoral fellowships and increase support of training for relevant scientific and clinical personnel; provide support for inservice training by State institutions; and furnish professional and technical assistance designed to assure acceleration of the dissemination and utilization of scientific and clinical findings.

2. The Public Health Service would provide funding for the new National Institute of Child Health and Human Development, which was authorized at the last session of Congress. The program of the new Institute would provide an additional resource for attacks on the causes and prevention of mental retardation in the context of the basic processes if human development. Program areas that would receive early attention in the new Institute would be research centers for the study of developmental abnormalities and perinatal biology; research projects related to premature infants, biological and behavioral development of the mentally retarded, the biological relationships between the mother and fetus with specific attention to the effects of drugs on the developing individual during pregnancy, childhood, and later life; training programs; national and international conferences; and dissemination of research information relevant to mental retardation.

3. Through the Bureau of State Services, the Public Health Service would support a wide range of professional training and community service activities for patients, families, and physicians directed toward the application of knowledge in prevention, early detection, diagnosis, treatment, and rehabilitation; the development of a demonstration training center for medical and allied medical personnel; and the development of a demonstration service center for a comprehensive community approach to mental retardation.

4. The Children's Bureau would promote research and demonstration projects in child welfare, with special emphasis given to projects related to mentally retarded children and their families; and expand the collection and dissemination of statistical information and a variety of special studies relating to mentally retarded children such as laws and legal procedures.

5. The Office of Education would support and conduct research in the learning process; expedite, through the establishment of research and demonstration centers, the application of research findings to actual teaching programs for the mentally retarded; and conduct studies on the improvement of curriculums, professional preparation of teacher training, the characteristics of children in need of special education, and the development of teaching aids.

6. The Vocational Rehabilitation Administration would initiate 25 additional research and demonstration projects, mainly in the areas of occupational centers for the mentally retarded, and of special education-vocational rehabilitation cooperative programs; develop centers for intensive training of counselors, social workers, pathologists, audiologists, workshop personnel, placement specialists, and research workers in the vocational rehabilitation of the mentally retarded; and expand State rehabilitation services to the retarded.

In addition to the extension and improvement of the research, training, services, and related activities listed above, increases also will occur in payments made under the public assistance and social security programs in behalf of mentally retarded persons. These payments are made by the welfare administration under the program of aid to the permanently and totally disabled and by the Social Security Administration from the old-age and survivors insurance trust fund in behalf of mentally retarded persons who are dependents of retired wage earners or survivors of deceased wage earners. Payments made under

these programs will increase from $96.8 million in fiscal year 1963 to an estimated $111.3 million in fiscal year 1964.

NEW LEGISLATION TO COMBAT MENTAL RETARDATION

Funds are included in the President's 1964 budget for a number of legislative proposals which would increase the scope of the national programs to combat mental retardation. These proposals, some of which are directed specifically to the problem of mental retardation and some of broader application which have provisions relating to mental retardation, would authorize the appropriation of $42.3 million in 1964, as follows:

New obligational authority, fiscal year 1964

Legislative proposal:	
Maternal and Child Health and Mental Retardation Planning Amendments of 1963 (H.R. 3386):	
Grants for planning comprehensive action to combat mental retardation	$2,200,000
Increase in maternal and child health services	500,000
Increase in crippled children's services	500,000
Project grants for research relating to maternal and child health and crippled children's services	500,000
Project grants for maternity and infant care	5,100,000
Mental Retardation Facilities Construction Act of 1963 (H.R. 3689, S. 756):	
Grants for construction of centers for research on mental retardation and related aspects of human development	6,050,000
Grants for construction of facilities for the mentally retarded	[1]
Vocational Rehabilitation Act Amendments of 1963	2,525,000
National Education Improvement Act of 1963 (H.R. 3000, S. 580):	
Training of teachers of handicapped children and research and demonstration projects in education of handicapped children	5,000,000
Special projects or programs directed toward improving educational quality and opportunity	20,000,000
Total	42,375,000

[1] Would begin in fiscal year 1965.

Each of these proposals is described in the sections that follow.

Grants for planning comprehensive action to combat mental retardation

This proposal would authorize a one-time appropriation of $2.2 million for grants to assist the States (including the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa) to plan for and take other steps leading to comprehensive State and community action to combat mental retardation.

Any such grants to a State would be used to determine what action is needed to combat mental retardation in the State and the resources available for this purpose, to develop public awareness of the mental retardation problem and of the need for combating it, to coordinate State and local activities relating to the various aspects of mental retardation and its prevention, treatment, or amelioration, and to plan other activities leading to comprehensive State and community action to combat mental retardation.

In order to be eligible for grants a State would be required, among other provisions, to assure full consideration of all aspects of services essential to planning for comprehensive State and community action, including services in the fields of education, employment, rehabilitation, welfare, health, and the law, and services provided through community programs for and institutions for the mentally retarded. Grants will be awarded on a selective basis to State agencies presenting acceptable proposals for this broad interdisciplinary planning activity.

Increase in maternal and child health services

The Social Security Act authorizes grants to State health agencies for services for promoting the health of mothers and children, especially in rural areas and in areas suffering from severe economic distress. The States must provide matching funds for one-half of the amount appropriated; the remainder is not matched and is distributed to the States on the basis of the financial need of each State for assistance in carrying out its State plan.

The law now authorizes $25 million annually for these grants.

This proposal would increase the amounts authorized for annual appropriation for maternal and child health services from the present $25 million as follows:

	Millions
For the fiscal year ending June 30, 1964	$30
For the fiscal year ending June 30, 1965	35
For the fiscal years 1966 and 1967	40
For the fiscal years 1968 and 1969	45
For the fiscal year 1970 and each year thereafter	50

During the fiscal year 1964 part of the increased funds—an estimated $500,000— would be expended on programs for the mentally retarded. This amount would increase in subsequent years.

The expansion of maternal and child health services would contribute to the reduction of infant and maternal mortality. The States would be in better position to keep pace with increased demands for these services as the child population continues to increase. More mentally retarded children could be served through special diagnostic clinics for these children provided through State maternal and child health programs. In 1961 over 15,000 children, as compared with 12,000 in 1960, received services through clinics. Despite this increase, applications for these services continue to exceed the resources of the clinics.

Increase in crippled children's services

The Social Security Act authorizes grants to State crippled children's agencies for services for locating crippled children and for providing medical, surgical, corrective, and other services and care, and facilities for diagnosis, hospitalization, and aftercare for children who are crippled or who are suffering from conditions which lead to crippling.

The States must provide matching funds for one-half of the amount appropriated; the remainder is not matched and is distributed to the States on the basis of the financial need of each State for assistance in carrying out its State plan. The law now authorizes $25 million annually for these grants.

This proposal would increase the amounts authorized for annual appropriation for crippled children's services from the present $25 million as follows:

	Millions
For the fiscal year ending June 30, 1964	$30
For the fiscal year ending June 30, 1965	35
For the fiscal years 1966 and 1967	40
For the fiscal years 1968 and 1969	45
For the fiscal year 1970 and each year thereafter	50

During the next fiscal year part of the increased funds—an estimated $500,000—would be expended on programs for the mentally retarded. This amount would increase in subsequent years.

The increased funds under the proposal would encourage and assist States to keep pace with the following needed developments already underway in crippled children's programs: (1) further broadening of the definition of "crippling" until all State crippled children's programs would serve children with any kind of handicapping condition or long-term illness; (2) the removal of unreasonable barriers to eligibility for services such as State requirements for court commitments or residence status; (3) extension of the programs to urban areas; (4) the development of outpatient centers for handicapped children organized and staffed to provide the comprehensive services needed by children with all types of handicapping conditions, thus bringing together the services now being provided in many separate clinics; (5) the development of home-care programs for the aftercare of homebound children following their hospitalization; (6) the development of inpatient and outpatient facilities appropriate for adolescents; (7) the provision of special services for children who are both deaf and blind;

and (8) the development of demonstration centers for the early care of children with paraplegia and quadriplegia brought about by accident or disease.

Project grants for research relating to maternal and child health and crippled children's services

Under its basic act of 1912, the Children's Bureau may conduct its own studies, but it does not have authority to make grants or enter into other cooperative financial arrangements for research studies.

A few research projects have been supported through the grants under the Social Security Act made to State agencies for maternal and child health and crippled children. While these programs are doing much to improve the health of mothers and children, they could be even more effective if accompanied by an adequate program of research directed toward the evaluation of program services and their improvement.

This proposal would enable the Secretary of Health, Education, and Welfare to make grants for research in maternal and child health or crippled children's programs. They could be made to public or other nonprofit institutions of higher learning and public or other nonprofit agencies and organizations engaged in research or in maternal and child health or crippled children's programs. Contracts for this purpose could also be made with such groups and with other private research groups and individuals. Congress would determine the sums to be used for this program. The President's budget for 1964 includes $2.1 million for these purposes, of which an estimated $500,000 would be for work in the field of mental retardation.

This proposal would enable the Children's Bureau to carry out more adequately its responsibilities in child health research, as complementary to and coordinated with the program of the National Institute of Child Health and Human Development.

The research under this proposal would contribute to improving the development, management, and effectiveness of maternal and child health and crippled children's services throughout the country.

Project grants for maternity and infant care

The prevalence of mental retardation is higher in those population groups where maternity care is inadequate. The rate of premature births is higher among these groups, and the rate of mental retardation is substantially higher among premature infants than among full-term infants. Women who are most likely to have premature babies, with the resultant increased proportion of mentally retarded and brain-damaged children, are predominantly women in families with low incomes, who receive little or no prenatal care and who have complications of pregnancy. There are increasing numbers of women, especially in our larger cities, who are receiving inadequate maternity care.

Complications of pregnancy are more prevalent among families with low income than in the rest of the population. For women with complications of pregnancy, it is of critical importance that good maternity care be provided during the prenatal period, labor, and after delivery. Their babies, especially if premature, will require intensive nursing care in hospitals. To improve this situation, the President's Panel on Mental Retardation recommended that a nationwide program should be launched concentrating on these high risk groups.

Under this proposal the Secretary of Health, Education, and Welfare would be authorized to carry out a 5-year program of grants to provide necessary health care to prospective mothers who are unlikely to receive all necessary health care because they are from families with low income or for other reasons. In addition to health care during pregnancy, the care would include, following childbirth, health care to mothers and their infants. The health care would be available particularly for prospective mothers who have or are likely to have conditions associated with childbearing which increase the hazards to the health of mothers or their babies, including those which may cause physical or mental defects in the infants.

The annual appropriation authorized for these grants and their administration would be $5.1 million for the fiscal year ending June 30, 1964.

The grants would be available to the State health agency or, with the consent of such agency, to the health agency of any political subdivision of the State. The grant would not exceed 75 percent of the cost of any projects.

This program would help to reduce the incidence of mental retardations caused by complications associated with childbearing. Of paramount importance would be efforts to decrease the number of premature births among which there

are notably larger numbers of children born with handicapping conditions, including mental retardation.

The grants would enable health departments to provide comprehensive maternity care to selected high-risk patients and to improve greatly the quality and adequacy of care for these mothers and their babies by paying for their care in hospitals equipped and staffed to provide services of high quality for mothers suffering from complications of pregnancy.

This program also would increase the availability of prenatal clinics and bring them closer to the population served, so that patients could be seen earlier and complications recognized and treated in their early stages. It would reduce overcrowding in the public hospitals. It would contribute to increasing our knowledge of ways of reducing childhood disability that is related to damage during childbirth.

Grants for construction of centers for research on mental retardation and related aspects of human development

Because of the increased birth rate, a decrease in infant deaths, and the longer life expectancy that has resulted from medical advances, the total number of mentally retarded persons in this country is growing. Unless major advances in prevention are made, it is expected that by 1970 the number will exceed 6 million, of whom at least one-half will be children.

Even though significant progress has been made in understanding the mysteries of normal and abnormal human development in recent years, the unsolved questions remain many and complex. Only continued research in numerous and diverse scientific disciplines can uncover all the factors affecting the origin and development of mentality.

Scientists from a variety of research disciplines are searching for clues that will enable them to understand the influences on mental development and provide insight into the many causes of mental retardation. The disciplines represented by these investigators include genetics, biochemistry, neurophysiology, brain chemistry, biology, embryology, epidemiology, virology, neurology, and psychology.

Their research efforts range from studies seeking a greater understanding of the processes in cell division which cause abnormalities, to clarification of the effect of specific neurohormones on brain function, studies of the effect of pharmacological agents on fetal development, development of accurate guides for identifying specific abnormalities in the young, and attempts to gain wider insight into the complex factors affecting a child's psychological development.

Under this proposal, grants would be made for the establishment, in universities or other research institutions or organizations throughout the country, of centers for research on mental retardation and related aspects of human development. These grants, which would provide $6 million in fiscal year 1964, would assist in meeting the cost of construction of facilities for research relating to human development, whether biological, medical, social, or behavioral. Research would be aimed toward finding the causes and means of preventing or ameliorating the effects of mental retardation.

In terms of the size and seriousness of the challenge, the research effort in mental retardation has been very modest. While a number of specific conditions that produce retardation have been identified, by far the largest number of cases result from incompletely understood physical, psychological, environmental, or genetic factors. These many unknowns deserve the attention of the Nation's medical research talents and skills.

The establishment of a number of new centers for research in mental retardation would help meet this objective. It would add to our store of basic knowledge about the functioning of the human brain and the development of man's capacities. It would provide the fundamental prerequisites for a successful attack on the complex and many-sided problem of mental retardation.

Grants for construction of facilities for the mentally retarded

About 96 percent of the Nation's 5.4 million mentally retarded people are cared for outside of residential institutions.

Few of the mildly retarded require institutional care, but a great number of the moderately retarded and almost all the severely retarded ultimately require care in a facility that provides not only educational and training programs but also medical treatment for complicating physical problems.

Only those portions of homes for the mentally retarded which provide an active diagnostic, treatment, or nursing service are eligible for aid under the

Federal-State hospital construction program. Relatively few projects of this nature have received Hill-Burton aid, and even this limited assistance does not help with the improvement and expansion of the educational, training, and residential services provided in these institutions.

It is proposed that a 5-year Federal program of grants to the States and territories be authorized to assist in the construction, expansion, remodeling, replacement, and equipping of facilities for the mentally retarded. The allotments would make possible the construction of facilities for medical diagnosis and treatment, education and training, sheltered workshops, and custodial care of the mentally retarded. Also included would be facilities for special training of doctors, nurses, and other professional personnel.

Beginning in fiscal year 1965, the annual appropriations authorized for these grants would be in amounts that Congress determines. The Secretary of Health, Education, and Welfare would make allotments from appropriated funds to the States on the basis of population, the extent to which the mentally retarded in the State need the facilities, and the financial need of the State. However, no allotment for any year may be less than $100,000, other than those made to the Virgin Islands, American Samoa, and Guam. Construction of facilities associated with colleges and universities would be emphasized.

The construction of new or expanded community facilities for the care of the mentally retarded would enable communities more adequately to bring all the benefits of modern medical knowledge and modern educational and training techniques to bear on behalf of the mentally retarded.

New patterns of care would evolve that are based, to a considerable extent, on the specific treatment needs of the retarded individual. Programs could be planned for a wide range of deficiencies, including long-term lifespan plans for some and other kinds of care and rehabilitation programs for the moderately and mildly retarded. The result would be a system of facilities tailored to the dimension of the need.

Vocational Rehabilitation Act Amendments of 1963

Seven amendments to the Vocational Rehabilitation Act are proposed which would assist in the rehabilitation of an additional number of the handicapped, including those who are mentally retarded, to productive and satisfying life. These are:

(*a*) *Expansion of programs for Vocational Rehabilitation Services.*—This amendment proposes a 5-year incentive grant program to States and other nonprofit groups to plan and initiate a further expansion of rehabilitation programs in States which seem to have a high potential for increasing the number of persons who could be rehabilitated and employed.

Many communities would be aided to start programs for those with types of disabilities who have not been helped much previously—the cerebral palsied, the deaf, or the retarded. Other localities would be able to expand markedly programs already underway.

(*b*) *Rehabilitation facilities.*—One of the basic requirements for effective service to the severely disabled is to have available modern rehabilitation facilities. Under the Hill-Burton facilities construction program, a substantial beginning has been made in improving rehabilitation clinics and centers associated with hospitals.

A comparable effort is needed in connection with those facilities which are primarily of a vocational nature, along with workshops in which the disabled person's work potential can be evaluated and job training given.

The proposed amendment would authorize a 5-year program involving Federal assistance to plan, build, equip, and initially staff rehabilitation facilities and workshops. Enactment of this amendment would enable the Vocational Rehabilitation Administration to begin to help States and communities to provide those additional resources.

(*c*) *Experimental projects.*—In many communities local public funds from a variety of sources such as the school systems, hospitals, and welfare departments could be made available to the States to help in the rehabilitation of handicapped local residents. Heretofore, these resources ordinarily have not been used for the vocational rehabilitation of their residents.

This amendment would permit Federal matching of such funds in the same manner and at the same rate as other State funds are matched. Local rehabilitation resources would be expanded, improvements made in existing services, and the numbers of disabled people given services would increase.

(*d*) *Duration of extension and improvement projects.*—State rehabilitation agencies have developed over 300 projects for the extension and improvement of rehabilitation services. These projects have contributed significantly to the development of specialized programs needed in the rehabilitation of the severely disabled and other hard-to-rehabilitate cases. Such projects are financed 75 percent by Federal funds and 25 percent by State resources. This amendment would extend from 3 to 5 years the favorable rate of Federal funds for these developmental projects.

(*e*) *Services to determine rehabilitation potential of the disabled.*—At the present time, services of the State-Federal vocational rehabilitation program can be provided only to disabled persons who, after initial evaluation, are considered to have a reasonably clear vocational potential.

This proposal would allow Federal funds to be used to help provide vocational rehabilitation services for a period of 6 months to selected handicapped persons whose vocational capabilities cannot be predicted as favorable at the outset.

In the case of mentally retarded persons and other persons with disabilities especially designated by the Secretary, the period could be extended to 18 months. During this time a more adequate evaluation of the real capacity of the mentally retarded could be undertaken. Their eligibility for more and complete help toward self-sufficiency and employment could be determined.

Under this proposal the State vocational rehabilitation agencies would work with more disabled public assistance cases, thus helping to return more people to self-help and employment and to reduce the high social and economic costs of their continued dependency.

It would mean that larger numbers of the mentally retarded would be prepared by the vocational rehabilitation agencies to assume a more productive and satisfying role in society.

No special Federal funds would be required to carry out this change in the method of evaluating disabled clients.

(*f*) *Flexibility in State administration.*—Under existing Federal law the State vocational rehabilitation program must be located either in the State education agency or a separate State vocational rehabilitation agency. These choices have seemed somewhat limited and unnecessarily restrictive in some States where efforts to streamline State governmental structure are underway.

This proposal would broaden the choice of administrative locations so that, in addition to the present options, the State vocational rehabilitation agencies could be located in a State agency which also includes major public health, public welfare, or labor programs. The vocational rehabilitation agency, however, would be retained as an organizationally complete agency of State government so that the administration and the operating staff would be a separate, effective entity in carrying out the vocational rehabilitation program. No additional Federal funds would be required.

(*g*) *Inclusion of private contributions.*—The present law is not clear on the point whether voluntary contributions of funds from private organizations to the State for expanding rehabilitation facilities and workshops may be matched with Federal funds (in the same manner as State funds from State tax sources). Such matching already is authorized in law in various other programs, such as the Hill-Burton Act for hospital construction.

This amendment would make clear that voluntary conrtibutions to States may be matched with Federal funds for expanding rehabilitation facilities and workshops. It would also clear up existing situations where donations are in question.

This amendment would encourage voluntary State-Federal cooperation in expanding, altering, and equipping more rehabilitation facilities and sheltered workshops for the handicapped and thereby lead to increases in the number of handicapped people who receive rehabilitation services and return to employment.

Total costs for these amendments to the Vocational Rehabilitation Act for fiscal year 1964 are estimated at $5.8 million. Of this total, it is estimated that $2.5 million would be for programs for the mentally retarded.

Teachers of the mentally retarded

Six million children and young people in the United States should have special education to help them progress, but for many of them no special educational opportunity exists. About 1½ million of these children are mentally retarded. A similar number have serious emotional problems which hold back their learning.

At the present rate of progress by States and local communities in providing educational opportunities, by 1968 only a little more than one-third of the Nation's mentally retarded children would be given the special educational attention they require.

Because of a lack of qualified teachers, only about one-fourth of our 1½ million school age mentally retarded children have access to the special education they need.

The President's Panel on Mental Retardation estimated that about 75,000 special teachers are needed to provide specialized instruction to all retarded children and youth in the United States. At present there are only 20,000 of these teachers, many of them not fully qualified to teach.

Legislation passed in 1958 authorizes grants to institutions of higher learning for training personnel who can, in turn, train teachers of mentally retarded children and grants to State educational agencies to assist them in providing training of teachers of mentally retarded children and supervisors of the teachers.

This proposal would amend the 1958 law to include all handicapped children, and the institutions could receive grants for training teachers of handicapped children, as well as the supervisors of the teachers. They would also receive grants for the training of specialists and research personnel for work with handicapped children.

The present limitation of $1 million per year would be increased to an authorization of $11.5 million for fiscal 1964 and such sums as Congress may determine for the following 2 fiscal years.

There would also be authorized $2 million annually for fiscal 1964 and the following 2 years for grants to States, State or local educational agencies, colleges and universities, and other public or nonprofit private educational or research organizations for research and demonstration projects relating to the education of handicapped children.

For fiscal year 1964, the proposal would authorize funds totaling $15 million for these purposes, including training teachers of the deaf. Of this amount, $5 million would be for the training of teachers and educational personnel for mentally retarded children and for research and demonstration projects in this field.

This program would help overcome the shortage in numbers of teachers for the mentally retarded by: (1) providing part of the cost of the initial preparation of teachers of the mentally retarded; (2) providing fuller or complete preparation for those teachers of the mentally retarded now only partially prepared; and (3) giving present teachers of the mentally retarded refresher-type courses or new knowledge to help them become more effective.

Special projects for the education of the mentally retarded

Distinctive educational problems have arisen in urban slum areas and in rural depressed areas. Two migrations of large numbers of people have contributed to these problems: The exodus of urban people to the suburbs and the migration of low income and generally large families from rural areas to the so-called gray areas that lie between the commercial districts of cities and the better residential sections.

Culturally deprived children, who can expect little if any help from their home and neighborhood environment, must look to their schools for the hand up they will need to attain satisfying, productive lives as adults. There are many of them. Ten or more years ago in the large central cities, 1 child in 10 was considered culturally deprived. That ratio today is 3 in 10. Children with environmental or other handicaps, living in depressed rural areas, likewise need special opportunities in education.

One part of the administration's proposal for assistance to elementary and secondary education, which totals $400 million for fiscal year 1964, includes special projects or programs directed toward improving educational quality and opportunity in the public schools, particularly for educationally deprived children in slums or other economically depressed urban or rural areas.

Not more than 20 percent of the allotment to each State may be used for such special projects, but at least 10 percent (or $40 million of the $400 million allotment) would have to be used for projects for such educationally deprived children. It is estimated that some $20 million of these projects would assist in removing or ameliorating conditions that produce mental retardation.

The proposal would pay part of the cost of demonstration or experimental programs by local educational agencies, public or nonprofit private agencies, organizations, or institutions to improve educational quality or opportunity.

One of the provisions of this proposal would make grants for "improving or developing programs designed to meet the special education needs of mentally retarded and other handicapped children."

These projects would help remove the self-perpetuating blight that settles upon those educated in the unfavorable environment of the slum and depressed areas of our Nation. They would help the schools ameliorate and, in certain cases, remove some of the cultural and environmental conditions contributing to milder forms of mental retardation.

These pilot projects for the mentally retarded could become a means of demonstrating new procedures and materials of instruction, thus helping to overcome the timelag between the discovery and application of new knowledge in the education of the mentally retarded.

They could aid in the professional preparation or improvement of teachers of the mentally retarded and serve as a means of recruiting promising young people as future teachers.

In addition, the high visibility that would be given these projects would serve as a means of bringing more general public awareness to the problems of mental retardation.

A Financial Summary of the Mental Retardation Program of the U.S. Department of Health, Education, and Welfare for Fiscal Years 1963 and 1964

A variety of programs administered by the Department of Health, Education, and Welfare relate to the problem of mental retardation, either in whole or in part. The following table contains estimates of the new obligational authority (from both appropriated funds and trust accounts) for mental retardation activities in the present fiscal year and the amounts proposed for fiscal year 1964 in the President's budget.

Also included in the table are the amounts relating to mental retardation in the administration's legislative proposals as contained in the President's special messages to Congress on mental illness and mental retardation (Feb. 5, 1963) and on education (Jan. 29, 1963).

New obligational authority

[In thousands of dollars]

Agency and activity	Fiscal year 1963	Fiscal year 1964			Increases (1964 total over 1963)
		Proposed activities under existing authority	Proposed new legislation	Total	
I. PREVENTION AND TREATMENT (INCLUDING RESEARCH, TRAINING AND SERVICES)					
Public Health Service:					
National Institutes of Health:					
National Institute of Mental Health	7,288	15,091	----------	15,091	7,803
National Institute of Neurological Diseases and Blindness	15,839	17,893	----------	17,893	2,054
National Institute of Child Health and Human Development	----------	3,200	----------	3,200	3,200
Construction of research centers in human development focused on mental retardation	----------	0	6,050	6,050	6,050
Bureau of State Services: [1]					
Neurological and sensory disease program	290	1,000	----------	1,000	710
Dental services and resources	143	105	----------	105	−38
Subtotal, Public Health Service	23,560	37,289	6,050	43,339	19,779

[1] Since 1958 the Public Health Service has been authorized, under the hospital and medical facilities construction program, to assist in the construction of facilities that provide an active medical diagnostic and treatment program for the mentally retarded. Since 1958 a total of 37 such projects have been approved, of which 11 are in operation, 20 are under construction, and 6 have received initial approval. It is not possible at this time to make an estimate of the funds that will be used under this program in fiscal year 1964.

New obligational authority—Continued

[In thousands of dollars]

Agency and activity	Fiscal year 1963	Fiscal year 1964			Increases (1964 total over 1963)
		Proposed activities under existing authority	Proposed new legislation	Total	
I. PREVENTION AND TREATMENT (INCLUDING RESEARCH, TRAINING AND SERVICES)—continued					
Welfare Administration:					
Children's Bureau:					
Maternal and child health services	1,665	2,665	500	3,165	1,500
Comprehensive maternity care	----------	----------	5,100	5,100	5,100
Research relating to maternal and child health and crippled children's services	----------	----------	500	500	500
Crippled children's services	----------	----------	500	500	500
Salaries and expenses	106	177	----------	177	71
Bureau of Family Services: Salaries and expenses	20	25	----------	25	5
Subtotal, Welfare Administration	1,791	2,867	6,600	9,467	7,676
Vocational Rehabilitation Administration:					
Grants to States for basic support, and extension and improvement of rehabilitation services	3,550	5,400	2,350	7,750	4,200
Research and training	1,225	3,235	----------	3,235	2,010
Salaries and expenses	----------	47	175	222	222
Subtotal, Vocational Rehabilitation Administration	4,775	8,682	2,525	11,207	6,432
Office of Education:					
Training leadership personnel for teaching of mentally retarded children	1,000	1,000	----------	1,000	0
Cooperative research program (including learning research) and new educational media research (National Defense Education Act)	517	1,081	----------	1,081	564
Salaries and expenses (exceptional children program)	61	129	----------	129	68
Special projects to improve education in slum and depressed areas	----------	----------	20,000	20,000	20,000
Teaching of handicapped children	----------	----------	5,000	5,000	5,000
Subtotal, Office of Education	1,578	2,210	25,000	27,210	25,632
Departmental program: Grants to assist States in planning for mental retardation	----------	----------	2,200	2,200	2,200
Total, prevention and treatment	31,704	51,048	42,375	93,423	61,719
II. INCOME MAINTENANCE					
Payments under public assistance program of aid to the permanently and totally disabled	[2] 33,000	36,000	0	[2] 36,000	3,000
Payments from trust funds under old-age, survivors, and disability insurance program	63,800	75,300	0	75,300	11,500
Total, income maintenance	96,800	111,300	0	111,300	14,500
Grand total, Department of Health, Education, and Welfare [3]	128,504	162,348	42,375	204,723	76,219
From appropriated funds	(64,704)	(87,048)	(42,375)	(129,423)	(64,719)
From trust funds	(63,800)	(75,300)	----------	(75,300)	(11,500)

[2] Information is not available on costs due to mentally retarded people who are receiving public assistance since data received does not single out this one cause as a factor of disability or dependency. The amounts shown are estimates based on a study made in 1951 as to the cause of disability or dependency and on the assumption that the percentage factor remains constant.

[3] In addition to the activities identified in this tabulation, certain aspects of the programs of the Food and Drug Administration relate to the problem of mental retardation. However, it has not been possible to make a specific allocation of the funds expended for this purpose.

Mr. ROGERS of Florida. Now, Mr. Chairman, may I just ask this, this doesn't go into what other departments of Government might be doing?

Mr. COHEN. No, sir.

Mr. ROGERS of Florida. This is confined to your Department?

Mr. COHEN. This is confined to our Department.

Mr. ROGERS of Florida. Yes, sir. Thank you.

Mr. COHEN. I believe that next I might submit for the record a brief summary of the subject of mental retardation which deals with the problem of mental retardation in its three components, the custodial, the trainable, and the educable aspects, so that the committee will have before it a succinct understanding of how the experts in this field classify the different types of mental retardation. This brief document, I believe, will show you not only how mental retardation is classified but also give the causes of mental retardation, the scope of the problem, and some of the related activities so that you will have a picture of the striking difference in the character of this problem of mental retardation from mental illness which was discussed previously.

(The material referred to follows:)

MENTAL RETARDATION

(Reprint from Health, Education, and Welfare Indicators, June 1962, U.S. Department of Health, Education, and Welfare)

Mental retardation is a condition, characterized by the faulty development of intelligence, which impairs an individual's ability to learn and to adapt to the demands of society.

The failure of intelligence to develop normally may be due to diseases or conditions—occurring before or at the time of birth, or infancy or childhood—that damage the brain. It may also be due to factors determined by heredity that affect the development of the brain. It is sometimes accentuated by home or social conditions which fail to provide the child with adequate stimulation or opportunities for learning.

DEGREES OF RETARDATION

The degree of retardation varies greatly among individuals. It can be so severe that the afflicted person must have protective care throughout his life. In others the retardation is so mild that many tasks can be learned and a measure of independence in everyday life can be achieved. In a substantial number of cases the affected persons can adjust in a limited way to the demands of society, and in many instances can, with help, become productive members of the labor force.

There is no fully satisfactory way of characterizing the degrees of retardation. They range, according to one classification, from profound to mild, and are related to intelligence quotient (IQ), developmental characteristics, potential for education and training, and social and vocational adequacy as shown in the following table:

Developmental characteristics of the mentally retarded

Degrees of mental retardation	Preschool age, 0 to 5, maturation and development	School age, 6 to 20, training and education	Adult, 21 and over, social and vocational capabilities
Profound	Gross retardation; minimal capacity for functioning in sensorimotor areas; needs nursing care.	Some motor development present; cannot profit from training in self-help; needs total care.	Some motor and speech development; totally incapable of sel-fmaintenance; needs complete care and supervision.
Severe	Poor motor development; speech is minimal; generally unable to profit from training in self-help; little or no communication skills.	Can talk or learn to communicate; can be trained in elemental health habits; cannot learn functional academic skills; profits from systematic habit training.	Can contribute partially to self-support under complete supervision; can develop self-protection skills to a minimal useful level in controlled environment.
Moderate	Can talk or learn to communicate; poor social awareness; fair motor development; may profit from self-help; can be managed with moderate supervision.	Can learn functional academic skills to approximately 4th grade level by late teens if given special education.	Capable of self-maintenance in unskilled or semiskilled occupations; needs supervision and guidance when under mild social or economic stress.
Mild	Can develop social and communication skills; minimal retardation in sensorimotor areas; rarely distinguished from normal until later age.	Can learn academic skills to approximately 6th grade level by late teens. Cannot learn general high school subjects. Needs special education particularly at secondary school age levels.	Capable of social and vocational adequacy with proper education and training. Frequently needs supervision and guidance under serious social or economic stress.

Source: Mental Retardation Activities of the U.S. Department of Health, Education, and Welfare, U.S. Government Printing Office, Washington 25, D.C., May 1962, 50 cents. This publication, portions of which are reproduced herein, contains detailed statements on the research, training, services, and other programs of the Public Health Service, Social Security Administration, Office of Education, and Office of Vocational Rehabilitation. It was prepared by the Department's Committee on Mental Retardation. The members of the committee are as follows: Office of the Secretary—Mr. Luther W. Stringham (Chairman), Dr. Grace L. Hewell, Mr. Allen Pond; Public Health Service—Dr. James M. Hundley, Dr. Richard L. Masland, Dr. Joseph M. Bobbitt; Social Security Administration—Mr. Charles E. Hawkins, Dr. Arthur J. Lesser, Mr. Rudolf Hormuth; Office of Education—Dr. Romaine P. Mackie; Office of Vocational Rehabilitation—Dr. Morton A. Seidenfeld. The following also contributed to the manuscript: Dr. Rick Heber; Dr. Bertram S. Brown; Dr. Harold M. Williams; and the Office of Financial Management, Department of Health, Education, and Welfare.

Another classification, used in relation to educational programs, makes use of a three-way division as follows:

Level:	*Intelligence quotient*
I. Custodial	Below 25.
II. Trainable	About 25–50.
III. Educable	About 50–75.

Other classifications group the retarded in somewhat different ways and make use of other terminology. Nevertheless, all of them recognize gradations of mental retardation, although the exact boundary lines vary. Regardless of the particular classification used, however, it should be understood that seldom, if ever, is IQ the only determining factor in mental retardation. Other factors that affect intellectual competency are emotional control and social adaptability.

THE CAUSES OF MENTAL RETARDATION

Based on present knowledge the causal factors in mental retardation may be divided into two broad categories: (1) Mental retardation caused by incompletely understood psychological, environmental, or genetic factors without any evident damage of the brain; and (2) mental retardation caused by a number of specifically identified conditions or diseases. The causal and contributing factors included in each of these categories are as follows:

1. Mental retardation caused by incompletely understood psychological, environmental, or gentic factors without any evident damage of the brain

This group contains 75 to 85 percent of those diagnosed as retarded. It consists of individuals who show no demonstrable gross abnormality of the brain

and who, by and large, are persons with relatively mild degrees of retardation. In general, the prevalence of this type of retardation is greater within the less favored socioeconomic groups within our culture.

A variety of factors may be operating within this large category. It is believed that some members of this group are products of very complex mechanisms of heredity, reflecting the fact that human beings show genetic variability in any characteristic, including measured intelligence. Environmental factors such as the psychological circumstances of life, social interaction patterns, and the richness of the environment with respect to intellectual stimulation play an important definitive or contributory role within this group. Finally, a variety of unfavorable health factors—including maternal health and prenatal care, nutrition, the conditions of birth, and other illnesses or injuries which may produce minimal and undemonstrable brain damage—probably contribute to a lower level of performance in many cases.

The total effect, thus, is a complex one, involving the action or the interaction of genetic factors, psychological experiences, and environmental influences. At the present time, it is impossible to assign clear weights to each of these general causative factors. It is known that all of them, however, operate more strongly in the underprivileged groups than among those more favorably situated in society. The prospects for prevention and amelioration should not be discouraging, however, since many of the environmental and psychological variables are subject to control, opening up the possibility of preventing some of the retardation, especially of milder degree, based upon this class of causation. Some of these conditions are preventable if treatment can be instituted early enough in the child's life. Most of the remainder can be ameliorated through a combination of resources, medicine, social work, education, and rehabilitation.

It should be very clearly stated that these same factors also affect retarded individuals whose difficulty stems from the more specific etiologies enumerated in category 2 below.

2. Mental retardation caused by specifically identified conditions or diseases in which there is demonstrable brain damage

In approximately 15 to 25 percent of diagnosed cases of mental retardation, a specific disease entity can be held responsible. The impact of such diseases can be most readily demonstrated in those instances where there has been gross brain damage and where the degree of retardation is severe. As mentioned above, it is uncertain to what extent these "organic" factors may operate to produce minor impairment among the less severely retarded groups. Such "organic" factors fall within seven general classes:

(*a*) *Diseases due to infections in the mother during pregnancy or in the infant after birth.*—German measles, occurring during the first 3 months of pregnancy, is known to result in mental retardation as well as other abnormalities. Other infections occurring during pregnancy have also been implicated. A number of the infectious diseases of infancy and childhood may cause brain injury resulting in retardation.

(*b*) *Brain damage resulting from toxic agents which are ingested by the mother during pregnancy or by the child after birth.*—Jaundice of the newborn due to Rh blood factor incompatibility and carbon monoxide or lead poisoning are examples.

(*c*) *Diseases due to trauma or physical agent.*—Brain injury occurring as a result of difficult delivery and asphyxiation due to delay in the onset of breathing at the time of birth are common causes. They occur with particular frequency in premature babies. Brain injury in childhood, especially from automobile accidents, is an added factor.

(*d*) *Diseases due to disorders of metabolism, growth, or nutrition.*—A number of disorders of metabolism, some of which are determined by heredity, produce mental retardation. Some of the most important of these disorders are phenylketonuria and galactosemia in which there are abnormalities of amino acid chemistry in the body.

(*e*) *Abnormal growths within the brain.*—A number of rare conditions, some determined by heredity, are characterized by tumor-like and other abnormal growths within the brain and produce mental retardation.

(*f*) *Diseases due to unknown prenatal factors.*—Recent discoveries prove that mongolism results from abnormal grouping of chromosomes probably at the time of formation of the ovum in the mother. Other congenital malformations have a similar basis. For some, however, an undetermined prenatal mechanism must be responsible.

(*g*) *Diseases due to uncertain causes but with evident damage of the brain.*—A sizable group of mentally retarded children have evident damage to the brain which is presumed to be linked to the mental retardation. The causes of the pathology of the brain in this sizable group remains unknown.

Data on patients in institutions show a higher prevalence of pathological conditions among the more severely retarded. Retarded children have other defects more often than the average child. They are often smaller than average, and have poorer muscular coordination. They have a greater than ordinary percentage of defects, such as hearing and vision, and have probably greater difficulty in perceiving what the sense organs bring to their minds. Thus many of them are multihandicapped in some degree.

SCOPE OF THE PROBLEM

As stated above, mental retardation is defined as impairment of ability to learn and to adapt to the demands of society. These demands are not the same in every culture. In fact, even within our own community they vary with the age of the individual. We expect little, in terms of intellectual pursuits, from the preschool child. During the school age, the individual is evaluated very critically in terms of social and academic accomplishment. In later life, the intellectual basis of social inadequacy again may be less evident. Numerous surveys directed toward determining the frequency and magnitude of the problem of mental retardation have shown that the number of individuals reported as retarded is highest during the school age. Less than one-fifth as many children in the age group 0 to 4 were reported by these surveys as mentally retarded as were reported in the age group 10 to 14. Similarly, only one-fourth as many persons in the age group 20 and over were identified as mentally retarded as compared with the number identified in the age group 10 to 14.

This varying prevalence by age is to some extent determined by differential survival rates and other demographic factors. However, the very high prevalence at ages 10 to 14 is due primarily to the increased recognition of intellectual handicap of children within the school systems. The very low number of infants from 0 to 1 year old identified as retarded is in part at least due to the fact that their intellectual deficiency is not yet apparent. Only gross impairment is evident in early childhood. Of striking significance is the fact that half of the individuals considered retarded during adolescence are no longer so considered in adulthood.

In view of these considerations, only the most crude estimates of the overall magnitude of the problem can be established. One such estimate may be derived through the use of intelligence quotients, and obtained from the samples upon which our intelligence tests have bene standardized. The numbers of mentally retarded persons by this criterion can be calculated roughly on the basis of this experience with intelligence testing. On most tests standardized nationally, experience has shown that virtually all persons with IQ's below about 70 have significant difficulties in adapting adequately to their environment. About 3 percent of the population score below this level.

Based on this figure of 3 percent, it is estimated that, of the 4.2 million children born each year, 126,000 are, or will be, classed as mentally retarded.

Of the 126,000, some 4,200 (0.1 percent of all births) will be retarded so profoundly or severely that they will be unable to care even for their own creature needs. About 12,600 (0.3 percent of all births) will suffer from moderate retardation—they will remain below the 7-year intellectual level. The remaining 110,000 (2.6 percent of births) are those with mild retardation and represent those who can, with special training and assistance, acquire limited job skills and achieve almost complete independence in community living.

Applying these same percentages to the total population it is estimated that there are approximately 5.4 million mentally retarded persons in the population. Of this number:

Sixty thousand to ninety thousand persons, mostly children and adolescents, so profoundly or severely retarded that they cannot survive unless constantly cared for and sheltered.

Three hundred thousand to three hundred fifty thousand are moderately retarded children, adolescents, and adults who can assist in their own care and can even undertake semiproductive endeavors in a protected environment. They can understand the meaning of danger. However, they have limited capacity to learn, and their shortcomings become evident when they are called upon to

understand the meaning of symbols as used in the written language. These people can learn many tasks when patiently and properly taught.

Some 5 million are mildly retarded children, adolescents, and adults who are able to perform more adequately, adjust in a limited way to the demands of society, and play a more positive role as workers.

ECONOMIC COSTS OF MENTAL RETARDATION

There are no reliable estimates of the total cost to the Nation, both direct and indirect, of mental retardation. The direct costs to families and to communities include those for institutional and home care and for special services. Indirect costs include the losses that result from the absence of earning capacity and inability to contribute to the production of goods and services.

Only 4 percent of the mentally retarded are confined to institutions. Yet, their care costs relatives and communities some $300 million annually. Additional amounts are required for the construction of facilities for custodial and educational purposes. The cost of institutional care, facilities construction, and special care in the family home totals more than $1 billion per year.

THE DEVELOPMENT OF NATIONAL CONCERN

Mental retardation thus is a serious problem affecting many aspects of our society. The host of problems presented by these people—to themselves, to their families, and to their communities—include biological, psychological, educational, vocational, and social areas of concern. Mental retardation must be approached through the whole life cycle, from consideration of genetics and conception through pregnancy, delivery, childhood, adolescence, adulthood, and old age.

Since 1950, interest in the problem of mental retardation has grown very rapidly. During the past decade increased activities have been stimulated by a few foundations, by the demands of parents, by interested lay and professional groups, and by members of legislative bodies who have been convinced of the urgent need for programs in this field.

Today, private efforts and public programs at all levels of Government—local, State, and Federal—take eight basic forms:

1. *Diagnostic and clinical services.*—There are over 90 clinics specializing in services to the retarded. Well over half were established within the past 5 years. These services need still greater expansion. The 20,000 children aided in 1960 represent only a small fraction of those who need the service.

2. *Care in residential institutions.*—Today there are over 200,000 mentally retarded patients in such institutions, approximately 10 percent more than there were 5 years ago. But the average waiting list continues to grow, and the quality of the service often suffers from limited budgets and salary levels. Increases in both facilities and manpower are necessary.

3. *Special education.*—The number of mentally retarded enrolled in special educational classes has been doubled over the past decade. In spite of this record, we are not yet meeting our existing requirements, and more such facilities must be provided. Less than 25 percent of our retarded children have access to special education. Moreover, the classes need teachers specially trained to meet the specialized needs of the retarded. To meet minimum standards, at least 75,000 such teachers are required. Today there are less than 20,000, and many of these have not fully met professional standards.

4. *Parent counseling.*—Counseling of parents is now being provided by private physicians, clinic staffs, social workers, nurses, psychologists, and school personnel. Although this service is still in an experimental stage of development, it offers bright prospects for helping parents to meet their social and emotional problems.

5. *Social services.*—Social services provided mentally retarded children and adults include case work, group work, and day care. These services are an integral part of clinical, rehabilitation, and other mental retardation programs. Social workers are also active in community organizations and in working with parents groups.

6. *Vocational rehabilitation.*—In the past 5 years the number of mentally retarded rehabilitated through State vocational agencies has more than tripled—going from 1,094 in 1957 to 3,562 in 1961. In terms of the number who could benefit from rehabilitation services, this number is very small. However, new

knowledge and new techinques are needed, for over 25 percent of those coming out of the special classes still cannot be placed.

7. *Preparation of professional personnel.*—The Federal Government is now promoting the training of leadership personnel in education, rehabilitation workers, research personnel, and medical and welfare specialists. In addition, programs are being provided that will increase the competence of the health professions in providing services for retarded persons. Nevertheless, shortages of qualified personnel remain one of the major bottlenecks in providing services to retarded persons and their families.

8. *Research.*—Support for research in the causes and amelioration of mental retardation has been greatly increased, especially during the last 5 years. Progress has been made in identifying specific conditions and diseases and in establishing basic problems of behavior and learning, but major research breakthroughs must be achieved before there will be adequate understanding of the pathological, genetic, psychological, environmental, and other aspects of mental retardation.

PROGRAMS OF THE FEDERAL GOVERNMENT

Primary responsibility within the Federal Government for activities relating to mental retardation is located in the Department of Health, Education, and Welfare. Within the Department these programs are administered by four operating agencies—the Public Health Service, Office of Education, Social Security Administration, and Office of Vocational Rehabilitation—and may be grouped under four main categories: (1) Research and studies; (2) professional preparation; (3) services; and (4) construction of a limited number of facilities that qualify for assistance under the hospital and medical facilities construction (Hill-Burton) program.

Research activities include (1) the intramural and extramural support programs of the National Institute of Mental Health, the National Institute of Neurological Diseases and Blindness, and the Center for Research in Child Health of the Public Health Service; (2) the Office of Education programs of studies, surveys, and cooperative research; (3) special project grants under the maternal and child health program of the Children's Bureau, Social Security Administration; and (4) the research and demonstration projects of the Office of Vocational Rehabilitation.

Professional preparation is supported through (1) Office of Vocational Rehabilitation grants to educational institutions for training of personnel for all phases of rehabilitation; (2) teaching and training grants of the National Institutes of Health; (3) intramural training programs of the Public Health Service; and (4) Office of Education training grants to colleges and universities and State educational agencies for leadership positions in the education of the mentally retarded.

Services include consultation and technical assistance in their respective areas of competence by (1) the Children's Bureau, under the maternal and child health and the child welfare services programs; (2) Office of Vocational Rehabilitation to State rehabilitation agencies; (3) the National Institute of Mental Health through its regional office staffs; and (4) the Office of Education to State and local school systems, educational personnel and voluntary groups. In addition, financial assistance to States is provided under the Federal-State programs of public assistance, and benefit payments for the disabled are made under the Federal program of old-age, survivors, and disability insurance.

In the 1963 fiscal year the Department of Health, Education, and Welfare anticipates expenditures in excess of $28 million from general funds for research, training, and services in the field of mental retardation. This total represents an increase of $4.3 million over the estimated level of funds available for this purpose for fiscal year 1962 and more than doubles the $12.4 million spent by the Department 5 years ago. In addition, it is estimated that over $63 million will be paid from the old-age, survivors, and disability insurance trust funds to persons with diagnosed mental deficiency—primarily adults who have had disabilities from childhood.

MENTAL RETARDATION AND THE FUTURE

The acceleration of effort—private and public—already has produced some encouraging results. Progress has been made in identifying specific disorders and their treatment, in training personnel, in providing additional facilities, and in improving services generally. Special education classes have multiplied. More rehabilitations have been completed. Parents get better counseling.

Even though such progress is gratifying, mental retardation will continue to be a problem of national concern. Unless there are major advances in methods of prevention, there will be as many as 1 million more mentally retarded persons by 1970.

Improved and more extensive prenatal, obstetrical and pediatric care have brought about marked increases in the infant survival rate in the Nation over the past 20 years. Such efforts, along with increasing the chances of survival of all infants, have also increased the survival rates of infants who are premature or who have congenital handicaps or malformations. Since mental retardation is one of the major conditions associated with such handicaps in infants, improved care has to an extent also increased the number of the retarded for whom special services will be needed.

Disease control, new drugs, and higher standards of living have steadily increased the lifespan of most Americans. While the mentally retarded as a group fall below the average life expectancy, the number of years the average retarded individual lives has been increasing proportionately with the overall average. This increase in lifespan adds materially to the number of mentally retarded persons, particularly in the upper age levels. With the increased availability of health services, the lifespan of mentally retarded persons may continue to increase and move closer to the average life expectancy of the general population.

The increased survival rates of retarded infants will probably bring with it an increase in the number of retarded persons who have associated physical handicaps. Current reports from clinical programs dealing with retarded children under 6 years of age indicate that even now in this group, 75 percent have associated physical disabilities. Likewise, because the older individuals are now living longer, we can expect many of them to present the physical problems of the aged in the general population.

Because of changing social and economic conditions, some of the problems of mentally retarded persons will become more acute in the future:

1. Families are growing larger and in fewer instances will a retarded child be an only child.

2. More mothers of young children are in the labor force: Many times the factors that induce mothers to work are even more forceful for the mother who has a retarded child. Substitute care for the retarded child, however, is more difficult to obtain. Frequently, too, the retarded child is less able to understand the need for a parent substitute, which makes planning more difficult to carry out.

3. More children are going to school longer: The general level of education is rising in the Nation. As this trend continues, the mentally retarded whose disability shows itself in this area will be more marked. As educational standards and achievements continue to rise, a greater number of individuals who cannot keep up or achieve these levels will be discovered and will demand attention.

4. Machines replace unskilled labor: In the past, the majority of the mentally retarded children completing special classes for the educable in urban areas were able to find jobs on their own. There is some question whether this will continue to be so in the next 10 years without additional special help. Increased industrial specialization, automation and the intensified tempo of industrial production, pose new problems. Elevated educational standards in rural areas also are adding to the problem. Farming, which years ago provided a field of employment for many of the retarded, has become so highly specialized that persons who would have been employed in the past have a different time finding employment at all now.

THE PRESIDENT'S PANEL ON MENTAL RETARDATION

Thus the problem of mental retardation presents a major challenge to society: To find causes, to seek prevention, and to provide the best possible assurance for lives of maximum usefulness. Manifestly, the needs remain great for more knowledge, more personnel, more facilities, and more services.

In October 1961, President Kennedy appointed a panel of physicians, scientists, educators, lawyers, psychologists, social scientists and other leaders to review present programs and needs, to ascertain gaps, and to prescribe a program of action. The President has asked the Panel to formulate a national plan to combat mental retardation and to report to him on or before December 31, 1962. The Panel's recommendations will provide the guidelines for future efforts and further progress in the years to come.

Mr. COHEN. As a next item, I would like to bring to your attention the report of the President's Panel on Mental Retardation which we sometimes refer to as the Mayo report since Dr. Leonard Mayo was the Chairman of this Panel and as was pointed out this morning that is a rather detailed report of over 200 pages. However, Dr. Mayo has prepared a brief 13-page summary of the entire 200-page report. If you would like we could put that in the record because the report of the Panel is so extensive that this would give you and your staff an easier opportunity to deal with the main recommendations.

Mr. ROBERTS. That will be included in the record.

(The material referred to follows:)

MENTAL RETARDATION: REPORT OF THE PRESIDENT'S PANEL

(Reprint from February 1963, Health, Education, and Welfare Indicators, U.S. Department of Health, Education, and Welfare)

(Leonard W. Mayo[1])

President Kennedy appointed the Panel on Mental Retardation in October 1961, with the mandate to prepare a national plan to help meet the many ramifications of this complex problem. In October 1962, the Panel presented its report, which was subsequently published early in 1963.

The 200-page document includes over 90 recommendations. Mental retardation is shown to be a major national health, social, and economic problem affecting some 5.4 million children and adults and involving some 15 to 20 million family members in this country. It estimates the cost of care for those affected at approximately $550 million a year, plus a loss to the Nation of several billion dollars of economic output.

In carrying out its mandate, the Panel employed four main methods of study and inquiry:

Task forces on specific subjects were appointed to which all members were assigned and advisers were designated to work closely with them.

Public hearings were held in seven major cities, at which public officials concerned with retardation, teachers, representatives of related professions, parents, and others reported on local and State programs and gaps in service and made recommendations.

Panel members and advisers visited England, Sweden, Denmark, Holland, and the Soviet Union to study methods of care and education of the retarded and to become acquainted with research in those countries.

A considerable body of literature and recent studies were reviewed, and Panel members visited and observed facilities and programs for the retarded in several States.

Highlights of the findings and recommendations in each of the main sections of the report are summarized herewith, with liberal quotations from the text.

RESEARCH

In research, the Panel recommends that:

Ten research centers affiliated with universities be established to insure continuing progress in research relevant to mental retardation in both the behavioral and biological sciences and to provide additional facilities for training research personnel.

Biological and behavioral research as presently conducted by individual investigators interested in problems germane to mental retardation be continued and extended.

[1] Mr. Mayo was the Chairman of the President's Panel on Mental Retardation. See also the author's "Report" for the National Rehabilitation Association's Journal of Rehabilitation, November-December 1962. Mr. Rudolf P. Hormuth, Specialist in Services for Mentally Retarded Children, Children's Bureau, prepared "highlights" from the report for the January-February 1963 issue of Children (reprints available). The report itself, "A Report of the President's Panel on a Proposed Program for National Action To Combat Mental Retardation," may be purchased from the U.S. Government Printing Office, Washington 25, D.C., at 65 cents. Some of the basic facts relating to the size of the problem, causal factors, and necessary services are contained in "Mental Retardation" in the June 1962 issue of Indicators (reprints available).

Population studies be undertaken as a basis for analyses of the characteristics and needs of the mentally retarded population on a national basis.

Government activity in developing plans for storage, retrieval, and distribution of scientific data be continued.

Congress provide funds to improve the serious shortage of laboratory space; private foundations are requested to review their policies and to consider grants designed to help alleviate this problem.

Scientists in both the biological and behavioral groups engage in highly specialized conferences to deal in depth with problems underlying retardation.

A Federal Institute of Learning be established under the general auspices of the Department of Health, Education, and Welfare (HEW).

The research budget for exceptional children in the U.S. Office of Education be augmented in accordance with the provisions of legislation proposed in 1962.

The National Institutes of Health and private foundations provide more postdoctoral fellowships, awards, and research and career professorships in fields relevant to retardation.

Programs to train research educators, sociologists, and psychologists in mental retardation be initiated.

Federal support be undertaken for a national program of scholarships for undergraduate college students possessing exceptional scientific ability and for the extension of research activities in undergraduate science departments.

An extensive program of Federal aid to education be designed to prevent loss to the scientific manpower pool of numbers of gifted youths who fail to enter college for financial reasons.

The graduate fellowship program in the U.S. Office of Education be extended to provide for preparing research specialists in the education of the mentally retarded.

PREVENTION

To develop a program to prevent mental retardation, the Panel proposes that:

All possible Federal, State, and local resources be mobilized to provide maternal and infant care in areas where prematurity rates are high and the consequent hazards to infants great.

High priority be given to making adequate maternal care accessible to the most vulnerable groups in our society, i.e., those who live in seriously deprived areas and who receive little or no medical care before, during, or after pregnancy, and that funds be substantially increased under title V, part 1, of the Social Security Act (maternal and child health), to provide for such care.

State departments of health and university medical centers collaborate in the development of multistate genetic counseling services in order to give young married couples and expectant parents access to such consultation, and that diagnostic laboratories for complex procedures (related to prevention) be developed.

The present review of drug testing procedures be endorsed and the current policy with respect to the distribution of drugs to physicians for field trials without adequate criteria or preparation be investigated.

Laws and/or regulations be enacted by all States (as they have by some) to provide for the registration, inspection, calibration, and licensing of X-ray and fluoroscopic machines and other ionizing radiation sources; and that lifetime radiation records be developed on a demonstration basis in selected areas for the recording and dating of diagnostic and therapeutic X-ray exposure.

Hospitals adopt every known procedure to insure the prevention of prenatal and neonatal defect and brain damage, and that they apply modern child rearing knowledge and practices in dealing with infants who may have suffered from trauma resulting from maternal separation.

Programs keyed to the needs of culturally deprived groups in specific areas be organized to reduce the impact of deprivation, which seriously affects the development of children's learning ability. State departments of health, education, and welfare are asked to join in promoting local community programs of prevention to offset the adverse effects of destructive community and neighborhood environment.

A domestic Peace Corps be established to help meet the personnel shortage and special needs in deprived areas and to give Americans an opportunity to serve their own and other communities effectively.

CLINICAL AND MEDICAL SERVICES

In this area, the Panel recommends that:

Inclusive programs of clinical services and medical care be made available to the retarded in or close to the communities where they reside. State and local health departments are urged to extend their services to children in the lower socioeconomic groups and to utilize procedures for the early detection of abnormalities.

Every related agency in the community include the mentally retarded and their families among those served.

State governments lift all present restrictions preventing retarded children with physical handicaps from receiving services available to all other physically handicapped children in the State crippled children's program; to make this possible, an increase of Federal funds to the crippled children's program (title V, pt. 2, Social Securiey Act) earmarked for the mentally retarded is recommended.

Additional clinics for the retarded be established wherever needed to provide services for additional patients and opportunities for training personnel.

To plan these program services more effectively, it is essential that adequately staffed biostatistical sections at the State and Federal levels be developed; that there be improved recordkeeping and data processing systems; and that community and epidemiological studies be designed and carried out.

EDUCATION

The Panel recommends that specialized educational services be extended and improved to provide appropriate educational opportunities for all retarded children.

This assistance, the report states, can be provided through a Federal extension and improvement (E. & I.) program, administered to assure the use of available funds for expansion or development of new services rather than for existing programs at current levels. Any proposal to extend or improve special educational services for retarded children should be considered for an E. & I. grant, and evaluated on a competitive basis. Universities, State departments of public education, local and county school systems, and other educational agencies should all be eligible to submit such applications.

At present, States usually assist local school systems by reimbursing local districts for a portion of the excess cost of providing special education services; however, the amount available for this purpose in the budget of the State departments of public instruction is usually limited. Any substantial extension of the specialized educational services for retarded children will require assistance and stimulation from sources beyond local and State school systems.

It is essential that adequate opportunities for learning intellectual and social skills be provided such children through formal preschool education programs designed to facilitate adequate development of skills such as speech and language, abstract reasoning, problem solving, etc., and to effect desirable patterns of motivation and social values.

Most retarded children live in city slums or depressed rural environments. Research suggests that deprivation of adequate opportunities for learning contributes to and complicates the degree of mental retardation present in these children. Formal preschool programs of increased learning opportunities may accelerate development of these children. Yet there are exceedingly few such programs now available to enrich the experiences of deprived preschool children.

The Panel suggests that instructional materials centers be established in the special education units of State departments of public instruction or in university departments of education, to provide teachers and other education personnel with competent consultation on instructional materials and to distribute and loan such materials for the mentally retarded.

The Panel strongly recommends that specialized classroom services be extended to provide for all mentally retarded children. Additional special class services are required for all age levels for both educable and trainable retarded children. However, it is doubtful that comprehensive programs will be developed in most communities without the additional incentive of external financial support, provided by the Federal Government through the E. & I. program.

The Panel suggests that services of educational diagnosis and evaluation be extended to all school systems to provide for early detection of school learning disabilities and to enable appropriate school placement.

The U.S. Office of Education is urged to increase its administrative leadership and staff of the program for exceptional children to a level commensurate with the importance of exceptional children in the Nation's program of public education.

The Panel underlines the need for an additional 55,000 trained teachers of the mentally retarded. If fully implemented, the Panel states, the following program would add 6,000 new teachers each year to the pool of skilled teaching specialists in retardation:

Government and private foundations should provide annually $9 million to be awarded to universities to provide scholarships and to support the training program.

Each State should appropriate an amount equal to at least 5 percent of its annual budget for special education for training grants to experienced teachers wishing to specialize in mental retardation. It is recommended that the Government match the funds allocated by the State departments of public instruction.

Local school systems (by granting leave-of-absence with pay), community agencies, and civic organizations should contribute to the education of those who will teach their retarded children. Concerted effort on the part of these local groups should enable them to achieve the reasonable objective of a contribution of $3 million annually—an average of $1,000 from each of the 3,000 local school systems now operating programs for the retarded.

The Panel also urges that methods be developed to provide for more effective training and use of personnel for teaching retarded pupils. Research and demonstration projects should be initiated to determine staffing patterns to conserve teaching manpower.

It is recommended that the fellowship program under Public Law 85–926 be extended to include provisions for preparing research specialists. Funds are currently available under Public Law 85–926 for the preparation of administrators, supervisors, and college and university instructors in special education, excluding, however, persons who wish to prepare for research careers.

VOCATIONAL REHABILITATION

Recent progress in vocational rehabilitation must be tempered by recognition that only about 3,500 persons were reported as rehabilitated under the Federal-State program over the past year. This figure is negligible when compared with even the most conservative estimate of the retarded who could benefit from this service. The Vocational Rehabilitation Administration (VRA) is deeply interested, however, and has been active for some time in developing this aspect of its program.

If the present need were being met in full:

Seventy-five thousand retarted youth in their final year of schooling would be receiving services such as prevocational counseling and evaluation, and job placement.

Nineteen thousand retarded youth would be receiving postschool preparation for competitive work in an employment training center or comparable facility.

One hundred and twenty thousand moderately retarded adults would be receiving services and working in workshops or similar places.

Seventy-five thousand severely retarded adults living in communities would be receiving services in facilities providing training in basic living skills, recreation, etc.

In the future the demand for vocational rehabilitation services will increase. Opportunities for jobs traditionally identified with the retarded are on the decrease. Competition for these jobs is becoming keener as unskilled workers, displaced by automation, seek jobs once held almost exclusively by the retarded. Adverse effects of recessions are likely to be felt more acutely by mentally retarded than by nonretarded workers.

The Panel recommends that vocational rehabilitation services for retarded youth and adults be expanded through earmarking of Federal funds under the Federal-State program of vocational rehabilitation.

If the productive capacities of the Nation's mentally retarded are to be realized, every retarded youth must have the following services available to him prior to, during, and after termination of his formal education: vocational evaluation, counseling, and job placement; training courses in appropriate vocational areas; joint schoolwork experience programs cosponsered by schools and vocational rehabilitation agencies; clearly defined and adequately supervised programs for on-the-job training; employment training facilities; sheltered workshops; voca-

tional rehabilitation services in conjunction with residential institutions; and counseling services to parents.

The report also calls for a Federal program to provide financial support for constructing, equipping, and initially staffing sheltered workshops and other rehabilitation facilities, through VRA. Comparable programs for other types of facilities exist in other agencies of Government and have, in general, proven highly effective. The Hill-Burton Act is the legal basis for one such program.

The Panel also suggests that VRA be given responsibility for leadership in planning, developing, coordinating, and supervising a system of sheltered work programs. The programs themselves should be operated by voluntary and public agencies with assistance from State and Federal rehabilitation agencies; they should be developed in stages with small-scale pilot projects serving as a base for expansion. Hopefully, this would lead eventually to the establishment of sheltered work programs in every major urban community in the Nation.

RESIDENTIAL CARE

In this area, the report recommends that:

Every residential facility be: An integral part of a statewide program for the retarded and closely related to the community; basically therapeutic or educational, and closely linked to appropriate community medical, education, and welfare programs; operated under flexible admission and release policies, similar to those of a hospital or school; and equipped to undertake research in some form as a part of its program.

Admission to residential care be reserved for those whose specific needs can best be met via such a facility.

Appropriate authorities in every State determine the status of all mentally retarded patients in State hospitals for the mentally ill at regular intervals and remove those who can profit by care designed primarily for the retarded.

Upon presentation of plans meeting criteria established by the Secretary of Health, Education, and Welfare, matching grants be provided to the States for institutions to facilitate planning and development, recruiting and training personnel, and research.

No institution for the retarded accommodate more than 1,000, and units now being planned for future construction not exceed 500 beds.

THE LAW AND THE MENTALLY RETARDED

The Panel approaches this problem from the point of view that, with the development of new alternatives in treatment, it should now be possible to overcome certain rigidities of the law in the interest of giving the retarded individual the benefit of modern knowledge. The Panel suggests that mandatory legal requirements be minimized wherever voluntary compliance can be obtained. The question of formal legal intervention is regarded as a residual resource which should not be utilized where social or personal interests can be adequately served through other means.

This section of the report, nonetheless, points out that the law must protect the rights of the retarded. Like other citizens they must be assumed to have full human and legal rights and privileges. The mere fact of mental retardation should never be considered in and of itself sufficient to remove their rights.

The Panel recommends specifically that:

Each State establish or designate a protective agency for the retarded, to provide for consultation for them and their families and for employers, guardians, and others concerned with their social and legal problems, and to supervise the private guardians of retarded persons.

Superintendents of residential facilities for the retarded accept as voluntary admissions only those adults who are capable of making such a decision.

No limited guardian of a mentally retarded adult be able to commit his ward to an institution without a judicial hearing unless the court order appointing the guardian gave him such discretion—in which case he should inform the court of his ward's change of residence.

Since State and local school authorities are constitutionally obligated not only to provide education for educable mentally retarded chidren, but also to provide training facilities and personnel for trainable mentally retarded children, these authorities reexamine the extent to which they provide education and training for mentally retarded children.

The court in deciding whether a confession to a crime was coerced—and hence inadmissible at trial—consider all the relevant circumstances, and assess whether the mentally retarded defendant's state of mind was such as to preclude the confessions being voluntary in any meaningful sense; and that caution be taken against giving any probative weight to the fact that a mentally retarded defendant remained silent when accused of a crime.

The mentally retarded individual who exhibits persistent uncontrolled behavior threatening the well-being of others requires special attention, which should be a subject of special study, since he is unsuited both to the typical prison and to most residential facilities for the retarded.

LOCAL, STATE, AND FEDERAL ORGANIZATION

Concerning local, State, and Federal organization and relationships, the Panel recommends that:

There be available to every retarded person either in his community or at a reasonable distance: A person, committee, or organization to whom parents and others can turn for advice and counsel; life counseling services; and a sufficient number of qualified professional and informed nonprofessional people willing to assist in developing a program for an individual, and in developing a local or State program.

Every health, education, and welfare agency provide a person, office, division, or other appropriate instrumentality to organize and be responsible for those agency resources or services relevant to mental retardation; and those agencies dealing with the retarded at a local, community, or State level establish committees with high-level representation to facilitate communication and cooperation.

A formal planning and coordinating body made up of all appropriate segments of the community be established with the mandate to develop and coordinate programs for the retarded.

The Federal Government take leadership in developing model community programs for the management of mental retardation in each of the Department of Health, Education, and Welfare regions. The objectives of such models would be: To develop concrete examples and demonstrations if what is believed to be the best possible care for the retarded on a coordinated basis; and to provide teaching resources in which present and future administrative and professional personnel could receive higher quality training.

The Secretary of Health, Education, and Welfare should be authorized to make grants to States for comprehensive planning in mental retardation.

Mr. COHEN. Next, I believe it would be appropriate to select out from the Mayo Panel's report a couple of pages which present their recommendations on the two provisions that are in the bill before you.

The Mayo Panel report consists of some 90 to 100 different recommendations in the field of mental retardation, some involving appropriations, some involving administrative actions of States and localities and private groups, and some involving new legislative authority.

The two suggestions that are incorporated in the bill before you today were recommendations made by the Mayo report, and each of them take a couple of pages. I believe it would be appropriate here to give you their reasons why the legislative authority for the new centers and for the construction of facilities is, in their opinion, needed and desirable.

(The material referred to follows:)

EXCERPTS FROM "A PROPOSED PROGRAM FOR NATIONAL ACTION TO COMBAT MENTAL RETARDATION" (THE REPORT OF THE PRESIDENT'S PANEL ON MENTAL RETARDATION, OCTOBER 1962), RELEVANT TO THE CONSTRUCTION OF MENTAL RETARDATION RESEARCH CENTERS AND OTHER FACILITIES

EXPANSION OF RESEARCH

In developing its proposals to expand the research effort, the Panel has been mindful of the significant advances in the attack on mental retardation which have taken place as a result of research findings. Such errors of inborn metabolism as phenylketonuria, "maple syrup urine" disease, and galactosemia have been intensively studied, and through the results of these studies, it has been possible to prevent many cases of mental retardation. The early findings of the collaborative perinatal project under the direction of the National Institute of Neurological Diseases and Blindness have pointed to some of the causes of prematurity, which is an important cause of brain damage and have focused on the association of oxygen deficiency at birth with abnormality of the offspring. Other important research findings have suggested how important it is that pregnant women be protected from both excessive X-rays of the fetus and German measles during the first few months of pregnancy.

These are merely illustrative of research findings which have led to the prevention of a significant number of cases of mental retardation. Other findings bear on the detection of brain disorders, such as electroencephalograms of newborn infants. Rapid progress has been made, and yet unfortunately it has unlocked the answers to perhaps only half of the 15 to 25 percent of the cases for which specific diagnoses can be attributed.

Research in the behavioral sciences is at present primarily addressed to therapeutic and rehabilitative possibilities. The most fertile unploughed area for further behavioral and social science research is indicated by the accumulating evidence that a host of social, economic, and environmental factors—often categorized as cultural deprivation—are correlated or associated to a high degree with the incidence of mental retardation, especially in its milder manifestations of low intellectual and social performance.

The Panel recommends that high priority should be given to developing research centers on mental retardation at strategically located universities and at institutions for the retarded.

The Panel believes that the importance of research in mental retardation and the very limited research resources now being devoted to this multifaceted problem require a special effort to create new centers of research competence. Such centers are needed for work in biomedical behavioral, and social science, and in interdisciplinary areas. Support for them should be drawn from State and private sources as well as from the Federal Government through the National Institutes of Health and other appropriate Federal agencies. Three such centers are desirable in the near future, established on a pilot basis, and on the basis of experience with them, decisions should be made on proceeding toward an ultimate goal of as many as 10 centers. The estimated cost of a center might be about $1.5 million for facilities and about $0.5 million a year for operating expenses.

These centers might (1) conduct basic and applied research in the laboratory and the field; (2) serve as educational centers for the training of additional research and service manpower in this field; and (3) carry on experimentation in the application of new findings and techniques.

In the biological and medical research areas, these centers might undertake basic studies in the neurobiological sciences and in clinical aspects of the problem of mental retardation. The heterogeneity of the disorders resulting in intellectual deficit would provide a wide and fruitful area for basic and clinical research and training. Classical techniques of neuropathology have not yet been exhausted in the search for important clinical pathological correlations. For example, the sciences of microbiology, particularly virology, pharmacology, toxicology, and nutrition, can help provide answers to prenatal and postnatal factors which interfere with normal development. Particular disorders which contribute to mental retardation need to be differentiated and their etiology and pathology characterized at the biological, psychological, and clinical level. More information is needed regarding the relationship of psychological deficits to known biological abnormalities. Longitudinal and prospective studies are also desirable to clarify the workings of complex factors in the etiology of mental retardation.

Within the framework of these research centers, universities would be encouraged to establish clinical research programs through teaching hospitals, thereby permitting medical school and graduate departments to undertake research in mental retardation. In addition to providing an opportunity for clinical research, these clinical centers would also be important prototypes in stimulating the application of laboratory findings to clinical practice.

The majority of the mental retardation cases are undifferentiated, with failures in the field of adaptive behavioral and intellectual functioning. As has already been indicated, this suggests the need for expanding both basic and applied research in the behavioral and social sciences with respect to such substantive areas as deprivation and developmental and learning processes. While a balance between basic and clinical research is essential, the fact that millions of retarded persons in our society require improved care, services, and education indicates that a high degree of applied research is needed in the behavioral sciences.

Among the studies in the behavioral sciences which should be considered for special attention by the research centers are the following: The psychological and cultural factors in the etiology of mental retardation; the development of the behavioral processes of the retardate; studies on methods of measuring behavioral skills at all age and ability levels; the adjustment of the adult retardate in various community settings; comprehensive studies in learning, including intramural and extramural demonstrations; responses to stimulative and motivational factors at different ages from infancy to adulthood; and studies of the methods and programs of special education.

Some focuses for research will necessarily represent interfaces among the various sciences to such an extent that meaningful explanation of the whole problem is dependent upon a multidisciplinary approach. Because such a large proportion of mental retardation is presently undifferentiated, it would seem only prudent to have centers concerned with interdisciplinary approaches as well as the other two areas discussed above.

An important starting point for any specific study in the behavioral and even in certain of the biological areas is in comprehensive epidemiological study of deprived conditions—nationwide, statewide, and in particular communities—from which arise the vast majority of the retarded and their possible direct or indirect causal role. In this connection, both cross-sectional studies and longitudinal studies of the development of behavioral processes of retardation as related to possible causal environmental and biological factors would be most helpful. No less important are careful studies of the factors which affect or help the mental retardate in attaining and maintaining satisfactory adjustment in family, community, educational, and employment spheres.

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The Secretary of Health, Education, and Welfare should review the requirements for construction of essential facilities for the mentally retarded under public and nonprofit auspices, including facilities which are not necessarily under direct medical supervision.

This review should be coordinated with the current review of the Hill-Burton program, and with the review of the national mental health program now underway in the executive branch. It should provide a more definitive analysis of need in the light of desirable patterns of service outlined in this report and clarify the exact extent and character of facilities to be aided.

There is a shortage of physical facilities for many types of needed programs for the retarded, including classrooms, workshops, "activity centers," day care, halfway houses, and full-scale residential care. High priority should be given, however, to construction of facilities for day and residential care and related community programs designed to express the new program concepts recommended in other sections of this report. It is estimated that when the full potentials of day care are realized, facilities for some 50,000 seriously retarded children and adults will be needed. Residential facilities are currently required for at least another 50,000 children and adults now not served; replacement for overcrowded and obsolete quarters now in use would bring the total to over 100,000.

To assist it in developing its plans, and in preparing principles and guidelines for standards basic to Federal participation, the Public Health Service should be advised by an expert group composed of persons within the Department familiar with the program needs of the retarded, together with representative officials responsible for State programing in the various areas, and national agency consultants.

The Panel recommends that local communities, in cooperation with Federal and State agencies, undertake the development of community services for the retarded. These services should be developed in coordination with the State comprehensive plan for the retarded, and plans for them should be integrated with those for construction and improvement of services in residential facilities.

As the States and the boards of public and private institutions plan for the future, problems of the size of institutions, program, and personnel are paramount. Bringing the provision of services as close as possible to the local community is a basic tenet on which the Panel's recommendations rest. This would be consistent with the general movement of health and mental health services in this direction, in itself an important and key movement in developing new services of the retarded.

Mr. COHEN. I believe that it would also be valuable to your further study for me to put into the record at this point the Federal percentages for the mental retardation construction grants for each State, State by State.

(The material referred to follows:)

1. Alabama	73.64	29. Nevada	48.51
2. Alaska	51.92	30. New Hampshire	62.64
3. Arizona	63.67	31. New Jersey	52.03
4. Arkansas	75.00	32. New Mexico	67.28
5. California	50.79	33. New York	49.72
6. Colorado	58.45	34. North Carolina	71.71
7. Connecticut	48.83	35. North Dakota	70.62
8. Delaware	46.00	36. Ohio	58.16
9. District of Columbia	45.67	37. Oklahoma	66.85
10. Florida	64.53	38. Oregon	59.66
11. Georgia	70.98	39. Pennsylvania	59.57
12. Hawaii	58.84	40. Rhode Island	60.36
13. Idaho	67.71	41. South Carolina	75.00
14. Illinois	52.59	42. South Dakota	68.44
15. Indiana	60.83	43. Tennessee	72.01
16. Iowa	63.18	44. Texas	64.88
17. Kansas	62.75	45. Utah	65.26
18. Kentucky	71.87	46. Vermont	66.41
19. Louisiana	70.86	47. Virginia	66.56
20. Maine	66.85	48. Washington	58.19
21. Maryland	56.64	49. West Virginia	69.94
22. Massachusetts	54.60	50. Wisconsin	61.01
23. Michigan	58.83	51. Wyoming	59.15
24. Minnesota	62.66	52. Guam	75.00
25. Mississippi	75.00	53. Puerto Rico	75.00
26. Missouri	60.18	54. Virgin Islands	75.00
27. Montana	64.08	55. American Samoa	75.00
28. Nebraska	62.10		

Mr. COHEN. The Federal percentage under the bill may vary State by State in relation to a number of factors, and we have prepared here what is our best evaluation from the law and the authority thereunder as to what the Federal matching proportion for each State would be.

Finally, taking the program in terms of the details given you, of the facilities which start at $10 million and in the fourth year $40 million, I have prepared here what the allotments would work out, State by State under the facilities construction part, and I am sure both of you and the rest of the committee would be interested, I will just quote the appropriate figures for Alabama. Under the $10 million in 1965 the Federal allotment would be $208,615.

In 1968, with $40 million, Alabama would receive $943,139. The comparable figures for Florida would be $257,465 in 1965 and, in 1968, $1,163,985. The table I will submit for the record contains the appropriate figures for each of the several States.

(The material referred to follows:)

Tentative allocations to States for construction of mental retardation facilities

	Amount		Per capita $10,000,000	Based on— $40,000,000
Total	$10,000,000	$40,000,000	$0.053	$0.212
1. Alabama	208,615	943,139	.062	.281
2. Alaska	100,000	100,000	.407	.407
3. Arizona	100,000	326,421	.066	.216
4. Arkansas	117,162	529,683	.064	.291
5. California	652,952	2,951,966	.038	.174
6. Colorado	100,000	377,582	.052	.198
7. Connecticut	100,000	444,070	.039	.171
8. Delaware	100,000	100,000	.213	.213
9. District of Columbia	100,000	123,798	.128	.158
10. Florida	257,465	1,163,985	.047	.213
11. Georgia	236,374	1,068,637	.058	.261
12. Hawaii	100,000	142,073	.144	.205
13. Idaho	100,000	169,500	.143	.243
14. Illinois	406,940	1,839,753	.040	.181
15. Indiana	218,624	988,390	.046	.210
16. Iowa	133,441	603,277	.048	.217
17. Kansas	105,114	475,216	.047	.214
18. Kentucky	181,147	818,957	.059	.266
19. Louisiana	193,944	876,811	.058	.263
20. Maine	100,000	232,163	.100	.232
21. Maryland	137,850	623,212	.043	.195
22. Massachusetts	211,471	956,050	.041	.185
23. Michigan	360,775	1,631,046	.045	.204
24. Minnesota	167,207	755,935	.048	.218
25. Mississippi	165,154	746,651	.073	.332
26. Missouri	194,802	880,689	.045	.203
27. Montana	100,000	157,878	.141	.223
28. Nebraska	100,000	310,510	.067	.209
29. Nevada	100,000	100,000	.299	.299
30. New Hampshire	100,000	133,295	.158	.211
31. New Jersey	243,240	1,099,676	.039	.176
32. New Mexico	100,000	249,070	.098	.244
33. New York	648,143	2,930,224	.037	.168
34. North Carolina	278,652	1,259,772	.059	.266
35. North Dakota	100,000	167,613	.156	.261
36. Ohio	441,899	1,997,804	.044	.198
37. Oklahoma	124,238	561,678	.051	.229
38. Oregon	100,000	374,235	.054	.201
39. Pennsylvania	503,479	2,276,200	.044	.200
40. Rhode Island	100,000	175,159	.116	.202
41. South Carolina	160,800	726,968	.066	.298
42. South Dakota	100,000	174,971	.139	.243
43. Tennessee	213,218	963,951	.059	.265
44. Texas	504,341	2,280,103	.050	.225
45. Utah	100,000	226,159	.103	.234
46. Vermont	100,000	100,000	.256	.256
47. Virginia	214,650	970,420	.051	.232
48. Washington	130,993	592,213	.044	.197
49. West Virginia	101,192	457,484	.057	.258
50. Wisconsin	188,762	853,382	.046	.209
51. Wyoming	100,000	100,000	.274	.274
52. Guam	4,948	22,367	.077	.346
53. Puerto Rico	188,104	850,407	.077	.346
54. Virgin Islands	2,629	11,887	.074	.333
55. American Samoa	1,675	7,570	.079	.359

Tentative State allocations, on per capita basis, for construction of mental retardation facilities (States ranked from highest to lowest)

	Based on $10,000,000
Total	$0.053
Alaska	[1].407
Nevada	[1].299
Wyoming	[1].274
Vermont	[1].256
Delaware	[1].213
New Hampshire	[1].158
North Dakota	[1].156
Hawaii	[1].144
Idaho	[1].143
Montana	[1].141
South Dakota	[1].139
District of Columbia	[1].128
Rhode Island	[1].116
Utah	[1].103
Maine	[1].100
New Mexico	[1].098
American Samoa	.079
Guam	.077
Puerto Rico	.077
Virgin Islands	.074
Mississippi	.073
Nebraska	[1].067
Arizona	[1].066
South Carolina	.066
Arkansas	.064
Alabama	.062
Kentucky	.059
North Carolina	.059
Tennessee	.059
Georgia	.058
Louisiana	.058
West Virginia	.057
Oregon	[1].054
Colorado	[1].052
Oklahoma	.051
Virginia	.051
Texas	.050
Iowa	.048
Minnesota	.048
Florida	.047
Kansas	.047
Indiana	.046
Wisconsin	.046
Michigan	.045
Missouri	.045
Ohio	.044
Pennsylvania	.044
Washington	.044
Maryland	.043
Massachusetts	.041
Illinois	.040
Connecticut	[1].039
New Jersey	.039
California	.038
New York	.037

	Based on $40,000,000
Total	$0.212
Alaska	[1].407
American Samoa	.359
Guam	.346
Puerto Rico	.346
Virgin Islands	.333
Mississippi	.332
Nevada	[1].299
South Carolina	.298
Arkansas	.291
Alabama	.281
Wyoming	[1].274
Kentucky	.266
North Carolina	.266
Tennessee	.265
Louisiana	.263
Georgia	.261
North Dakota	.261
West Virginia	.258
Vermont	[1].256
New Mexico	.244
Idaho	.243
South Dakota	.243
Utah	.234
Maine	.232
Virginia	.232
Oklahoma	.229
Texas	.225
Montana	.223
Minnesota	.218
Iowa	.217
Arizona	.216
Kansas	.214
Delaware	[1].213
Florida	.213
New Hampshire	.211
Indiana	.210
Nebraska	.209
Wisconsin	.209
Hawaii	.205
Michigan	.204
Missouri	.203
Rhode Island	.202
Oregon	.201
Pennsylvania	.200
Colorado	.198
Ohio	.198
Washington	.197
Maryland	.195
Massachusetts	.185
Illinois	.181
New Jersey	.176
California	.174
Connecticut	.171
New York	.168
District of Columbia	.158

[1] Indicates States receiving minimum allotment.

Mr. COHEN. Now, Mr. Chairman, I think that I should mention that the points that have been discussed here, relate to some of the distinctions we should keep in mind between the mental health program that

Mr. Jones discussed, and the mental retardation program that I am discussing.

First, in line with what Mr. Rogers asked this morning, I think we must keep in mind that there is a very important distinction between mental illness and mental retardation, which is the basic policy consideration as to why we have constructed these two programs into two separate categories.

I would like to first dwell on that for a moment.

Mental retardation and mental illness in most instances are separate health problems. It appears that the greater part of mental illness manifests itself in young and older adults after a period of relatively normal development. Mental retardation is usually a condition resulting from developmental abnormalities that start prenatally and manifest themselves during the newborn or early childhood period.

Mental illness includes problems of personality and behavior disorders especially involving the emotions. Mental retardation includes intellectual defects frequently present at birth or in early childhood.

There is always a defect in intellectual function in mental retardation, but mental illness may or may not involve such a defect. If there is such an involvement it is not usually of the nature and degree found in mental retardation.

These two problems are related in that they frequently occur in the same patient, and frequently involve some of the same kinds of professional skills to diagnose or assist the patient.

On the other hand, each problem does occur independently of the other, and adequate professional skill to deal with one problem does not assure competency to deal with the other.

The ability to clearly distinguish between these problems in a given patient and deal with each appropriately is often the crux of good care.

Now, the second factor in our thinking for the construction of these bills in somewhat separate manner is the fact that unless there is a categorical earmarking of funds for each of them separately, we believe that neither of them will receive the full support and attention in the local community and in the State that they deserve. We believe that while there are groups in each community that are interested in both problems, we should keep in mind that there are different groups interested in each of these problems in the local community.

There may be a local community mental health organization or society and there also may be a group related to mental retardation.

As a matter of fact, many times you will find parents and community organizations of teachers and other groups who are interested in mental retardation while there are other groups in the community who are interested in mental health. That is fundamentally the difference between the diagnosis, and treatment of these two problems, the need for doing something in both of them, and the fact that in communities the organizations and facilities that deal with them and the community response will be handled somewhat differently. This is why we believe that these have to be looked at in these separate and specialized ways.

Now, if I could put it perhaps in another way. The problem of mental health has probably received more attention, both community and professional, over the last 100 years—let's say, since Dorothea Dix and others were instrumental in trying to get Congress to take

action in this area—while mental retardation programs have not, both nationally and communitywise, as rapidly as those in the field of mental illness.

It is for that reason, that in the mental retardation bill, we are proposing the construtcion of approximately 10 centers in which we would attempt to foster throughout the United States research and scientific and highly developed professional attention to some of the basic problems of mental retardation.

The report of the President's Panel, the Mayo Committee, on which were represented many of the outstanding experts in the United States, made this recommendation in the belief that by a rather important decentralization of activity and focusing of the key scientific and professional people in a number of centers, we might be able more rapidly to develop the basic understanding and thinking as to the prevention and cure of this more important problem.

While I should say that is the basic reason why the centers, the specialized centers in title I of this bill, are there, and that, of course, is quite a distinct feature from, let's say, the community mental health area, where there has been a good deal of research, and attention to the problems of mental health coming out of the National Institute of Mental Health over the last 15 years.

Now, with respect to the second feature in the bill, the construction of mental retardation facilities, I should make it clear that these facilities involve some important differences from the comprehensive community mental health centers that Mr. Jones discussed. The problems of dealing with the mentally retarded are not simply those that might be said to be oriented around medical problems. The problems of mental retardation of both children and adults involve the training of these children at an early age, their education, developing various work programs and recreation programs, and attempting for those that are both educable and trainable to make them productive citizens, by adjusting the needs for work to their particular capabilities.

As a matter of fact, I have just returned from studying at firsthand the one in Conway, Ark., in which they are doing some interesting research which shows that the potentialities of education of these people and training is greater than we had thought in the past. And therefore a number of clinical psychologists and teachers are working in that area. And this might well be a component of a mental retardation facility that one wouldn't find in a comprehensive mental health facility, because you are dealing with a large number of children and young adults here who, if we do not incorporate these education, training, and work programs, easily may become custodial cases for the rest of their lives. And many of these children and young adults can be made into productive citizens if at an early enough age a total continuum of services is made available to adjust to their needs.

So in that case the mental retardation facility is likely to involve a broad pattern of professional staff, and perhaps in total less physicians and psychiatrists in the mental retardation clinic, and more teachers and psychologists, let us say, than there would be in the staffing pattern for the community comprehensive mental health centers.

Now, that is not to say that in a great university or in some very outstanding medical complex that we might not find both of these centers together. I can well conceive that in some of the very great

universities and very great medical schools where they will have a medical school, where they will have a nursing school, where they have a rehabilitation facility, where they will have a hospital that they are getting money for under Hill-Burton, and they will always have, perhaps, a comprehensive mental health center, they might have a mental retardation research center, and they might also have a mental retardation facility, because they happen to have the complements of trained personnel and the know-how that would be, for a particular State, a very key combination of circumstances.

But that would not mean that other communities might not have just one of these or, it might, because of its bcakground and experience, start with mental health in one community and mental retardation in another, in an attempt to deploy its force, in terms of the limitation of trained manpower that Mr. Rogers mentioned, in a way that it felt was most important in meeting its needs in terms of the organization of people in its communities.

It may well be that parents in a particular community are much more concerned about mental retardation, they happen to be well organized, and there may be mental retardation facility there. And in another community they might also be very well organized, there might be 10 years of work in community mental health and they might have a mental health facility, and hopefully, maybe 5 or 10 years, there may be both.

Mr. ROGERS of Florida. May I ask a question at this point.

Would you put in the record, the personnel in your mental retardation centers—I believe you said you would construct 10 in the beginning—and then the personnel you would envision in your retardation facility.

Mr. COHEN. I would be glad to do that.

(The material referred to follows:)

STAFFING PATTERN OF CENTERS FOR RESEARCH ON MENTAL RETARDATION AND RELATED ASPECTS OF HUMAN DEVELOPMENT

It is difficult to visualize a single staffing pattern for a mental retardation research center, as these would vary according to institution and research program area. In some cases, a center may involve primarily biological scientists working on problems of fetal-maternal metabolism, whereas, another center may focus on the behavioral and learning components of mental retardation. Other centers may combine biological and behavioral sciences and scientists. Since these research centers will be university or institutionally affiliated, teaching and service programs would also affect the form of the staffing patterns as some persons may have dual roles and joint assignments.

The problem is made more complex because some centers may be new, whereas in other cases, they may regroup, utilize, and expand parts of existing research programs and facilities.

In any event, the staff of these centers will range from 10 to 20 scientists with supporting technical and administrative staff of 30 to 50 persons. Scientists involved may be biochemists, geneticists, physiologists, speech pathologists, audiologists, psychologists, sociologists, educators, and most of the many medical specialists.

STAFFING PATTERN OF A FACILITY FOR MENTALLY RETARDED

Staffing patterns in health facilities are often subject to manpower availability and personal qualifications. Flexibility should be permitted with efforts continually being made to evaluate effectiveness of different staffing patterns.

The annual operating costs of a facility will vary from community to community depending on such factors as the number of different services and personnel

to be included, sharing of existing services, use of consultants, rent requirements, use of volunteers, etc.

The smallest facility will offer primarily diagnostic services with others increasing in size to include one or more of the following treatment services: speech and hearing training, educational training, vocational and physical rehabilitation, parent counseling and health education, and professional training programs.

In some cases, the facility may be a part of a research center with a sharing of staff, space, and equipment.

Mr. ROGERS of Florida. Just as a brief summary now, I realize you may not have all the facilities you want to put in, but what would you envision in a retardation center?

Mr. COHEN. In a retardation center, as pointed out——

Mr. ROGERS of Florida. The kind of personnel.

Mr. COHEN. The kind of personnel, yes. I think you are going to find there a very high level of professional competence. You are going to find people who can deal with microbiology and virology and pharmacology and nutrition, because they are going to be working on all these problems of the care of the mother and the child before it is born.

Mr. ROGERS of Florida. This is the research center?

Mr. COHEN. This is the research center.

Mr. ROGERS of Florida. Would this be supervised by doctors?

Mr. COHEN. Well, you think it would have to be supervised by someone who has a very high degree of professional competence, I wouldn't say it should necessarily be an M.D., but it might be a person who is a trained scientist in one or more of the fields, and most likely, most of the time, if not all of the time, it would be an M.D.

Mr. ROGERS of Florida. You can give us the specifics on it.

Mr. COHEN. Yes.

Now, I think that I should also point out to you one other important difference in this bill——

Mr. ROGERS of Florida. Let me just ask you now, on the facility itself, what do you envision on the personnel?

Mr. COHEN. On the facility?

Mr. ROGERS of Florida. Just to follow that up.

Mr. COHEN. On the facility itself I would say, to again make the point as distinct from what Mr. Jones talked about, a mental retardation facility is probably going to involve more teachers and more custodial help than the professional help that is involved in the comprehensive mental health center.

Mr. ROGERS of Florida. Do you envision it more as a teaching facility than as a health facility?

Mr. COHEN. I would not say as a teaching facility, but I would say that it would not be oriented solely as a health facility, it would be oriented as a facility dealing with a totality of the problems of mental retardation, of which education and training are a very important component.

Mr. ROBERTS. Would the gentleman yield?

There is no provision in any Federal statute for your mental retardation center.

Mr. COHEN. That is correct.

Mr. ROBERTS. That is strictly up to the local people. What you are saying is that it may be that primarily the need will be for teachers

or custodial care or for people to train them, perhaps, in useful work, and things of that nature.

Mr. COHEN. Yes. And there would have to be some physicians and some psychologists and some nurses and some paramedical personnel, just as Mr. Jones said in connection with the comprehensive mental health facility.

Mr. ROGERS of Florida. Would you set any minimum standard for them?

Mr. COHEN. This would be in connection with the construction grant. We provide that there must be minimum standards for the maintenance and operation of the facilities. The component of that—let me put it this way: We would not want to make a construction grant for the Federal Government to spend a lot of money unless the community gave some assurance that in its maintenance and operation it was going to carry out what the construction was for.

But as Mr. Roberts says, the important distinction here is that there is no staffing grant funds on the 4-year basis for the mental retardation facilities such as there are in connection with the comprehensive community mental health services.

Mr. ROBERTS. Would you yield?

Mr. ROGERS of Florida. Yes.

Mr. ROBERTS. For instance, I happen to have in my home community a nonprofit, volunteer group which has obtained some property, and they operate about, I think, 2 days a week strictly on UGF funds, or I think they do get some money from the city and county. And they maintain this community facility for, say, 2 days a week, the best that they can do with the volunteers they have. Some of these ladies are teachers, some psychologists, some have had various types of workshop training, and some know something about rehabilitation. Now, would that type of facilities be able to participate in this program?

Mr. COHEN. Well, when you use the word "facility" there, do they already have a building that comprises all of this?

Mr. ROBERTS. Yes.

Mr. COHEN. Well, the main factor in title II of this bill is the grant for the construction of the adequate facilities.

Mr. ROBERTS. That would be up to the State, probably the State health department or some similar agency, to determine whether or not this type of operation would be eligible under the act?

Mr. COHEN. Yes.

Let me explain first how the Federal act would operate.

First, the Federal Hospital Counsel as expanded by this bill would, after consultation with the Surgeon General and the Secretary and the other persons concerned with this, lay down general regulations as outlined in section 203 of the bill for determining the kind of services that are needed for the mental retarded, the general manner in which the State agency shall determine priority on the general lines of the Hill-Burton concept of priority, general standards of construction and equipment, and provision for adequate facilities for these individuals.

Then, in the light of those general regulations that one sent out to all of the States, each State and each locality would have to propose a series of projects with priority in the State for getting this money.

And probably if this community that you are saying already has an adequate facility, then another community that didn't have one at all would probably end up with a much higher degree of priority in terms of the limited amount of Federal funds, because the thought behind that program is to extend these facilities to areas that don't have them.

Mr. ROBERTS. Of course, as the facility is now, it is not adequate, in that they can only operate about 2 days a week, and as a matter of fact, they have many, many applications from people they would like to help, but they simply cannot take care of them under the limited resources that they have.

Now, I wouldn't want us to write a piece of legislation that would discourage this type of local effort, I would want it to certainly encourage it, and where there is need for this particular type, I wouldn't want to penalize the pioneers and the people that are going ahead, you might say, without any State help. And these people are doing it within a metropolitan area of about 40,000 people. So I would want the Secretary to consider that very carefully before we put anything in there that might eliminate them.

Mr. COHEN. Yes. The big point here, Mr. Roberts, is that in this area we do not give this facility the staffing aid that we give the comprehensive community mental health facilities. And I don't know the situation that you are speaking of, but if the problem was that they didn't have enough funds or personnel or both to man the facility as extensively as they wanted, the problem would still remain as a local financing problem under this bill, because they couldn't get any operational cost help as they could in the other area.

Now, in the area that Mr. Jones mentions there may well be a community mental health service that was not comprehensive that had two or three items, as Mr. Jones suggested. But with the addition of some more personnel and some more facilities, it might be able to become a comprehensive community mental health center within a short period of time. In that case, they would then be able—that, however, is not the case here with the mental retardation facilities, we just haven't had as much background or experience in dealing with this, and it was for that reason that we did not add the staffing grant funds.

However, I would have to be frank and say that in the light of the questions you asked, that would still be a problem for many communities.

Mr. ROBERTS. Of course, I understand too that the supply of trained personnel, teachers of the deaf and handicapped, would come under another committee.

Mr. COHEN. Yes.

Mr. ROBERTS. I understand why you are not requesting that.

Mr. ROGERS of Florida. Is there any reason who you didn't provide for some staffing of the mental retardation factilities?

Mr. COHEN. Well, I think it is because we are in a more, as I tried to say, an earlier stage of development here. And in the work that we have done of this we were not as able to be—to see ahead just what was involved. I would say, if you asked me in principle, I would say that probably they ought to get some staffing help just like the community mental health centers. But since we didn't know enough

about it, we were rather cautious, and we felt that if we got some of these centers and facilities started and there did appear that there would be a problem after a period of time, our only recourse would be to come back and recommend to you how that would be handled.

Mr. ROBERTS. Of course, I know you know the bill, and I am not trying to make any discussions here except to say that I am wondering if, as this develops in some of the 10 regional research centers that are going to be set up, if that could be a kind of a place for training some of these people who would be farmed out, or maybe loaned, to some of these small communities who so desperately need this help. Could that be worked out?

Mr. COHEN. Yes, Mr. Roberts. That is very definitely a fundamental conception underlying this entire program. The point I mentioned about the centers being connected with universities—and in fact these centers could be used so that internships and residencies and predoctoral and postdoctoral traineeships would be developed here so that it would help to expand the volume of trained personnel—I was going to mention the point, I was going to mention earlier when I said there was one more distinctive feature of that bill, and that is, in title II, section 201 in connection with the construction of the mental retarded facilities, we have earmarked exactly half the moneys that are authorized or that we thought we would request to be appropriated only for grants for the construction of these facilities for the mentally retarded which are associated with a college or university hospital, or other appropriate part of a college or university the ground that with a limited amount of money, some of it should definitely be associated with an educational, teaching, medical complex, so that you would be training personnel to meet the manpower shortage.

If we were just to construct all of it in places where it was solely treatment, as important as that might be, it wouldn't generate the new personnel that is necessary to do a better job. And we think, if you are going to spend Federal money, it should definitely have a teaching and a manpower increase element in it.

Mr. ROGERS of Florida. So you envision 10 centers for half of it?

Mr. COHEN. No, I am talking about the facilities on the half. The 10 centers, I don't know where they would exactly be, but I think a large number of them would end up in some kind of a medical education complex, because the need for such highly professional personnel—let's say personnel in the field of genetics, you are going to have to have Ph. D.'s in the field of genetics, you are going to have Ph. D.'s in the field of psychology, you are going to have to have pharmacologists—you are not just going to have those people in appropriate numbers outside of some educational-medical complex.

Mr. ROGERS of Florida. What do you estimate the cost of maintaining a staff for one of these facilities would be?

Mr. COHEN. The maintenance of the staff for a mental retardation facility—I don't happen to have that with me, but I will be glad to put that in the record.

I think you are going to find on that one that the probability is that the operational costs on that are going to vary a good deal. It was that very factor that made us think twice before recommending to you that the Federal Government undertake financing it. There perhaps is some experience in the United States on that, but I think

we would really have to wait for actual local experience before we would have a good estimate. But we will put in the record the best we have.

(The material referred to follows:)

Examples of staffing patterns of three types of services offered in facilities for the mentally retarded and estimated costs

Staff	Outpatient diagnostic services			Day-care treatment combined with diagnostic services		Residential care for 20-bed unit combined with diagnostic services and day-care treatment	
	Average salary (thousands)	Number	Total annual cost (thousands)	Number	Total annual cost (thousands)	Number	Total annual cost (thousands)
Physicians	$17	1	$17.0	2	$34	2	$34
Psychologists	11	1	11.0	2	22	2	22
Social workers	8	1	8.0	2	16	2	16
Teachers	6	½	3.0	3	18	3	18
Nurses	6	½	3.0	1½	9	1½	9
Speech pathologists	8	½	4.0	1	8	1	8
Audiologists	8	¼	2.0	½	4	½	4
Dentists	14	¼	3.5	½	7	½	7
Nutritionists	6	¼	1.5	½	3	1	6
Other professional consultants	10	1	10.0	1	20	2	20
Recreational leaders	6			1	6	1	6
Vocational therapists	6			1	6	2	12
Administrative staff	5	2	10.0	7	35	17	85
Total		8¼	73	23	188	35½	247

Mr. ROBERTS. I think this has been very beneficial to the committee, and I would like to thank you, the Secretary, Mr. Jones, Dr. Terry, and all of you who have attended. I appreciate it very much. I am sorry we have had to hold you all day, but I think that this will be very helpful to us, and we are grateful to all of you gentlemen.

Mr. COHEN. Thank you, Mr. Chairman.

Mr. JONES. Thank you, Mr. Chairman.

Mr. ROBERTS. The Chair would like to announce that the hearings will continue tomorrow morning in the same hearing room at 10 o'clock.

(Whereupon, at 3:55 p.m., the hearing was adjourned to reconvene at 10 a.m., Wednesday, March 27, 1963.)

MENTAL HEALTH

WEDNESDAY, MARCH 27, 1963

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

The subcommittee met at 10:22 a.m., pursuant to recess, in room 1334, Longworth Building, Hon. Kenneth A. Roberts (chairman of the subcommittee) presiding.

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

The hearings today on mental health and mental retardation will continue and our first witness today is the distinguished Governor of the State of Tennessee, the Honorable Frank G. Clement. We are very happy to have the Governor with us today. I think most of you know that he is one of the outstanding young Governors in our great Union, a keynoter of our Democratic Convention in 1956, and the Governor appears here today in his official capacity, and we are particularly happy to have you, Governor.

I might mention this is a double pleasure to me in that your press secretary was formerly a staff member and worked with us here for some time in the field of highway safety. I know of the fine leadership that you have taken in this field, the fine work that is being done, and was done in your first administration. I am sure it will continue under your next administration as Governor of the great Volunteer State.

It is a real pleasure to have you with us and we will be happy to have your testimony at this time.

STATEMENT OF HON. FRANK G. CLEMENT, GOVERNOR OF THE STATE OF TENNESSEE, ACCOMPANIED BY EDWARD F. JONES, PRESS SECRETARY TO THE GOVERNOR

Governor CLEMENT. Thank you very much, Chairman Roberts. To you and your two distinguished associates who are here I can only say this, that you took the words out of my mouth. I was going to remark about the fact that you were kind enough to loan Eddy Jones to me and we are glad to have him, I will put it that way, as press secretary.

I am not going to take up a great deal of your time, Chairman Roberts, and you gentlemen of the committee. I appreciate the chance to appear on behalf of the bills that I understand you are considering because they bear on a subject that I have been closely identified with for the past 10 years.

While this identification with mental health has not qualified me to speak as a professional in the field, I might add this, although I do

not have my commissioner of mental health with me today, it is for a very good reason. He has got two other engagements. He suggested to me that he did have some friends here who he felt were fully qualified to speak and if there are any technical questions, I will be delighted to call them to my side and between us we will do the best we can.

This has given me an opportunity to see at close range some of the developments that have been occurring in public programs for the mentally ill and the mentally retarded in the last few years.

To begin with, like Tennessee, most States have awakened to the fact that they have been sadly neglecting their mentally ill and their mentally retarded. They have taken stock of their situation and have found that they were the proud possessors of several sets of more or less ancient buildings, which by a stretch of the imagination were called hospitals. I think they could be more appropriately called institutions.

Almost without exception, these buildings were in a state of disrepair through lack of maintenance, and by the time I came into office at least, many more people were housed in them than they were designed for. Professional treatment personnel were so woefully outnumbered by their patients that there was practically no chance for any patient to receive individual care. And this was the baseline that most States started from—not 100 years ago but in the past 10 to 20 years.

Gentlemen, if I don't make any other point to you today, I would like to bring out into the open the fact that it is only in the last 10 to 20 years in my opinion as a three-term Governor of Tennessee that we have brought this subject of mental health out of the shadows and into the sunlight.

During this recent period, I have no doubt that more money has been spent on public mental health programs by the various States than was spent in America in the preceding 100-year period, and yet there is still the problem of overcrowding and lack of adequate professional staff. These problems confronted me when I first took office as a young man of 32 as Governor of Tennessee, and that was in the year of 1953, and while great progress has been made, some of them were there waiting to meet me when I took office again in January of this year.

Now our program has improved tremendously in Tennessee during these past 10 years. We have created a separate department of mental health which has been headed continuously by a qualified psychiatrist. We have added intensive treatment buildings to our old hospitals. We have built three entirely new hospitals. We have started 12 new community mental health clinics and other experimental projects. This is not a unique record.

I wouldn't sit here and try to make you think today that I am the only Governor who has done anything about mental health. In their own way other States, perhaps your States, have responded to the problem with equal determination. Each one has experimented with ways to improve on the old models, the old models for care which were inherited from the past. And yet, gentlemen, no State can say that it has achieved a satisfactory way of dealing with this mental health problem.

Perhaps 10 years is not a fair test, but it is the only test that I personally can apply. After all, we are attempting to correct the accumulated ills of many decades. In any case it cannot be said that the States have waited to act until they were assured of Federal aid.

The States have been acting, and I can say to you that Tennessee acted without regard to whether the Federal Government did or did not do something about it. The bills under consideration today acknowledge this and provide impetus for still further action.

What makes these measures especially attractive is the fact that they point in substantially new directions. For example, I am advised that House bill 3688 stipulates that any community mental health center seeking Federal support must provide, as a minimum, diagnostic services, inpatient care, outpatient care and day care for mentally ill persons, and I would submit to you, gentlemen, that one of the things that I as a Governor appreciate is the fact that you as Congressmen would lay down certain rules, give us certain guidelines, and say to us that while you are going to give us certain help, that at the same time you expect us to do certain things, and I think that these minimums are important.

Perhaps the most important words are those which I can quote here, "inpatient care." The effect of this would be to provide a complete psychiatric service in the patient's own community. Thus, for the first time, a citizen would have the opportunity to get prompt, expert and complete care near to his or her home. It seems obvious that if this kind of care were available on a large scale, the character of public psychiatric service in America would change substantially.

Whether or not it would make the large State hospital obsolete, as some experts seem to claim, I would certainly not try to predict. But if there were enough of these small clinics strategically located about the various States, it should certainly not be necessary to continue crowding sick patients into large institutions where it is almost impossible to provide extra care on an individual basis.

While the provisions of this particular bill would not bring about this change overnight, it would make possible a significant beginning and would demonstrate very dramatically the value of comprehensive psychiatric care in the community.

House bill 3689 is equally important in that it does recognize for the first time the need for Federal action in the field of mental retardation.

It is hard for those of us who have not seen a disorder of this kind in our own families to appreciate the tragedy it involves. Of all the various kinds of human beings who are dependent on the public conscience for help, these are among the foremost because they have been deprived of the intelligence necessary to care for themselves.

No Governor can be in office very long and remain ignorant of the needs in this field. He becomes educated very promptly by the families who call him, pleading for help for a retarded child in their own family. Here, too, there have been significant changes in the past few years.

The bill also recognizes the urgent need for more facilities to provide comprehensive care for retarded people, many of whom are completely dependent because of multiple handicaps. Gentlemen, I feel, as a citizen and as a Governor, that these bills deserve to be passed. The solu-

tions to the problems to which they are addressed are truly in the public interest.

While I am not here to represent any State except Tennessee, I would like very much to add that these bills are compatible also with the spirit of the policy statement adopted by the Governors' conference on mental health at which time I was not privileged to be present. It was held in Chicago in November 1961. For these many reasons, gentlemen, I respectfully commend them to you for your favorable consideration.

I want to add this one thing, Mr. Chairman Roberts, if I might. I don't know, and I think I said this to you and the other two Congressmen before you took your seats, and while we were sitting there talking, I don't know where my first interest in mental health took place but I don't mind anyone knowing that it is my pet project. I am interested in it.

I will try to answer any questions which you may have to ask, and I want to say this, that after I started making my statement I was delighted to see that my Congressman, the distinguished gentleman from Nashville, Davidson County, the Fifth Congressional District, the Honorable Richard Fulton, came in.

Dick, it is good to see you.

If you want to ask me any questions, gentlemen, I will be glad to try to answer them. I have got some experts here from New Jersey, Kentucky, and other places who say that they will be glad to try to help me field your questions.

Mr. ROBERTS. Thank you, Governor. We certainly appreciate your fine statement. I think your appearance here and the appearance of Mr. Fulton, the Member from the Fifth District of Tennessee, bring to my mind the fact that for many years our chairman of the full committee was a gentleman named Percy Priest who did so much for this country in the field of health. I think it is highly significant that the Governor of his State and his Congressman are here today to testify in favor of these two very important bills.

When I first came to this committee some years ago I was privileged to serve on a subcommittee called Health and Science and Percy Priest was the chairman of that subcommittee because as you have and as I am sure Mr. Fulton has, he had a great devotion to this field of public health and many of the things that we are doing in this committee go back to his loyalty and his great service in this field of public health.

He was a tremendous man, and had, I think, more friends than any man who ever served in the Congress, who served at the time he did.

Again I wish to thank you for taking the time out of what I know to be a busy schedule to come here and give us the benefit of your testimony. We are also happy to have you, Mr. Fulton.

Mr. FULTON. Thank you, Mr. Chairman.

Governor CLEMENT. It has been a real pleasure. Let me ask you, Mr. Chairman, if I might, didn't you and Congressman Priest serve together on the same committee?

Mr. ROBERTS. That is correct. I served with him I believe for about 6 years prior to his death.

Governor CLEMENT. Well, I would like for the record to show that I know exactly who was here when I talked. I believe we have

Mr. Nelson here, am I correct, sir? And I believe we have Mr. Brotzman here. Am I correct? How do you pronounce it?

Mr. BROTZMAN. Actually we use the short "o" down here.

Governor CLEMENT. You pronounce it for me, will you?

Mr. BROTZMAN. We call it Brotzman.

Governor CLEMENT. Down in Tennessee we like to pronounce it the way you want it pronounced. We will just put it on——

Mr. BROTZMAN. That is what I am used to.

GOVERNOR CLEMENT. I do want to say this in conclusion, Mr. Chairman. To me I know that you have got many problems, that you have got items involving everything from outer space and billions of dollars on down and I have before me in Tennessee right now a bill which should attract your interest. We call it the miscellaneous appropriations bill. It involves millions of dollars and I have to sit there and line item veto things which cost me many votes, and I know that when I am doing that, but there is one thing if I could just leave here today and let you four Congressmen believe this, my trip to Washington will have been a success, and that is you have it in this subcommittee within your power to do something for those who cannot help themselves.

Mr. ROBERTS. Thank you.

Governor CLEMENT. Thank you very much.

Mr. ROBERTS. The gentleman from Minnesota?

Mr. NELSEN. Governor, I wish to also express my appreciation to you for your appearance here. I have a question a little apart from the bill involved. Do you still have John MacDonald on the Noontime Neighbors program down in Nashville?

Mr. JONES. Yes, sir.

Governor CLEMENT. This is the first time that the press secretary answered before a Governor had an opportunity to do so.

Eddy, come up here. We are going to put you on the spot. Yes. We are going to make John a little bit famous today.

Mr. NELSEN. Years ago—you will be interested in this little human interest angle—years ago I ran the REA administration under President Eisenhower and John had me on his program at noon and he rings a little bell when the program starts and the bell was not of good quality; the tone was rather dull; this surprised me. I thought Tennessee could do better.

I said to John, "John, I have a better bell than that in the grove on my farm back in Minnesota," and John said, "Why don't you all send it down here?"

I did, and it cost me $13 to ship it down here, but every noon when John's program starts the bell rings and the bell that rings came from my farm in Minnesota. So I want to add to the cultural background of your State.

We are happy to——

Governor CLEMENT. I have to say this. There is nothing like the Governor of the Volunteer State of Tennessee coming up, and with the permission of the press—they won't let me do it, I am sure, but I am going to go off the record anyway—I will put it this way. We are going to repay you and through you we are going to take care of Mr. Rogers, Mr. Fulton, the chairman, all of you, Mr. Brotzman, and we are going to take care of all of you.

There is one thing we are going to do. We are going to repay you for that bell by giving you, each of you, a pair of cuff links which represent the great seal of the sovereign State of Tennessee.

Now, don't ask me how much these cost and don't ask me who paid for them. But you are going to get them, gentlemen. So that is all I can say. [Laughter.]

Mr. ROBERTS. Governor, our distinguished chairman, the gentleman from Arkansas is here and we always appreciate his appearance——

Governor CLEMENT. It couldn't be Mr. Oren Harris, could it? Let me say hello to him, if I might.

Mr. HARRIS. A pleasure. The last time I saw you I think we rode an airplane.

Governor CLEMENT. I believe, if I am correct, aren't you the chairman of the full committee, Mr. Harris?

Mr. HARRIS. Yes. I have that distinction and honor. I should say responsibility. I get a lot of help from people like those you see here, too.

Governor CLEMENT. We are delighted to be here with you.

Mr. HARRIS. Let me join the chairman and the other members of this committee in welcoming you here and thanking you for taking time out of what I know is a very busy schedule to come here and testify on this important program. I am glad to have an opportunity to be present while you are here. I compliment you on what I know has been a very fine presentation.

Now, I will probably offer a word of caution on the promise you have just made. I remember that during World War II, it was difficult to get nylon hose and an outstanding businessman in our State made an offer to present the wives of the Arkansas delegation with nylon hose. A certain news reporter evidently found out about it and called one of the wives and she acknowledged that she was looking forward to getting the hose, and it was written up all over the country. He got a little uneasy, and they never did get the hose. [Laughter.]

Governor CLEMENT. But you are going to get the cuff links. In fact, I am going to say this, if I might, Mr. Chairman. You are going to get the cuff links before the day is over, before sun sets tonight. Now, you have already got your pair. These other gentlemen, you will notice by remote control I just kind of sit back here and these things happen. You have got yours, haven't you?

Mr. HARRIS. Yes, sir. Let me say that this is one of the most efficient new Members of the House I think I ever saw come here because he has already given me the cuff links that you promised.

Governor CLEMENT. Well, we try to do things expeditiously in Tennessee. We try to be on the ball, but these other gentlemen will have theirs before the sun sets on Washington today.

Mr. HARRIS. Thank you vry much.

In all seriousness let me say, what you don't know is that I am a collector of cuff links. I have more cuff links and different kinds I suppose than anybody around here. I have several boxes filled with them.

Governor CLEMENT. I did not know that.

Mr. ROBERTS. Governor, I am sorry the chairman made that statement because I have missed several pairs lately. [Laughter.]

Mr. HARRIS. I am glad to have these to add to my collection.

Governor CLEMENT. If I might say, Mr. Chairman Roberts, first of all, Congressman Roberts, I did not know that Congressman Harris was going to be here, and secondly, I did not know that he was a collector of cuff links. So I feel like, you know, it is kind of like "clement" weather, "inclement" weather, and there seems to be clement weather today. I seem to have done fairly well.

Let me say this: I think you will notice on those cuff links, Mr. Chairman, that you have industry represented and commerce, agriculture, and we just hope that in some way or other you will think of Tennessee in particular, the Nation in general, and that we will be able to get some legislation which will be in the name of mental health. That is all I can say. Thank you.

Mr. ROBERTS. Governor, I would like to mention that I do appreciate the offer of the cuff links and I also have one thing that I am very proud of. I am an honorary captain in the Tennessee Highway Patrol and it has been very helpful to me on certain occasions when I can get down to my district in a hurry. Your patrolmen are very nice to visiting Congressmen.

Governor CLEMENT. Well, what route do you follow?

Mr. HARRIS. Don't answer that.

Governor CLEMENT. You are in the——

Mr. ROBERTS. I try to take a different one each time.

Governor CLEMENT. Mr. Chairman, you are in a position now where you are going to have to make a speedy decision, is it better to tell him which I do follow or don't follow. What do you follow going from Washington? I believe it is Anniston, am I correct?

Mr. ROBERTS. That is right.

Governor CLEMENT. Well, I try to keep up with you, Congressman. I just want you to know that. What route do you follow?

Mr. ROBERTS. I usually go Route 11, but the patrol has become so efficient that sometimes I take a little detour.

Governor CLEMENT. Let me see. Is Captain Cross here? Come here just a minute. You go up here—is it all right if he comes around—you go around there and shake hands with Chairman Roberts and explain to him that from now on out he is going to have a certificate making him a colonel on the Governor's staff and that he can explain to them that he is in a hurry to get back to Anniston. We will take care of that real quick.

Mr. ROBERTS. This has been a real fine day for me.

Governor CLEMENT. This is Captain Cross of the highway patrol from Tennessee.

Now, Dick, we have taken care of the chairman of the whole committee and the chairman of the subcommittee, and I am still interested in mental health. But these two gentlemen have also got votes. What can we do for them here?

Mr. NELSEN. You can bring greetings to my good friend John MacDonald in Nashville.

Governor CLEMENT. All right. Well, we have got that taken care of through Mr. Eddy Jones who—well, he is the reason I am here. He said, you have just got to be there and testify. This Congressman Roberts—I am not going to tell you what he said about him but he indicated he was a pretty nice fellow. So he said you have just got to be there and testify on the subject of mental health. I used to work with him.

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So we will take care of you and I will tell you what we will do. Now, you are from Minnesota. When can you come to Tennessee and accept your commission as a colonel on the Governor's staff from John MacDonald on the noonday program?

Now, when can you do that?

Mr. NELSEN. When is the turkey or the hunting season on?

Governor CLEMENT. Whatever time you want. We will put a turkey up any time. You name it. We will put one up. You just let us know. That is all. [Laughter.]

Now we are around finally—we have gotten you taken care of. We are around finally to the gentleman whose name I will never be able to prounce, but I will always remember.

Congressman, what can we do for you?

Mr. BROTZMAN. Governor, all you have to do is answer a couple of questions for me.

Governor CLEMENT. Well, I am not at all sure I can but I will try.

Mr. BROTZMAN. I think you can and I, too, would like to thank you for making yourself available to this committee. I know you are very busy and I am assured of your good faith and your interest in this particular field. And time being rather short, I would like to ask you just a couple of questions.

Governor CLEMENT. Please do.

Mr. BROTZMAN. Because I am vitally interested in the problem too. I am also interested in the relationship between what we are doing and what you Governors of the States of this country are doing, and not to spoil a good time here, because I am certainly enjoying it, but I have one question.

You alluded in your statement on page 3 to the policy statement of the Governor's conference, I believe, on mental health in Chicago in November 1961, and I wonder if you could just speak to that for a moment because I am not aware of what that policy was or if there has been any particular change in it.

Governor CLEMENT. Congressman, I can only answer it by saying this. I have in front of me the policy statement to which I referred. It was a policy statement of the special Governors' conference on mental health adopted at Chicago, Ill., November 10, 1961, and as I indicated, I was not Governor at that time.

Mr. BROTZMAN. Yes. I understand.

Governor CLEMENT. But it is rather—it is a rather lengthy statement. With your permission, Congressman, I would like to make this policy statement a part of your record. I think that it all adds up to one thing, that the Governors seemed to feel at that time, and as I say, I was not one of them then, that this is a joint function that both the Federal Government and the State government and the local community level should participate in and they felt that they ought to do something particular to try to place real emphasis. I gather that what they were trying to do was to really emphasize the need for attention on mental health, and with your permission, sir, I would like to make this a part of the record.

Mr. BROTZMAN. I think that would be very helpful. I would like to see that.

(The statement referred to follows:)

POLICY STATEMENT OF THE SPECIAL GOVERNORS' CONFERENCE ON MENTAL HEALTH, ADOPTED AT CHICAGO, ILL., NOVEMBER 10, 1961

For more than a decade, the Governors of the several States have been profoundly concerned over the inadequacy of care and treatment of the mentally ill—still the No. 1 health problem of the Nation. Their concern was evidenced not only by requests to the Council of State Governments for comprehensive studies of the mental health programs of the States and of methods for converting their custodial institutions into active treatment facilities, but also by their calling, as a result of these studies, the historic special National Governors' Conference on Mental Health, in Detroit, in 1954. A basic 10-point program was adopted at that meeting, urging intensification of efforts in the areas of community services, treatment, rehabilitation, and aftercare as well as research and training.

The Joint Commission on Mental Illness and Health, pursuant to congressional authorization, has been studying these problems for the past 6 years. The Commission's final report—"Action for Mental Health"—is the first survey in our Nation's history which relates the problem of mental illness to the various responsibilities of Federal, State, and local governments. The report indicates that progress has been made in the last few years, but leaves no doubt that much too little has been accomplished. We heartily commend the Joint Commission for an excellent study; we accept the findings that much remains to be done; and we endorse the concept that Federal, State, and local government as well as private and voluntary efforts must be combined to achieve the goals we seek.

Approximately half of all hospital beds in the United States still are occupied by patients suffering from emotional disturbances. Many of the State hospitals are seriously overcrowded; about half of their patients receive no more than custodial care rather than active treatment. Financial support has been woefully inadequate and must be increased. Shortage of professional personnel has been the prevailing condition, even when funds are available.

Community mental health services are in such short supply that almost all clinics have waiting lists making it necessary for them to delay services to applicants for periods of from 3 months to a year. Many States do not appropriate any special funds for research. Aftercare services are lacking in most States. Where they exist, they often are inadequate, leading to avoidable readmission of large numbers of patients to hospitals. Programs of patient care are fragmentary, lacking in continuity and coordination.

In the light of new knowledge and treatment potentials, a balanced State program for the mentally ill should include: Prevention and early case finding and treatment; a complete range of community-based services, emphasizing continuity of treatment; active treatment, rather than custodial care during necessary periods of hospitalization; rehabilitation and aftercare services; specialized services for patients suffering from conditions closely related to mental illness, such as mental retardation, alcoholism, delinquency, drug addiction, deterioration connected with old age, research, recruitment, training, and imaginative utilization of paid staffs and volunteers; effective centralized responsibility for all State-supported services; and involvement of professional associations, and voluntary mental health and social agencies in the basic planning and provision of the highest quality of care for all mental patients.

After careful consideration, the Governors' conference on mental health, meeting at Chicago, Ill., November 9–10, 1961, recommends that such a program be implemented as follows:

I. COMMUNITY MENTAL HEALTH SERVICES

1. Indications are that 75 percent of the acutely mentally ill who receive intensive treatment in community facilities will not require costly institutionalization. Long-term, costly hospitalization of the mentally ill should be avoided, not only for the sake of economy but also in the best interest of the patient. Whenever possible the patient should be treated in the community, through mental health clinics, emergency and short-term psychiatric services in general hospitals, day and night hospitals, halfway houses, and other rehabilitation facilities.

2. The enactment of community mental health services legislation, under which a State provides matching grants to local communities and nonprofit

groups, has served as a stimulus in the development of such services in several States and may serve as an example for others.

II. INPATIENT SERVICES

1. Every American who is suffering from mental illness is entitled to intensive treatment in a facility which is easily accessible to him. Since the so-called chronic mentally ill patient often can be salvaged and returned to the community, any arbitrary distinction between those who suffer from acute mental illness and those suffering from chronic mental illness is to be deplored—all are entitled to the best psychiatric care.

2. This treatment can best be given in small hospitals providing both inpatient and outpatient care in the heart of the community. Programs, therefore, should follow the recommendation of the joint commission that smaller hospitals should be constructed and that no beds be added where large facilities exist. Where they do exist, steps should be taken to decentralize them internally into units of appropriate size to insure the best patient care and maximum efficiency.

3. While for purposes of clarity it has been found expedient to list these recommendations under separate headings, it should be clearly understood that a patient is the same person, whether receiving care in the community or in a hospital, on an inpatient or outpatient basis, and that each treatment facility and medium must be considered an integral part of a continuum of services rendered a patient at various stages of his illness. It therefore is of utmost importance that inpatient services be integrated with community services and that the hospital reach out to the community, particularly to aid in the rehabilitation and aftercare of the patient.

III. PSYCHIATRIC SERVICES IN GENERAL HOSPITALS

The rapid growth of psychiatric services in general hospitals has been encouraging. Because they are expensive to operate in the shortrun, although cheaper in the longrun, it is recommended that States allocate specific appropriations for the support of psychiatric beds in general hospitals.

IV. RESEARCH

1. Research into the causes of mental illness offers hope for its eventual prevention, control, and cure. The States must recognize a responsibility for research and include in their mental health budgets support for substantial research.

2. There is urgent need, moreover, for the various levels of government to apply joint and immediate research efforts toward establishing best possible mental health services in relation to specific population and area requirements on the basis of current knowledge.

3. In addition to Government-supported research, a much greater expansion of research activities by nongovernmental groups and organizations is recommended.

V. CLEARINGHOUSE

Planning mental health programs requires information which can be collected and disseminated only by a centralized clearinghouse. It therefore is recommended that the National Institute of Mental Health establish a clearinghouse to supply the States, the local communities, and the general public with mental health information.

VI. PERSONNEL

1. Revised programs for the care and treatment of the mentally ill require review and analysis of staffing of mental health facilities.

2. Review of personnel policies also is recommended for best utilization of available manpower. For example, to enable professionals to devote as much time as possible to their specialties, they should have sufficient assistance to carry on the pure administrative aspects of their duties. Such a policy, at the same time, would offer an opportunity to upgrade the positions of persons qualified to carry out such responsibilities and would serve as a challenge to them.

3. The manpower shortage also can be reduced by:

(a) provision of more competitive salaries on all levels of employment;

(b) a review of the hospital patient load with a view to alternative disposition of patients inappropriately admitted and retained;

(c) assistance by the professionals in the recruitment of professional staff for psychiatric facilities;

(d) reexamination of the qualifications required for service in public mental hospitals.

VII. TRAINING

1. A partial solution to the present shortage of professional manpower lies in better utilization of existing personnel and the addition of substantial numbers of less highly trained staff, intensification of recruitment and training.

2. We must have more people knowledgeable in the techniques of teaching and encouraging mental health and trained in recognizing the symptoms of mental illness.

3. We must lend our efforts to upgrade the counseling skills of teachers, members of the clergy, general practitioners, law enforcement officers, social workers, volunteers and others.

4. We must educate the public in the nature of mental illness. Consultation with community groups, maximum use of the time of qualified professional people in educating others in the community, and close coordination with mental health associations will bring about community acceptance of mental disorders as illnesses.

5. The States must recognize a responsibility for training and include in their mental health budgets support for substantial training.

VIII. ORGANIZATION OF A STATE'S MENTAL HEALTH ACTIVITIES

It is of utmost importance that all State mental health services—including institutions for mentally ill and retarded adults and children, statewide community services, and training and research—be unified and integrated under responsible, competent and professional leadership.

IX. ADMISSION PROCEDURES

We recognize no stigma attached to mental illness. The treatment of mental illness should be on the same basis as the treatment of physical illness. A practice of voluntary admission should be encouraged, and it is recommended that there should be movement toward admission without formality, and similar to admission to general hospitals, where appropriate.

X. INTERSTATE COOPERATION

1. Patients should be treated in the locale which is determined to be best for them therapeutically, rather than on the basis of residence requirements. The States, therefore, are urged to adopt the Interstate Compact on Mental Health.

2. In an increasing number of locations in various parts of the country large municipal complexes cross State lines, requiring—for greatest usefulness and economy—the operation cooperatively of comprehensive mental health centers by adjoining States. The Interstate Compact on Mental Health provides for such cooperative arrangements and should be applied in appropriate areas. We urge Congress to enact legislation to permit Federal participation in the financing of interstate facilities built pursuant to an interstate compact, on the same basis as now available to individual States.

XI. FINANCING

1. The Joint Commission on Mental Illness and Health has recommended that the local, State and Federal Governments work together to triple the expenditures in the field of mental illness over the next 10 years. No set figure can be uniformly applied to all of the States, but it is obvious that substantially greater sums must be appropriated by all levels of government to accomplish the objectives stated in this policy declaration.

2. The States must encourage the support of nongovernment hospitals, clinics, and various related services for the mentally ill.

XII. MENTAL HEALTH INSURANCE

We shall ask our insurance commissioners to request companies admitted to do business in our respective States to review their health insurance plans with a view to including coverage of mental illness.

XIII. ACTION BY THE GOVERNORS' CONFERENCE

1. We recommend that the executive committee of the Governors' conference be requested to draw attention to the findings of this special Governors' conference on mental health and that the next annual meeting of the Governors' conference recommend the establishment of a standing committee on mental health.

2. We commend and express gratitude to the members of the medical profession and all other persons who serve the States and Nation in public mental health facilities and programs. Their service and their cooperation with Governors and legislators have contributed substantially to the significant progress of mental health programs within the States and Nation.

RESOLUTION ADOPTED BY THE SPECIAL GOVERNORS' CONFERENCE ON MENTAL HEALTH ON NOVEMBER 10, 1961

Whereas medical and social scientists find that patients suffering from mental disease and tuberculosis need to be near their families and home communities while undergoing treatment and rehabilitation for these disorders; and

Whereas community care for these patients depends in many instances on adequate public assistance benefits; and

Whereas expensive and inappropriate public institutional care for these patients may be prevented or terminated by provision of such social security benefits; and

Whereas the Social Security Act in its present form specifically precludes patients in public and private institutions for mental disease or tuberculosis as well as patients in community nursing and foster homes from receiving Federal public assistance; and

Whereas the Senate Advisory Committee on Public Assistance recommended a review and study of this subject (S. Doc. 93, January, 1960): Now, therefore, be it

Resolved by the Governors' conference on mental health, meeting in Chicago, Ill., November 10, 1961, That concern be expressed over the lack of Federal participation in public assistance programs that would facilitate early, less expensive and more humane forms of community care for mental disease and tuberculosis, and that the Federal Government be requested to institute a study into the implications of these public assistance exclusions to determine what basis may exist for considering further amendments to the Social Security Act on behalf of these patients.

Mr. BROTZMAN. May I ask you one more question? Is there a more recent pronouncement than that particular document by the Governors of the various States?

Governor CLEMENT. Insofar as I know—I might check with——

Mr. JONES. I don't believe so.

Governor CLEMENT. Insofar as I know, there is no more recent pronouncement, but I will say this to you. There will be a pronouncement the next time I attend the Governors' conference because I am that vitally interested in this subject of mental health. So we will have at least from one Governor another pronouncement about mental health.

Mr. BROTZMAN. This will be a very general type of question in this area, Governor, but do you find a great deal of incentive on the part of those Governors from your prior experience to try to work on this problem?

Governor CLEMENT. Well, it is really not a very general question. Let me answer it by saying this, if I might, and then I will come back to your specific question and try to do the best I can to answer it.

It is not a real general question. Let me go back and say this. Ten years ago when I first became Governor, and I know that what I am saying now is becoming a part of the record, and the newsmen are picking it up and whatnot, and that just is all right. I understand that. Ten years ago when I became Governor I found that people—

and I think this is something that will enlighten all of us just a little bit—I found that people were interested more in who was in the penitentiary, or just almost anything else you could think about, than admitting that Uncle John or Aunt Sally or little Bobbie was either in a mental hospital or was mentally retarded. They didn't want to talk about it.

In the last 10 years it has been my personal observation, both as Governor and as a private citizen, that we have come out of the shadows and that people now are willing to accept mental illness as just another disease like tuberculosis or the flu or pneumonia and not to try to hide it. But again, Mr. Chairman, to go back, 10 years ago my personal observation was that they would rather talk about a cousin in the penitentiary than they would an aunt or an uncle who was in the mental hospital.

Now, I believe, and I hope I am right, that this thing has turned around and that people are now today willing to admit mental illness as just another illness, period, but I think it is incumbent upon you as Members of Congress and upon me as a Governor, upon all of us as citizens, to do something to continue to treat this illness rather than sweeping it under the rug.

And now to go back to your specific question, Congressman, I don't know anything I can add to it unless you have something else that you want to ask me about it.

Mr. BROTZMAN. I have to go to another meeting. I would like to to ask you about two or three questions about your program, if I may.

Governor CLEMENT. Please do.

Mr. BROTZMAN. I looked at page 1 and page 2 of your testimony here concerning your program and I think you state you have built 3 new hospitals and you have started 12 new community mental health clinics.

Governor CLEMENT. Yes.

Mr. BROTZMAN. And other experimental projects. Now, with that foundation, very quickly, do you know, Governor, what percentage of your State budget is budgeted for the mental health problem?

Governor CLEMENT. Specifically I am going to have to say no, that I cannot specifically—I will get you that answer and I will provide it to you and with your permission I would like, if you would, to put it into the record. I can give you that. I would say this——

Mr. BROTZMAN. I am not worried about exactitude. Just a rough estimate or your opinion of what it is.

Governor CLEMENT. I will say this, that when we started out 10 years ago—I am speaking about 1952 when we got into the picture—it was rather small. Now today I have got a record here in front of me but I am not going to do you gentlemen of Congress the injustice which I think a lot of people do, Governors and otherwise, that they present you with these facts and these charts and all, and I very frankly don't feel that I can tell you exactly what it means. What I would like to do is this: I would like to give you the exact answer to the question you asked and have it put in the record, Congressman. Is that all right?

Mr. BROTZMAN. I think that would be very helpful.

Governor CLEMENT. I have got a chart here and if you want to try to evaluate it, all right, but these fellows with these dollar marks in

their eyes, they don't always get across to me. I will just be honest with you, and I am not sure I understand this chart.

Mr. BROTZMAN. I join in your problem. Don't give me the chart.

Governor CLEMENT. All right. But I will say this, that I will give you the answer specifically and we will tell you exactly what we have done. It has been significant. Up until 1953, except for maintaining institutions, we had done practically nothing. We doubled and tripled and we just really elaborated on our mental health program. We have done a great deal, but I would not want to tie myself down to a dollar figure without checking back with my people.

Mr. BROTZMAN. Are you increasing the program now, Governor, since you have resumed office?

Governor CLEMENT. Yes.

Mr. BROTZMAN. As I recall, you were in office before and then you had a period out and now you have resumed the governorship again. Are you increasing this expenditure?

Governor CLEMENT. Yes, sir. To get specific, we went into office in 1953 and we became known rightly or wrongly, I hope it was rightly, we became known as the mental health Governor of Tennessee. Some people, as your know, run on one program and some on another. In our State of Tennessee I became known as the Governor who was the first one who was really interested in mental health.

Now, this was 1953 when we took office. We went out of office in 1959. We came back into office in January of this year, 1963. We have again reidentified ourselves with the mental health program and reemphasized the mental health program and we are spending more money than ever before on the State level.

One of the things we are trying to do is this: We believe that there are a lot of people, Congressman, we believe there are a lot of people who need mental health who cannot afford, socially, because of their family or otherwise, to commit themselves or permit themselves to be committed, and this, if I don't make another point up here today, I think this is important. There are a lot of mothers, for instance, who just can't afford for the sake of their children, their relationship in their church, the PTA or whatnot, they just can't afford to be committed to an institution for 6 months or a year as a mental patient. But they can do this, and they will do it. They will do it. We found out they will do it. If you will just give them the chance, they will become an outpatient. They will become a person who will come during the day when maybe the husband or the children or the neighbors think they have gone to town, they will go out, accept treatment, go back home and serve dinner to their children that night.

That is real important. We have got them in Tennessee today. I could sit here right now, which I, of course—I know you wouldn't ask me—will not do, and I could call you off the names of mothers who leave home after the children go to school in the morning, after the husband goes to work, and they go out to Central State Hospital and get their treatment and then come back home, and when the husband comes home that night and the children get home from school, the mother is back home and for all they know, she was just uptown shopping, but she got mental health treatment. I think that is very important.

Mr. BROTZMAN. How are you handling the senile dementia case which is basically a custodial case, I think, and the alcoholic problem?

Governor CLEMENT. Excuse me. I didn't hear the first part of your question.

Mr. BROTZMAN. How are you handling the senile dementia problem and the alcoholic problem down in Tennessee?

Governor CLEMENT. On the first one I would have to say that we are working hard to try to bring ourselves to grips with the problem. I will say that. I am not sure that I can give you a real definite answer to the first part.

The second one, you ask about the alcoholism problem. When we went into office in 1953 we established what was known as the alcoholism commission. Four years later my successor, Governor Ellington, in his wisdom abolished that commission. It was just put out of business. I am sure that he must have felt that it was not doing the job that they should have done.

Four years later I am putting them back into business but on a different basis. This time I am bringing this alcoholism program into the mental health department. Now before I had a separate alcoholism commission. This time, after talking with Dr. Baker, who has got some friends here from Kentucky, New Jersey, and other States, we decided that we would still keep the alcoholism commission, or rather reestablish it, but that we would put it as a division of the mental health department and let them work with it. So that is the answer to your question.

Mr. BROTZMAN. Under the laws of your State, is an alcoholic who is incapable of taking care of his property unassisted committed to a State institution under the mental laws?

Governor CLEMENT. Well, as a lawyer—I can't answer your question as Governor. I don't know. But as a lawyer, I would have to answer it by saying this: It could be but not necessarily so. And I would have to check and I will also ask Mr. Jones to get you a definite answer to that. We will give you an answer but I would not want to commit myself.

Mr. BROTZMAN. Have you had any recent changes in your commitment procedures in the State of Tennessee? Have you changed those?

Governor CLEMENT. If I remember correctly, and, Eddy, you correct me if I am wrong, but if I remember correctly we passed a bill this last session and they just—the legislature just adjourned sine die on Friday, the 22d. We passed a bill whereby they are going to study that very problem.

Now, am I correct or not?

Mr. JONES. Yes. Judicial reform bill.

Governor CLEMENT. So that is one of our judicial reform bills and we are going to study that.

Now, our legislature meets every 2 years in Tennessee for 75 days and we are studying that problem right now.

Mr. BROTZMAN. Governor, I have to go, and I thank you very much for——

Governor CLEMENT. Well, I will say this——

Mr. BROTZMAN (continuing). Attempting to "lead us from the shadows into the sunlight" a little bit in this particular area. We appreciate your coming here.

Governor CLEMENT. I want to say this. I am very much obligated to you and to your associates here for the fact that you will give me

the opportunity and ask me about these things. As I said, gentlemen, I will end up, if you don't have any more questions, my statement by saying this: I don't know where my first interest in mental health started. It might be something involving my childhood. I just don't know. Or my family. But I do know this. I don't think there is anything the Congress of the United States can do that is more important than helping those who cannot help themselves. Thank you.

Mr. ROBERTS. Thank you, Governor.

Before you leave us, I am sure your own Congressman would like to be recognized and the Chair would like to accommodate him.

Mr. FULTON. Thank you, Mr. Chairman. Governor, I would like to express my appreciation for your attendance here before the subcommittee this morning. I can certainly vouch for the Governor's interest in mental health. Tennessee has come from very, very far behind and we are going forward at a rapid pace. I just visited several weeks ago Clover Bottom Homes, one of our homes there in Nashville for mentally retarded children, and the superintendent and the doctors were all greatly encouraged over House Resolution 3688 and, Mr. Chairman, if this subcommittee will report this bill out favorably, they have a vote from Dick Fulton of Tennessee.

Governor CLEMENT. Thank you, Congressman.

Mr. ROBERTS. I think at this time, Governor, since you have made a very fine statement, the Chair without objection would like to put into the record a number of very fine statements. I am sorry that time will not permit the Chair to read each one of these statements. They are from Governors and from heads of mental health commissions, authorities, State departments of health.

I have one here from Gov. Pat Brown, State of California. Two from the Governor of Illinois, the Honorable Otto Kerner. One from Gov. Orval Faubus, Governor of Arkansas, Gov. Terry Sanford, Governor of North Carolina. Gov. Harold E. Hughes, Governor of Iowa. Gov. William Scranton of Pennsylvania. Governor Hughes, Richard J. Hughes, of New Jersey. Gov. Albert M. Carvel, Governor of Delaware. Gov. Carl Sanders of Georgia. Gov. Ralph Paiewonsky of the Virgin Islands. Gov. John M. Dalton of Missouri. Gov. John Dempsey of Connecticut. Gov. Matthew Welsh of Indiana. Gov. Albert D. Rosellini of the State of Washihngton. Gov. William Guy of North Dakota. Gov. Donald S. Russell of South Carolina, and two from Gov. John A. Burns of Hawaii.

The other letters from the heads of mental health commissions, authorities, and State departments of health, if there is no objection, will be inserted at the conclusion of the hearings.

Without objection I would like to include the Governors' statements in the record at this point.

(The documents referred to follow:)

STATE OF CALIFORNIA,
GOVERNOR'S OFFICE,
Sacramento, Calif., March 20, 1963.

Hon. KENNETH A. ROBERTS,
Chairman, Public Health and Safety Subcommittee of the House Interstate and Foreign Commerce Committee, House Office Building, Washington, D.C.

MY DEAR CONGRESSMAN: I would like to express California's strong support of H.R. 3688 and H.R. 3689. The objectives of these bills are completely in line with goals of California's mental hygiene program; namely, the development of com-

munity-centered programs for the mentally ill and mentally retarded, combining private initiative with public efforts.

We have made considerable progress toward having the mentally ill and retarded treated close to home rather than in large, distant State hospitals. We are convinced this is the best approach, both in terms of effective treatment and economic efficiency. However, to provide the intensity of treatment at a local level necessary for a significant breakthrough, local and State governments need matching financial assistance from the Federal Government. Passage of H.R. 3688 and H.R. 3689 will be a great step forward in helping the mentally ill and retarded. My earnest request is for unanimous committee approval.

Sincerely,

EDMUND G. BROWN, *Governor.*

SPRINGFIELD, ILL., March 26, 1963.

Hon. KENNETH ROBERTS,
Chairman, House Subcommittee on Public Health and Safety, House of Representatives, Room 1334, New House Office Building, Washington, D.C.:

House bills 3688 and 3689 which embody the President's recent recommendations in the area of mental health meet with my hearty approval. A similar program of community mental health centers has recently been inaugurated here in Illinois. Our program is formulated to serve our citizens with the most advanced facilities and therapy in the Nation. In our opinion, a gigantic step forward in the care of the mentally handicapped has been undertaken in the initiation of this program on a nationwide basis. It is generally accepted that the recruit ment of adequate personnel is one of the major problems. Assistance toward staffing these mental health centers is provided in title II.

In the area of mental retardation, lack of scientific knowledge has only recently been recognized. In order to make necessary progress in this area, a broad research program to indicate directions where progress can be made must be developed. Through H.R. 3689, great help to the States in undertaking this research will be provided.

Too frequently, a shameful and degrading treatment is accorded the mentally retarded in crowded institutions. Title II of 3689 will provide assistance to the States for construction of facilities for the most overlooked group of needy citizens. For the above reasons, we in Illinois strongly urge support and passage of this vital legislation.

OTTO KERNER,
Governor of Illinois.

SPRINGFIELD, ILL.,
March 5, 1963.

Hon. OREN HARRIS,
U.S. Representative,
Representative Building, Washington, D.C.:

I would like to express myself as being in favor of House bills 3688 and 3689 which are designed to help carry out the President's recent recommendations in the area of mental health.

Here in Illinois, we have already begun a similar program of community mental health centers. Such a program is designed to service our citizens with the most advanced facilities and therapy in the country. We in Illinois feel that this program on a national basis will be a gigantic step forward in the care of our mentally incapacitated.

As we all know, one of the major problems is to secure adequate personnel. The provisions of title II would provide assistance toward staffing these mental health centers.

Lack of scientific knowledge in the area of mental retardation is one which only recently has been brought to the fore. If we are going to make the necessary progress in this area, we must first have a broad research program to point to directions where progress can be made. H.R. 3689 would provide great help to the States in undertaking this research.

Crowding in the institutions for mentally retarded is a most shameful and degrading treatment. Title II of 3689 would aid the States in constructing facilities for the most overlooked group of needy citizens. For these reasons, we in Illinois strongly urge support and passage of these vital measures.

OTTO KERNER,
Governor of Illinois.

LITTLE ROCK, ARK., *March 26, 1963.*

Congressman KENNETH ROBERTS,
Public Health and Safety Committee,
House Office Building, Washington, D.C.:

Please be advised that I approve of H.R. 3688 and H.R. 3689, and state that Arkansas will make arrangements to participate in the construction program provided in these measures, should same be approved by the Congress.

ORVAL E. FAUBUS,
Governor of Arkansas.

RALEIGH, N.C., *March 26, 1963.*

Hon. KENNETH ROBERTS,
Member of Congress, Chairman, House Subcommittee, Public Health and Safety, Room 1334, New House Office Building, Washington, D.C.:

I urge the passage of the Community Mental Health Centers Act of 1963 and the Mental Retardation Facilities and Construction Act of 1963 which are before Congress. These bills represent needed Federal efforts to encourage, initiate, and expand local efforts directed toward finding remedies for mental retardation and other mental illnesses.

I am happy to support both of these measures.

TERRY SANFORD,
Governor of North Carolina.

DES MOINES, IOWA.

Hon. KENNETH ROBERTS,
Member of Congress, Chairman, House Subcommittee, Public Health and Safety, Room 1334, New House Office Building, Washington, D.C.:

I wish to express my full support of President Kennedy's legislative proposal on facilities for the mentally ill and retarded as expressed in H.R. 3688 and H.R. 3689.

HAROLD E. HUGHES,
Governor of Iowa.

HARRISBURG, PA., *March 26,1963.*

Hon. KENNETH ROBERTS,
Chairman, House Subcommittee on Public Health and Safety,
New House Office Building, Washington, D.C.:

The proposal for development of community mental health centers has our hearty endorsement. The Office of Mental Health of the Commonwealth of Pennsylvania has been programing for the past several years toward the development of resources within the community for a continuum of care necessary in the treatment of mental illness. We would like to encourage the development of more community resources for the mentally retarded as well as greater efforts in the field of prevention, but we see little hope of moving as rapidly as necessary through this transitional period from a State hospital-centered program to a community-centered program without financial help. The knowledge and skills are at hand; citizen interest and support are at their highest; and all that is needed is the means to mobilize these skills and this support to productive activity. There is a real danger of much of the existing momentum being lost by failure to act boldly and decisively. Your effort toward favorable action in support of the development of community mental health centers is strongly urged so that fight against mental illness can move forward with new vigor.

WILLIAM W. SCRANTON,
Governor of Pennsylvania.

TRENTON, N.J., *March 26, 1963.*

Hon. KENNETH ROBERTS,
Member of Congress,
Chairman, House Subcommittee on Public Health and Safety,
New House Office Building, Washington, D.C.:

As Governor of New Jersey, I strongly support passage of H.R. 3688 and H.R. 3689 which would implement significant parts of President Kennedy's program on mental health and mental retardation. The New Jersey Legislature is currently considering proposals for amendment and recodification of statutes pertaining to the mentally ill and mentally retarded which are oriented in the direction of the President's proposals. Passage of these bills would give impetus to new programs and planning already well underway in New Jersey as a result of the combined leadership of physicians and other mental health professionals, organized citizen groups, and legislative and executive officials, in our State, county, and local governments.

RICHARD J. HUGHES,
Governor of New Jersey.

STATE OF DELAWARE,
EXECUTIVE DEPARTMENT,
Dover, Del., March 25, 1963.

Hon. KENNETH ROBERTS,
Member of Congress, Chairman, House Subcommittee on Public Health and Safety, Room 1334, New House Office Building, Washington, D.C.

DEAR CONGRESSMAN ROBERTS: As Governor of Delaware I wish to express on behalf of the people of our State my firm support of H.R. 3688 and H.R. 3689 which would implement the President's programs on mental health and mental retardation.

The Governors of the United States have made many studies in the field of mental health and have solidly backed programs which should insure a breakthrough in this area and a reduction of those in mental institutions of 50 percent during the next 10 years.

In order to accomplish this tremendous progress it will be necessary to triple our expenditures in the areas of patient treatment, providing small-size institutions at the community level, and stepping up the training of psychiatrists, psychologists, and psychiatrist helpers.

Presently there is an acute shortage of this personnel, and this is one of the main reasons why we are not making greater progress today. In view of the fact that there are millions unemployed, one of the encouraging aspects of the President's program is to provide funds for increasing the number of people who are being trained to do this work.

I know that the Congress, when they realize that as many as 30 percent of our population may have some mental affliction, will appreciate the tremendous importance of this great problem. I know that when they realize that with sufficient funds we can cut the populations of our mental institutions in half in the next 10 years, they will take steps to see that President Kennedy's program will be a major contribution in this effort. For these reasons I strongly urge the prompt enactment of this important legislation.

Cordially yours,

ELBERT N. CARVEL,
Governor of Delaware.

ATLANTA, GA., *March 27, 1963.*

Hon. KENNETH ROBERTS,
Member of Congress, Chairman, House Subcommittee, Public Health and Safety, Room 1334, New House Office Building, Washington, D.C.:

Urge your influence to assure favorable consideration of H.R. 3688 and H.R. 3689 relating to Federal assistance in construction and operation of mental health centers and construction of research centers and facilities for the mentally retarded.

CARL E. SANDERS,
Governor of Georgia.

MARCH 27, 1963.

Hon. KENNETH ROBERTS,
Chairman, House Subcommittee on Public Health and Safety, House of Representatives, Room 1334, New House Office Building, Washington, D.C.:

Virgin Islands sorely in need of additional facilities to accommodate and provide for mentally ill and mentally retarded. I strongly urge and recommend favorable consideration by your committee of H.R. 3688 and 3689 aid to Virgin Islands under mental health and mental retardation programs vital to insure construction of mental wings of proposed hospitals in Virgin Islands. If necessary members of our mental health staff will be available to further justify this request.

RALPH M. PAIEWONSKY,
Governor.

JEFFERSON CITY, MO.,
March 25, 1963.

Hon. KENNETH ROBERTS,
Member of Congress, Chairman, House Subcommittee,
Public Health and Safety, New House Office Building,
Washington, D.C.:

House bills 3688 and 3689 have my strong support. They are in line with our plans to improve Missouri's program for mentally ill and mentally retarded. Missouri has found small centers for the rapid treatment of mentally ill to be humane and economically sound. I have endorsed program now before our State legislature to create three mental health centers in next biennium.

JOHN M. DALTON,
Governor, State of Missouri.

HARTFORD, CONN.,
March 20, 1963.

Congressman KENNETH ROBERTS,
Chairman, Health Subcommittee,
House Office Building, Washington, D.C.:

Two measures now before your honorable committee, H.R. 3688 and H.R. 3689, will, if adopted, make possible great new achievement in the diagnosis and treatment of mental illness and retardation. Connecticut's experience in these fields clearly demonstrates the soundness of the approach recommended in both these bills.

May I respectfully urge upon your distinguished committee favorable consideration of H.R. 3688 and H.R. 3689.

JOHN DEMPSEY,
Governor of Connecticut.

INDIANAPOLIS, IND.,
March 27, 1963.

Hon. KENNETH ROBERTS,
Public Health and Safety, New House Office Building,
Washington, D.C.:

The day of the ever-expanding central State institution for the care of the retarded or the mentally ill is behind us. We have increasingly come to recognize that both for the patients and for the taxpayers, smaller centers close to the homes of patients are more effective and, in the long run, less costly. Our experience in Indiana with 11 State institutions now caring for approximately 25,000 patients a year, has convinced us that the President's proposal for community centers for the mentally ill and the retarded is both the most economical and the best medical method for meeting our responsibilities to those among us who suffer these disabilities. I give my wholehearted support to the President's courageous and farseeing proposals as contained in H.R. 3688 and H.R. 3689.

MATTHEW E. WELSH,
Governor of Indiana.

OLYMPIA, WASH,
April 9, 1963.

Congressman KENNETH ROBERTS,
Public Health and Safety Committee, Washington, D.C.:

Would like to add my personal appeal for your support of House bills 3688 and 3689 regarding Federal aid to further State mental health programs and research in field of retarded. Critical need exists to increase funds in these areas toward improved research, training, and treatment programs. Legislature, State of Washington, unable to appropriate additional moneys to take care of all requests of our State mental hospitals and institutions for retarded. Believe Federal aid to State mental hospitals and institutions of retarded necessary and urgent at this time. Urge your personal support and consideration.

ALBERT D. ROSELLINI,
Governor of Washington.

BISMARCK, N. DAK.,
April 1, 1963.

KENNETH ROBERTS,
Chairman, House Subcommittee on Public Health and Safety, Room 1334, New House Office Building, Washington, D.C.:

H.R. 3688 and 3689 embodying the principles of the President's recent message on mental illness and mental retardation are of major importance to North Dakota to supplement our programs of treatment and rehabilitation. Because of the effort now being devoted to this field in our State and the encouraging results apparent to date, H.R. 3688 and H.R. 3689 have my unqualified support.

WILLIAM L. GUY, *Governor.*

COLUMBIA, S.C., *March 6, 1963.*

Hon. KENNETH ROBERTS,
Chairman, Subcommittee on Public Health and Safety,
Washington, D.C.:

Would like to recommend favorable action on Senate bills 755–756, House bills 3688–3689.

DONALD S. RUSSELL,
Governor of South Carolina.

STATE OF HAWAII,
EXECUTIVE CHAMBERS,
Honolulu, Hawaii, April 2, 1963.

Hon. KENNETH ROBERTS,
Chairman, Subcommittee on Public Health and Safety,
Washington, D.C.

DEAR ———: We have been apprised of the introduction of H.R. 3688, a bill to provide assistance in the construction and initial operation of community mental health centers, and would appreciate your support of this bill.

With warm personal regards. May the Almighty be with you and yours always.

Sincerely,

JOHN A. BURNS, *Governor.*

STATE OF HAWAII,
EXECUTIVE CHAMBERS,
Honolulu, March 21, 1963.

Hon. SPARK M. MATSUNAGA,
Congressman from Hawaii,
New House Office Building, Washington, D.C.

DEAR SPARK: I am writing to request your support of H.R. 3689 (S. 756), Mental Retardation Facilities Construction Act of 1963, and H.R. 3386, Maternal and Child Health and Mental Retardation Planning Amendments of 1963. These carry out the proposals contained in the report of the President's Panel on Mental Retardation.

We have one reservation about H.R. 3689, title II, page 5, which states that the first $5 million of construction funds will be allotted only for facilities on a college or university campus. This restriction would prevent the health department from utilizing funds for much needed construction at Waimano Training School and Hospital.

It is our hope that the President's program will be enacted.

With warm personal regards. May the Almighty be with you and yours always.

Sincerely,

JOHN A. BURNS, *Governor.*

Mr. ROBERTS. Governor, again on behalf of our subcommittee we appreciate your very fine appearance and your statement, and above all, your interest in this vital problem.

Governor CLEMENT. Mr. Chairman, I certainly want to thank you again.

I would like to do justice by my own commissioner of mental health by saying this. Since he called me and said, Frank, shall I cancel my engagements and be there, I said by no means. He said, we have got two men there who are personal friends of mine. I am sure he has got some others. I would like the privilege of presenting to you distinguished Congressmen, Dr. Davis of New Jersey, and Dr. McPheeters, I believe it is, of the State of Kentucky, who were here to answer any questions if I had been asked any questions on the technical side.

Gentlemen, will you stand up. Thank you very much.

Mr. ROBERTS. Thank you. These gentlemen will be heard a little bit later in testimony.

Governor CLEMENT. Thank you very much.

Mr. ROBERTS. Thank you for your appearance.

Governor CLEMENT. A privilege to be with you.

Mr. ROBERTS. Thank you, sir.

It is a genuine pleasure for the chairman to have as our next two witnesses, Senator Roland Cooper, State senator, Camden, Ala., and the Honorable Ashley Camp, State representative from Talladega, Ala., which is in my own district.

We are very happy to welcome you, gentlemen.

Representative Camp serves as chairman of the Alabama Interim Legislative Committee on Mental Health and Mental Retardation. Senator Cooper is the ranking Senate member of that committee. Both of these gentlemen are legislative veterans in the State of Alabama. I once had the honor to serve for a short time as a State senator. They have studied this problem for a long time. They know a lot about it. And I believe Representative Camp has a resolution which was unanimously adopted by the committee to which I referred.

It is a real pleasure, gentlemen, to welcome you to our subcommittee hearings. I appreciate very much your willingness to come, I know at some effort on your part. Both of you are busy men, important men in State affairs. We are very happy to have you come and speak to these bills today.

Mr. Camp?

STATEMENTS OF HON. ROLAND COOPER, STATE SENATOR, CAMDEN, ALA., AND HON. ASHLEY CAMP, STATE REPRESENTATIVE, TALLADEGA, ALA.

Mr. CAMP. Chairman Roberts and Mr. Nelsen, we appreciate the opportunity of appearing before the Subcommittee on Health. Congressman Roberts happens to be my own Congressman from the Fourth District—it is the State at large now, but I claim him as my own.

We have a resolution adopted unanimously by the Alabama Interim Committee on Mental Health and Mental Retardation. It reads as follows:

Whereas the Alabama Interim Legislative Committee on Mental Health and Mental Retardation has been making an extensive study of the problems of mental health and mental retardation in the State of Alabama and ways and means of solving such problems; and

Whereas the interim committee has become aware of the magnitude of the problems of mental health and mental retardation confronting the people of Alabama and other States: Be it therefore

Resolved by the Interim Committee on Mental Health and Mental Retardation of Alabama, That this committee hereby commends the President of the United States, the Honorable John F. Kennedy, for his forthright, comprehensive, and forward looking message to Congress on the tremendous need for an aggressive program by the Federal Government to attack the problems of mental health and mental retardation; be it further

Resolved, That the interim committee hereby heartily endorses the recommendations made by the President to our Congress and urges immediate consideration of these recommendations by the Congress: Be it further

Resolved, That a copy of this resolution be sent to President Kennedy and Members of the congressional delegation from Alabama.

Upon motion by Representative Ulie Sullivan and seconded by Representative Tom Bevill.

Signed by Representative Ashley L. Camp, Jr., chairman, Talladega, Ala.; Representative A. K. Callahan, vice chairman, Tuscaloosa, Ala.; Senator Roland Cooper, Camden, Ala.; Senator A. C. Shelton, Jacksonville, Ala.; Senator James S. Clark, Eufaula, Ala.; Representative Tom Bevill, Jasper, Ala.; and Representative Ulie Sullivan, Reform, Ala.

And I submit it for the record.

(The resolution referred to is as follows:)

RESOLUTION OF HOUSE OF REPRESENTATIVES, STATE OF ALABAMA

Whereas the Alabama Interim Legislative Committee on Mental Health and Mental Retardation has been making an extensive study of the problems of mental health and mental retardation in the State of Alabama and ways and means of solving such problems; and

Whereas the interim committee has become aware of the magnitude of the problems of mental health and mental retardation confronting the people of Alabama and other States; be it therefore

Resolved by the Interim Committee on Mental Health and Mental Retardation of Alabama, That this committee hereby commends the President of the United States, the Honorable John F. Kennedy, for his forthright, comprehensive, and forward looking message to Congress on the tremendous need for an aggressive program by the Federal Government to attack the problems of mental health and mental retardation; be it further

Resolved, That the Interim Committee hereby heartily endorses the recommendations made by the President to our Congress and urges immediate consideration of these recommendations by the Congress; be it further

Resolved, That a copy of this resolution be sent to President Kennedy and Members of the congressional delegation from Alabama.

98493—63——12

Upon motion by Representative Ulie Sullivan and seconded by Representative Tom Bevill.

Senator A. C. SHELTON.
JACKSONVILLE, ALA.

Senator JAMES S. CLARK.
EUFAULA, ALA.

Representative TOM BEVILL.
JASPER, ALA.

ASHLEY L. CAMP, Jr.,
Chairman.
TALLADEGA, ALA.

Representative A. K. CALLAHAN,
Vice Chairman.
TUSCALOOSA, ALA.

Senator ROLAND COOPER.
CAMDEN, ALA.

Representative ULIE SULLIVAN.
REFORM, ALA.

Mr. CAMP. I might tell our Congressman that we have been meeting continuously since the 7th of August to come up with a comprehensive program for the State of Alabama. And we have had as one of our witnesses Governor Clement's good Dr. Baker, and if he doesn't watch us we are going to borrow him, because he is a very capable man. And in my opinion the mental health program under his leadership and Governor Clement's leadership in Tennessee is making great strides.

In Alabama we are pushing for a comprehensive program to place all mental health agencies under one head, and the committee feels it is very important to get the groundwork off on this, because the code hasn't been changed since 1919, and we are having to knock a few heads to accomplish these principles.

We feel that in the President's program of getting down to the local community basis for your regional mental health clinics and facilities for your mentally retarded children, and setting up your research centers, is the only way that we will ever diminish or stop the custodial care necessary in the larger institutions.

And Congressman Roberts and Mr. Nelsen, I appreciate the opportunity of appearing before your committee.

Mr. ROBERTS. We are certainly happy to have you and to have this resolution. I certainly want to congratulate you on the fine job that you are doing as chairman of the interim legislative committee. I know that you have studied this problem for a long time, and I know you have a deep understanding of the State problem. And we are very grateful to you for your appearance here today.

I have no questions, other than to say that we do welcome you here, and we greatly appreciate the fine interest you have shown on coming to Washington on this occasion.

Mr. Nelsen.

Mr. NELSEN. No questions, except also to add a word of welcome.

Mr. ROBERTS. I would also like to say that Mr. Nelsen is one of the finest turkey shooters I have ever seen. And Mr. Camp comes from a very fine turkey area. Now, don't invite him down there unless you intend for some of the turkeys to be killed.

Mr. CAMP. We will tie some out.

Mr. ROBERTS. Do you have anything else youwant to say?

Mr. CAMP. I might say, Mr. Nelsen, that my interest in mental retardation stems about as close as it could be to anyone, that is, I have

a mentally retarded child myself, and I know the problems that the parents of such children have.

Mr. NELSEN. Mr. Chairman, in view of the statement just made I might say this. We have a neighbor at home, and they have a little boy who is mentally retarded. He is a very fine little boy. But they have the problem of finding a place where he can receive the training that he can accept. They can't send him to the public school. And there is no place where this child may go. And yesterday I made the observation that it is almost a tragedy that throughout the country where we have a limitless number of rural school facilities standing empty, with their school organization and playgrounds and equipment. So now at least we should harness that until we have something better.

I thank you for your statement.

Mr. CAMP. Mr. Nelsen, in Alabama we have this for those children. Under special education in our public schools we have classes for the educable. And this fall we will start additional classes for the trainable child, that is, the child with the IQ from 25 to 50 as well as from 50 to 75, in our public schools.

Mr. NELSEN. Wouldn't there be an advantage if you had a separate facility where the children would be in a sort of a group where they could play together, and they would not be disturbed by others? I just had the idea that perhaps by some isolation at least, and not being disturbed by others, there would be an advantage to that type of facility.

Mr. CAMP. As a general rule they are separated in another building.

Mr. NELSEN. A second classroom?

Mr. CAMP. That is correct.

Mr. NELSEN. Thank you.

Mr. ROBERTS. Thank you.

We would like to welcome Senator Roland Cooper of Camden, Ala. He is a successful businessman and has been a leader in the State senate for many years. He has been interested in this problem and other public problems in the State of Alabama for many, many years. He is a longtime friend of mine.

I want to extend to you a warm welcome to our subcommittee and our appreciation for the fine job you have always done since you have come into public life, and especially for you coming to our hearings today.

Senator Cooper has a formal statement which he will present to you.

Senator COOPER. Thank you, Chairman Roberts and Mr. Nelsen.

I am Roland Cooper, of Camden, Ala., a senator in the Alabama State Legislature. And as previously introduced, Dr. Camp at my right is a member of the house and the State legislature, and chairman of the interim committee on mental health and mental retardation.

Both H.R. 3688 and H.R. 3689 are strongly endorsed by the Alabama Interim Legislative Committee on Mental Health and Mental Retardation.

The problems of mental health and mental retardation have been largely ignored in all but a few States, in favor of other needs which lend themselves to more immediate cure. This Nation's historical disinterest in responding to the acute needs in the mental illness field can be illustrated by an interesting statistic.

It is a known fact that the greatest interest in mental health throughout the United States has been alarming.

Although mental illness is commonly referred to as our No. 1 health problem, it ranked only eighth in the total funds collected nationally in 10 leading voluntary health campaigns during the period 1950–59. The amount of funds collected was roughly only one-twentieth of the amounts collected for polio, one-tenth of that for TB and one-tenth of that for cancer.

Despite all of the publicity concerning major mental illness in recent years, the average proportion of general State expenditures and of State health expenditures allocated to the care of mental hospital patients has actually declined. Perhaps, the most significant finding contained in the 1961 report of the President's Joint Commission on Mental Illness and Health is the statement that no more than 20 percent of 277 State mental hospitals have participated in modern advances designed to make them therapeutic as contrasted to custodial institutions.

With respect to the problem of mental retardation we are told that there are between 5 and 6 million mentally retarded children and adults in this country today, with 126,000 new cases each year.

These figures are disturbing. The President has stated that the broad programs proposed in these bills are designed largely to stimulate State, local, and private action through the initial use of Federal resources. We believe that if the Congress gives its support to these proposals, this objective will be achieved.

The concept of a network of community mental health centers—centralizing most, if not all, of the interrelated services necessary to the diagnosis, treatment, and rehabilitation of the mentally ill—is, in our opinion, a sound approach to this complex health problem.

I think that the former witness, Governor Clement of Tennessee, brought that out so vividly in his illustration of the housewife in Tennessee. And that is certainly true in other States. We believe that they can be treated on a local level, and where we have 9,000 patients in our mental institutions in Alabama, that probably could be reduced 50 percent in a few years. I am certain that would be true in other States as well.

We are hopeful that this committee and Congress will give these ambitious and challenging legislative proposals the favorable consideration which we believe they rightly deserve.

In Alabama the Alabama Legislature is very aware of the mental problem in our State. As a result, our interim committee on mental health and mental retardation was authorized in 1962. We believe that we are making progress in Alabama. But to us this is a national problem, and we plead with this subcommittee to give these bills a favorable report.

Mr. Chairman, that finishes my statement. I want to say that it is a pleasure for me to be here.

I would like for Mr. Nelsen to know that Congressman Roberts is my Congressman, due to the fact that we lost one and gained eight. And we have been friends through the years. And it was only in this recent election that I have had the opportunity of voting for our chairman here. And I was privileged to do so.

And, Mr. Nelsen, in Wilcox County we have turkeys, too. I don't have the cuff links to give you, but I can assure you that if you will

come to Camden I have some friends that will carry you turkey hunting, and you can kill the turkeys. Please bear in mind that I didn't say I would carry you to where you would kill them.

If there are any questions, I would be glad to try to answer them.

Again, I don't have a sidekick as Governor Clement had here to answer for me, except my buddy on our interim mental health committee.

Mr. ROBERTS. Thank you, Senator Cooper. And I, of course, appreciate the kind and courteous remarks you have made to the committee.

I know that you and Representative Camp and other members of the interim committee have studied Alabama's problem. And I am sure that you have visited out State institutions at Tuscaloosa, Ala., many times, and you know the tremendous load of cases that they have in that institution. I wonder if you believe—I believe you did state so—that if these proposals were approved by Congress, and we do more of this work on the community level, the custodial part which is so heavy at the present time will show a great decrease after these programs have developed are in operation.

Mr. COOPER. That is right, Congressman. I believe again that prevention is better than cure. And I believe the overall cost of the mental problem in our country could be greatly reduced by seeing these people in time, especially the mentally ill. And I think that under these bills it would be a step in that direction.

Mr. ROBERTS. Do you believe, too, that the public is more aware of this problem than they have been in the past?

Mr. COOPER. I think that is definite. And again, as Governor Clement said, 15 years ago in our State it was a crime to be in a mental institution, but it wasn't necessarily a crime to be in a penitentiary. Today that has been brought out and laid on top of the table, and we realize that it is our No. 1 problem. And it is up to the different States and the Federal Government, in my opinion, to do something about it.

Mr. ROBERTS. It is your belief, then, that many of these cases that probably are past the point of help would be taken at the inception of the first symptoms, and yet in many cases you would not have a prolonged siege of mental illness before it ever comes to the attention of the physician, or someone who knew something about it.

Mr. COOPER. That is right, Congressman. And I might say this. It hasn't been touched on this morning. We realize that the 9,000 that we have in our institutions in Alabama represent a loss of earnings. If that could be reduced to 4,500 then we would have that many taxpaying citizens rather than those dependent on the State or Federal Government.

Mr. ROBERTS. Do you believe that we are past the point of reluctance on the part of people to admit that there is a problem?

Mr. COOPER. I think that is correct. I think it is realized by practically everybody now that it is a problem, it is a problem that we must tackle. And I believe that these bills here would be a step in that direction.

Mr. ROBERTS. And hasn't this been just about the history of practically every disease that we have had? First of all, you have got to recognize the problem, and then take some steps to do something about it?

Mr. COOPER. Yes, sir. I remember when TB was in the stage that mental illness was 10 years ago. As you know, Alabama was one of the leaders in TB eradication in that State under the leadership of one of our senators from our county. It is not a problem in Alabama now as it was 15 or 20 years ago, and the cure is much better and shorter. And I think that we have made great progress in that field. And I believe that mental illness is the field now in which it is our responsibility to do something.

Mr. ROBERTS. I know that I had some personal experiences with the new regional hospitals which are developed under the Hill-Burton program. And I think you will agree that with those institutions, being over in various regions of the State easily accessible to the people, we do not find the reluctance to go in for treatment that we found years ago when you said there was some stigma attached to it as to some people who were unfortunate enough to show up some sign of infection. But now people seek the opportunity to be admitted when they find they are so afflicted.

Mr. COOPER. Yes, sir.

Mr. ROBERTS. Congressman Nelsen.

Mr. NELSEN. What dollar figure do you have in your State budget at the present time?

Mr. COOPER. We appropriate about $10 million annually.

Mr. CAMP. That is to our State hospitals. We also have under the department of health the division of mental hygiene, and also under another department, the commission on alcoholism. Those agencies we are trying to coordinate at present. So there would be several appropriations.

Mr. NELSEN. A number of years ago in Minnesota we started our mental health program. I was then a State senator, and I well remember the budget that we worked on, it was quite extensive. We had a very good program going on. And the design of this bill is first to provide the incentive to get the States to move, because I think we all realize, as the chairman has pointed out, what little we can do from this level dollarwise when we spread it all out, it is not very great, we are going to have to depend largely on the States to do the job. But the point is to get them to see the problem and get some assistance.

So that, of course, is the theory back of the way this bill has been drawn. And the bill put the burden on the States heavily, and they must realize that they must carry the ball. You have the same problem in your State as we have back home.

I want to compliment you on the effort that has been made in your State. And keep the turkeys healthy in Alabama.

Mr. COOPER. Thank you. We appreciate this opportunity.

Mr. ROBERTS. I am going to call Mr. E. B. Whitten, executive director of the National Rehabilitation Association, 1029 Vermont Avenue, Washington, D.C. Yesterday Mr. Whitten was on the list, and was kind enough to come back today.

We are very glad to have you, Mr. Whitten. It has been my pleasure to work with you in other fields through the years. I want to commend you on the fine job you are doing in your present capacity and welcome you here.

STATEMENT OF E. B. WHITTEN, DIRECTOR, NATIONAL REHABILITATION ASSOCIATION

Mr. WHITTEN. Thank you, Mr. Chairman. I am sorry that I cannot bring to you either cuff links or a hunting preserve. I will say, though, that if you are dashing through Tennessee and forget to fasten your seatbelt and have trouble as we will try to have a rehabilitation center ready for you.

I will ask that my statement be filed.

Mr. ROBERTS. Without objection.

(The statement of Mr. Whitten is as follows:)

STATEMENT OF E. B. WHITTEN, DIRECTOR, NATIONAL REHABILITATION ASSOCIATION

Mr. Chairman, I am E. B. Whitten, director of the National Rehabilitation Association. I appear in behalf of the association to support H.R. 3688, the Community Mental Health Centers Act of 1963, and H.R. 3689, the Mental Retardation Facilities Construction Act.

The National Rehabilitation Association has long been concerned for the education, training, and rehabilitation of the mentally ill and mentally retarded. It was one of the organizations that joined hands to establish the Joint Commission on Mental Illness and Health, the recommendations of which have influenced many parts of H.R. 3688. I served on the Joint Commission throughout its history and as a result gained new insights into the nature and extent of the problems of mental illness and mental retardation and how they can be dealt with more effectively. The National Rehabilitation Association has also cooperated to the fullest possible extent with the President's Panel on Mental Retardation, and its committees have studied the report carefully. I do not believe that the report exaggerates the extent of the problems, personal and social, caused by mental retardation, and I consider its recommendations to be basically sound. Many of these recommendations are reflected in H.R. 3689 and in other legislative proposals now before Congress.

It is not my purpose to go into detail in stating the needs of the mentally ill and mentally retarded or in analyzing the legislative proposals before you. To do so would be needless repetition. Both bills are sound in their objectives, in that they attack the problems both on the basis of research to gain new knowledge and on the basis of program development to apply existing knowledge. We believe this dual approach to be essential.

In attempting to improve services, the proposals begin where they should, that is, in helping communities get the facilities they need for their service programs and in helping them get staff to provide the personal services that are needed at all levels. We have already had many demonstrations of how the availability of even limited Federal funds can stimulate State and local activity leading to the establishment of various types of community facilities. We have no doubt that the stimulant will be equally effective in the case of mental retardation and mental illness, since we believe that States and local communities are already thoroughly conscious of the great unmet needs in these fields.

We believe that the same principle will apply to staffing the facilities. This will be a difficult but not impossible problem. It has been demonstrated that the actual availability of employment in desirable settings attracts people to these fields. It will be necessary, of course, to continue to do everything we possibly can to encourage the entry of more outstanding individuals into the professions.

Fortunately, there are many existing programs upon which we can build as we enter into an expanded program for the mentally ill and mentally retarded. There is an extensive program of research into the causes of mental illness and, to a lesser degree, of mental retardation. There are also programs to increase the supply of manpower needed in many of the professional specialities, and legislation recently reported by the committee should be another important stimulant.

A great deal of progress has been made in the development of educational opportunities for mentally retarded and emotionally unstable children. There have been many demonstrations, planned and otherwise, as to how appropriate services can be made available to the mentally retarded and the mentally ill.

In this connection, the demonstration programs carried on by the Vocational Rehabilitation Administration under its special project program are of great significance. This program had its beginnings in the midfifties. These demonstrations almost always involve the cooperative efforts of State rehabilitation agencies, local mental health or mental retardation organizations, community rehabilitation facilities, and many others.

There are currently underway 39 demonstrations in the mental retardation field. Over 1,000 mentally retarded persons are being served in these projects, a high percentage of them being in the young-adult group. All are from moderate to severely retarded. Two hundred and forty-six of these individuals have left the demonstration projects to go into competitive employment. Many others will go into competitive employment when their programs are completed. Nine of the demonstrations have ended. In every case, local communities have continued the programs when Federal financial support through the special project terminated.

Sixteen demonstrations are currently underway in the field of mental illness. Some are in rehabilitation centers, others in halfway houses or similar facilities. Although involving a smaller number of individuals, the results are equally significant.

These research and demonstration projects have produced convincing evidence that a high proportion of the mentally ill and mentally retarded can be rehabilitated into gainful employment, if facilities, personnel, and funds are available to assure that they get the opportunity at the appropriate time.

Many State vocational rehabilitation agencies, in addition to their cooperation in the special projects referred to above, are developing statewide programs of comprehensive nature designed to serve a much larger number of the mentally ill and the mentally retarded. Significant progress has been made in training the staffs of vocational rehabilitation agencies to work more effectively with the mentally ill and retarded. Among the States taking great strides in such programs are Arkansas, Louisiana, Alabama, West Virginia, Rhode Island, North Carolina, Massachusetts, Kentucky, Pennsylvania, and Vermont. The annual reports of the Vocational Rehabilitation Administration will indicate that the number of mentally ill and mentally retarded persons for whom rehabilitation is being completed is increasing each year.

Vocational rehabilitation programs will be much more effective when undergirded by approved medical, educational, and related programs, which should result from the passage of H.R. 3688 and H.R. 3689. When combined with approved vocational rehabilitation programs envisioned in H.R. 3740 and related bills, we should be able to make great strides in helping mentally ill and mentally retarded individuals attain their maximum potential for happy and productive lives.

Members of this committee know that the mentally ill and the mentally retarded profit from many existing service programs. It is important that we remember that the mentally retarded are people and that mentally ill individuals are people. We must carefully refrain from an overemphasis upon the categorical approach to the solution of problems in these fields. Although special programs aimed at mental illness and mental retardation, such as envisioned in these legislative proposals, are necessary, we believe everyone shall agree that we must not lose sight of the fact that the ultimate objective of all of our efforts is to try to help mentally retarded and mentally ill individuals attain the ability to live happy and useful lives in the general community. We do not want a society segregated according to disability. It has been found, for instance, that both the mentally ill and the mentally retarded do well when in rehabilitation facilities which accept individuals of many varying disabilities. It has likewise been found that mentally emotionally disturbed and mentally retarded individuals do well in the normal school situation, when special efforts are made to meet their individual needs. Stronger programs of special education for handicapped children and vocational rehabilitation programs for youth and adults are essential parts of a total program for the mentally ill and the mentally retarded.

Careful coordination of the new programs with existing related programs will be necessary. For instance, rehabilitation facilities and workshops are developing under the Vocational Rehabilitation Act, which program will be expanded under other proposed legislation. Needs of the mentally ill are being studied with the assistance of grants from the National Institutes of Health. Proposed legislation amending the Social Security Act will make available Federal assistance for making studies of the needs of the mentally retarded. These

studies will require coordination and effort and should be closely related to other community studies that will probably be underway.

Administration of all these programs at the Federal level by the Department of Health, Education, and Welfare makes close coordination practical. It will be more difficult at the State and local levels, where more diffuse administrative machinery exists. We believe this committee in its report should emphasize the importance of coordination of effort at Federal, State, and local levels to assure maximum utilization of the services of all existing agencies in the advancement of the programs proposed under the new legislation and to avoid any possibility of major duplications of effort.

AMENDMENT TO DEFINITION OF FACILITY FOR THE MENTALLY RETARDED

We suggest one amendment to the definition of a "facility for the mentally retarded" which begins on line 16 of page 20. After the word "individuals" on line 19, insert these words "when parts of comprehensive facilities constructed under this title."

The purpose of this amendment is to clarify the relationship of this legislation to existing and proposed legislation in the vocational rehabilitation field. Federal vocational rehabilitation funds appropriated for general vocational purposes may now be used to expand vocational rehabilitation facilities but not for new construction. Numerous rehabilitation facilities, principally workshops, have been assisted under this legislation. As another part of its "mental illness and mental retardation package," the administration is recommending amendments to the Vocational Rehabilitation Act, one of which will set up a program for the construction of rehabilitation facilities and workshops, including new construction. These facilities would be for handicapped individuals in general, rather than on a categorical basis as H.R. 3688 and H.R. 3689 provide. Probably the principal uses of the facility funds under the Vocational Rehabilitation Act will be the construction and staffing of workshops. The amendment we suggest will assure that workshops are constructed under the Vocational Rehabilitation Act, instead of under H.R. 3689, unless such workshops are parts of comprehensive facilities constructed under H.R. 3689. Authority under both bills being considered by this committee and also under vocational rehabilitation proposals reside with the Secretary of Health, Education, and Welfare, so it will be possible to establish within the Department effective machinery for coordinating the programs and avoiding any duplication of effort.

The administration is not opposed to this amendment, and we believe it will be generally acceptable to those promoting these legislative proposals.

Mr. WHITTEN. You are familiar with the facts that the National Rehabilitation Association is concerned with the rehabilitation of all handicapped people without regard to the category of disability. Our emphasis has been on those programs which will result in the vocational rehabilitation of these individuals. For years we have been promoting programs and have had legislation introduced into Congress which includes some of the elements and principles embodied in these legislative proposals that you have before you. We are gratified that the administration has now come forward and presented these specific proposals which you are considering.

I shall not attempt to discuss them in great detail. They are sound. We support them strongly.

I think it should be encouraging to you to know that it has been demonstrated in the research and demonstration programs of the Office of Vocational Rehabilitation during the last 8 years that a very high percentage of the individuals with whom you are concerned in this legislation can be vocationally rehabilitated if there are the right kind of medical and vocational services available to these individuals at the time they first require them. There is no reasonable doubt of that any longer, in view of the accomplishments in these demonstration projects, the record of which are available to you.

Now, I wanted to call your attention to the fact that another part of the President's proposals in connection with mental retardation and mental illness is found in the Vocational Rehabilitation Act amendments, already introduced in the Senate. This measure was not introduced in the House unless it was introduced yesterday. It is ready for introduction. A bill comparable to it as relates to facilities is H.R. 3740, which is a bill the National Rehabilitation Association is sponsoring. I think the provisions as related to facilities are identical, if not they are virtually identical.

Under the Vocational Rehabilitation Act, it is now possible to build certain types of rehabilitation facilities. And such facilities are being constructed. There have been some difficulties, though, in the program. One is the fact that there is no earmarked money for facilities. Another is that new construction is not permitted. And there are some others I might mention if I had some time. The administration is proposing to liberalize the law to make earmarked money available, and to establish a program principally for the construction and staffing of what we might call the vocationally oriented rehabilitation facilities. I think your committee should be familiar with this bill as you draft your own legislation.

Now, in this connection I am suggesting one amendment to the mental retardation facilities bill. On line 16, page 20—this is the definition of the mental retardation facility—we are suggesting an amendment.

Mr. ROBERTS. What is the page number again?

Mr. WHITTEN. It is page 20, line 16.

The suggestion we are making is that this be amended in such a way as to make it clear that workshops—and I think you know what we mean when we speak of a workshop—will not be constructed under this legislation you have before you unless the workshop is a part of a comprehensive mental retardation facility. The reason we are suggesting this is that the workshop itself is an entirely different type of facility from other types of facilities that might be envisioned in this legislation.

It uses work as the principle element in the services it provides; work for evaluation, work for therapy, work for production. The staffing pattern is quite different, the medical component being either very small, generally on a consultative or part-time basis.

The other professional workers do not work under medical supervision. Vocational teachers, production managers, and so forth, constitute an important part of the staffing of such an organization. And it is the administration's position, we understand—and we certainly concur in it—that where a workshop is built as a workshop, that this be built under the Vocational Rehabilitation Act rather than under this act.

Incidentally, the administration is not opposed to this amendment which we are suggesting. We have discussed it with the administration people.

We had not proposed an identical amendment to the mental illness bill, that is H.R. 3688, although we think now we may do so. If so, this would come on page 19 of H.R. 3688 where you find the definition of a mental health center.

We think that we may do so now in the light of Mr. Jones' testimony yesterday, during which he mentioned the workshops specifically as

one of the facilities that might be built independently under that proposal. You may remember that testimony. We had not assumed that that would be true, but if there is any confusion about this we probably will suggest an amendment that will make it clear that the workshop as such will be built under the Vocational Rehabilitation Act, although we have no objection whatever to a workshop being constructed as a part of a comprehensive rehabilitation facility under this bill.

We think that in keeping some of our lines straight on things like this we can avoid confusion, and that the result will be conducive to the purposes we all have in mind.

Now, Mr. Chairman, I am here in town, and easily accessible to the committee and its staff, and I am not going to make any other statement now, but I will defer, unless you have questions that you want to raise.

Mr. ROBERTS. I have no questions, except to thank you for your appearance, and also for the suggested amendments. I think I am in agreement with you and your viewpoint on the two amendments. I haven't had time to study them, but I think in my opinion I would go along.

Mr. WHITTEN. There is something else, Mr. Roberts.

You remember you were interested yesterday in how a facility such as you described in your own district might profit from this legislation?

Mr. ROBERTS. Yes.

Mr. WHITTEN. Actually, in my judgment, the type of facility you are talking about—and you have several such in Alabama— will come nearer getting benefits through the rehabilitation vocational amendments, which does include staffing, than under H.R. 3388, which does not.

In other words, workshops could be staffed under the Rehabilitation Vocational Act amendments. And knowing your facilities there as I do and the vocational emphasis that is put upon them, I think these facilities might get their benefits through the Vocational Rehabilitation Act, although some of them no doubt would be appropriate for assistance under the mental retardation and mental illness acts.

Mr. ROBERTS. I might say that I certainly would desire that this effort, which I think has been very beneficial in our statement, it would be my desire that that effort be continued and expanded. And I would certainly hope that we could do a better job of staffing. A lot of that has been volunteers with limited resources.

We have done a good job, but I think more needs to be done. I know in my own particular area of one workshop that has not been able to operate more than about 2 or 3 days a week. And they have a backlog of applicants that could benefit from 5-day operation.

Mr. WHITTEN. Your State constitutes one of the best illustrations in the United States of how voluntary agencies and public agencies have combined their efforts to create a chain of workshops in which the mentally ill and the mentally retarded among others are being served.

And, incidentally, you have in Minnesota at Minneapolis the Minneapolis Retardation Center, which is one of the facilities of the kind for which we think there is the greatest need in the vocational field.

Mr. NELSEN. At the University of Minnesota Medical School we have a similar operation.

Mr. WHITTEN. In fact, the center I am referring to, the Minneapolis Retardation Center, is used as a place where handicapped adults of all classes come, and they are evaluated and then referred to whatever community facility is best able to serve them. You have a very fine cooperative spirit in Minneapolis and St. Paul, and in fact the whole State in developing rehabilitation facilities.

Mr. ROBERTS. Thank you very much.

I am going to pass from Mr. Ray for the time being, as he is from Arkansas, and the chairman, Mr. Harris, expressed the desire to be here when Mr. Ray testified. And we are running pretty close to the noon hour. And at this time the committee will be in recess until 1:45 in the same hearing room.

(Whereupon, at 11:55 a.m., the committee recessed to reconvene at 1:45 p.m., of the same day.)

AFTERNOON SESSION

Mr. HARRIS (presiding). The committee will come to order.

Our first witness this afternoon will be to the Honorable Arnold Olsen, our friend and colleague from the State of Montana.

Mr. Olsen we are honored to have you here today.

STATEMENT OF HON. ARNOLD OLSEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MONTANA

Mr. OLSEN. Thank you, Mr. Chairman, I am happy to be here.

There are some 5 million Americans who are mentally retarded. This is one of the greatest problems facing our country today. Care facilities for these individuals must be integrated into the mental health program of every community.

The extent to which this situation will grow in future years depends upon our ability to research the problem. Some breakthroughs have been effected and it has become possible to prevent some mental retardation. However, much more has to be done to alleviate the growing number of persons who become afflicted each year. Therefore, more research, trained personnel, and financing must be made available. We also need better standards of care for the institutionalized retarded, special educational programs, day-care centers within the community, counseling services for the parents of retarded children and efforts to create job opportunities for retarded adults. To make such programs possible the Nation also needs additional facilities.

Emphasis should be placed on research facilities, for I believe the ultimate answer to this problem is one of prevention. We must recognize that mentally retarded individuals must be cared for and they must also be educated and trained to the very maximum of their capacities.

Psychiatric knowledge, techniques and tools have now progressed to the point where it is feasible, as well as desirable, to treat a mentally ill patient in the confines of his home environment. Community care will enable all practicing physicians to participate in the treatment of their mentally ill patients.

Title I of H.R. 3688 pertains to the construction of community health centers. Few communities have the resources necessary for adequately developing and expanding their mental health services.

The use of matching grants for the construction of community health centers will place within reach of the community the opportunity to provide the needed services to its residents.

The President, in his admirable message to Congress on February 5, relative to mental illness and mental retardation, stated: "We need a new type of mental health facility, one which will return mental health care to the main stream of American medicine." He added, "Ideally, the center could be located in an appropriate community general hospital, many of which already have psychiatric units." Later in his message the President commented, "For the first time, a large proportion of our private practitioners will have the opportunity to treat their patients in a mental health facility served by an auxiliary professional staff that is directly and quickly available for outpatient and inpatient care." I am in complete agreement with these statements and hope they will be carried out in the administration of the law should this bill be enacted. In this regard, then, the already established general hospital should be given priority in planning for the establishment of the community mental health center. In most instances the general hospital provides the best opportunity for continuity of treatment and integration of service in caring for the mentally ill. This does not establish the general hospital as the sole facility to sponsor such centers. As outlined in the President's message, other already existing outpatient facilities could also be used.

Mr. Chairman, I want to urge this committee to pass favorably on this legislation. The community mental health center should be integrated into the existing medical complex of the community.

Mr. HARRIS. Thank you for your fine statement.

We will continue by hearing our colleague from our 50th State, the Honorable Spark Matsunaga.

STATEMENT OF HON. SPARK M. MATSUNAGA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF HAWAII

Mr. MATSUNAGA. Thank you, Mr. Chairman, I appreciate the opportunity to make this statement in support of H.R. 3688, the Community Mental Health Centers Act of 1963.

I believe that passage of this bill will mark the beginning of the greatest advancement in the treatment of mental illness in the United States we have yet witnessed. It will make possible a more efficient treatment of our mentally ill and in the long run, effectuate tremendous savings to us at the State, local, and National levels, not only monetary-wise but in human resources.

Mental illness is one of the greatest problems of our age. The concern of the people of Hawaii was well expressed by its Governor, the Honorable John A. Burns, a former Member of the House when in a speech before the State comprehensive mental health program committee in Honolulu on March 20, 1963, he stated:

> Mental illness is a critical problem in our community, as it is across the Nation; and we, in Hawaii, have an opportunity to join in the recently accelerated national attack on this problem. At any one time, an estimated 12 to 15 percent of the Hawaiian population is mentally ill.
>
> Incapacity of this magnitude presents a terrible waste of human resources, untold suffering, and major drains on the financial resources of individuals and the public. We must make a concerted effort to lessen its burden.

The State of Hawaii is making needed plans to take advantage of the program offered by this proposed legislation. The people of Hawaii and the other 49 great States of our Union will reap untold benefits under the provisions of this bill. I urge your favorable report.

Mr. Chairman, I also wish to express my views on H.R. 3689, the Mental Retardation Facilities Construction Act of 1963.

I wish to register my support of the bill with just one qualification. I am apprehensive that the restrictive use of $5 million of the sums appropriated for the fiscal year 1965 and $10 million of the sums appropriated for each of the succeeding 4 fiscal years to facilities associated with college or university hospitals or other appropriate parts of a college or university would prohibit the construction of needed facilities at State institutions for the mentally retarded. The Honorable John A. Burns, an esteemed former Member of the House and now Governor of the State of Hawaii also shares this view.

It is respectfully requested, therefore, that the restrictive provision be deleted and the proposed program thereby be made more widely applicable.

I believe that the bill has much merit, and I intend to vote for its passage on the floor of the House provided the suggested change is made.

Mr. HARRIS. Thank you, Congressman, for your fine statement.

The next witness will be Mr. David B. Ray, Jr. Mr. Ray is superintendent of Arkansas Children's Colony, Conway, Ark.

Mr. Ray, I have heard a lot about the children's colony at Conway. I have never had the privilege of visiting there, but my colleague and your Congressman, Mr. Mills, has been telling me about this program, of the fine things that you are doing there and the outstanding record that you have had there. I think that with the experience that you have had in our State on this problem it is highly appropriate for you to give the committee the benefit of that experience. And on behalf of the committee, and Mr. Mills, your own Congressman, of the Ways and Means Committee, I want to tell you how happy we are to have you with us.

I believe you have a statement that you would like to present.

STATEMENT OF DAVID B. RAY, JR., SUPERINTENDENT, ARKANSAS CHILDREN'S COLONY, CONWAY, ARK.

Mr. RAY. Yes, sir.

Honorable members of the committee since my report is written, and so much has been said in the past, and you gentlemen know it, I would just like to make a few quotes from my statement, because after making the trip if I went home and told the board I didn't say anything I would feel guilty.

Mr. HARRIS. You may have your statement included in the record, and you may proceed in the way you choose.

Mr. RAY. Thank you, sir.

First of all, I would like to say that since there are so many distinguished people that will comment on H.R. 3688 that pertains to mental health centers I will not make any comment on it, I favor it, but my field is mental retardation, and I will comment on that.

First of all, I have had the opportunity of working in the States of Iowa, Arizona, and Arkansas in this field. And each of these States are different, I don't think there is any question about it. But I think there is one thing that they have in common with the other States that I have had a chance to visit. They are seeking the answers to help the mentally retarded. And I have had real opportunities to do some traveling in this country and I find other States feel the same. And this is why H.R. 3689 will be a challenge to those very fortunate States that might be chosen for research training centers or to those that apply for certain grants that might be available.

I would be extremely gratified if Arkansas happened to be chosen for one of these centers. But this is not the important thing. I think the important thing is that they will be chosen on the merits of the contributions that they can make to the field of mental retardation.

If Minnesota is chosen, this in the long run will help Arkansas, and Arkansas will benefit from research that is carried on in Minnesota.

With the support and guidance of the Governor of Arkansas, the board of trustees of the children's colony, and the citizens of the State, we do feel that we have a very unique facility. We are a very new facility. In the beginning many new concepts were tried, many of these are now proven facts but we feel that there is much more to be proved.

You might say, What does this have to do with H.R. 3689?

It has this to do: The States that will benefit from this bill, if it is passed, can develop new ideas, and their citizens will be given a chance to accept this work as part of a progressive community. These States will have the privilege of contributing knowledge that will be helpful to every other State in their approach to mental retardation.

I do feel, because of the nature of the philosophy, that some research and training centers can be oriented more from the prevention and medical standpoint, but I would hope that certain centers can be oriented more from education and training standpoints, because we have these millions of retarded that we need to develop better answers for.

And, in line with that, in my report—which, if you gentlemen see fit can be part of the record—you can see that we are fortunate in Arkansas that the Governor has just signed a bill enabling the framework to be set up so that the State of Arkansas can deal with the Federal Government and negotiate on Federal money that might be available in the field of mental retardation.

In some States, it is very complicated to go into contract with the Federal Government, so we are proud that Arkansas passed the law.

Gentlemen, in closing using the basic concept that our world is changing rapidly, that over the years, particularly in this country, that we are much more specialized, less repetitive employment is available, and we are changing from a rural society to a highly competitive urban society, with this in mind, what is the role of the retarded?

We are seeking those answers.

How can we meet their needs? What should be the role of State institutions, public schools, and community services?

I brought something from Arkansas. This, gentlemen, is a collection of the different sized screws that are used in making a new bus.

We have a bus-body factory located in Conway. And in the process of the day the men on the assembly lines drop many of the screws on the floor and they are all swept together at the end of the day, and they can't afford to pay these people maximum wages to separate them. And we have the retarded separating the screws by proper size.

That is only one answer. I could give some other examples, but time is short.

So with over 5 million mentally retarded in our country, let's develop a unified approach to meet their needs. This bill, if utilized in the proper way, will help each State to realize its responsiblities for the retarded and help to create an environment where they can be accepted. Each of you on this very distinguished committee has an opportunity to be different, the same as the other people in this room. By being different, we can find new methods of working with the mentally retarded. These new methods from a purely economic standpoint, I feel, can save this country millions of dollars.

But more important, these methods will give these human beings, many of whom in the past have been sadly neglected, the opportunity to live a richer life of happiness and dignity.

Thank you very much, gentlemen.

Mr. HARRIS. Thank you very much, Mr. Ray,

Did you want to include the bill in your remarks for the information of the committee? You had it attached to your statement.

Mr. RAY. It is attached to the statement, sir.

Mr. HARRIS. Let it be received as part of your statement.

(The statement and bill referred to are as follows:)

STATEMENT OF DAVID B. RAY, JR., SUPERINTENDENT, ARKANSAS CHILDREN'S COLONY, CONWAY, ARK.

Mental retardation is a complex problem, but this statement within itself does not explain how it reaches into the lives of millions of individuals throughout the country. Statistically, there are approximately 5,400,000 children and adults in the United States who are mentally retarded.

If you multiply this number by the number of individuals that make up each retarded person's family, you come up with a staggering number of people that are affected directly by this problem. Again, when you take this number and add in the schoolteacher, the preacher, the doctor, and the storekeeper, you find that millions and millions of others are affected indirectly.

For a problem that is so vast, there is no one answer that will solve it all. To have a complete and coordinated program for all types of retarded, we need the assistance, guidance, and help of all of the people directly and indirectly affected, plus, the other citizens in the community. At all times, regardless of what service is indicated, the focus of attention should always be on the retarded person and his family.

To say that one service for the retarded is more important than another would be like a mother and father saying that they love one child in their family more than another when in reality it takes all of the children and the mother and father to make a complete family unit. It is true that one retarded child would benefit from one service more than another retarded child would benefit from the same service. The decision on which services are most needed can only be reached with adequate professional and parent consultation.

I am honored that I have the privilege of appearing before this distinguished committee to discuss legislation proposed by H.R. 3688 and H.R. 3689.

My major responsibility and experience is in the field of mental retardation; but as a citizen and a taxpayer, I certainly am interested in H.R. 3688 which pertains to construction of community mental health centers. I am sure that many people, much more qualified than I, have testified as to the value of such centers. I am not a psychiatrist, but I do know the value of such community centers and I heartily endorse them.

Inasmuch as my specialized training is in the field of mental retardation, today I appear on behalf of H.R. 3689.

I have had the opportunity of working with the handicapped in the States of Iowa, Arizona, and Arkansas. There is no question that these three States are different insofar as population, population growth, natural resources, and per capita income are concerned; but one thing they all have in common—they are seeking answers to help the mentally retarded. And, from traveling I find that most all other States are seeking these same answers.

Because mental retardation is so complex, it is difficult, from a State level, to secure adequate funds for the operation of institutions, special classes, and other needed services for the mentally retarded.

Therefore, this bill, H.R. 3689, will be a challenge to those very fortunate States that might be chosen for a research and training center. I would be extremely gratified if Arkansas should be chosen for one of these research and training centers, but I also am very proud to know that these proposed centers will be chosen on the merits of the contributions they can make to the field of mental retardation. The law provides those safeguards. That is a credit to you and to members of the Office of Health, Education, and Welfare.

With the support and guidance of the Governor of Arkansas, the board of trustees of the Arkansas Children's Colony, and the citizens of the State, a unique facility was developed 3 years ago. This facility, according to many national experts who have visited the colony, is a "noninstitutionalized" type institution. In the beginning, many new concepts were included in the education and training program. Most of these are now proven facts. We had a unique experience when we opened. Many newspapers carried pictures and lengthy news stories concerning a local boy or girl chosen to be admitted to the Arkansas Children's Colony.

So you might say, what does this have to do with H.R. 3689?

It has this to do with it—States that might be fortunate enough to be chosen as a site for one of these research and training centers will have the opportunity of stepping forward with new ideas, and its citizenship will be given the chance to accept this work as part of a progressive community. These States will have the privilege of contributing knowledge that will be helpful to every other State in their approach to mental retardation. I hope that all centers established, if this bill is passed by Congress, will be multidisciplinarian in their approach.

But I do feel, because of the nature of the philosophy, that some research and training centers can be orientated more from the prevention and medical standpoints—others from the educational and training standpoints. Each center should be part of a master blueprint of action to meet the needs of the mentally retarded on a local, State, and National level.

From a training standpoint, let me quote to you from a letter from an 18-year-old coed at Henderson State Teachers College, Arkadelphia, Ark.: "Please consider this letter my application for employment in the Arkansas Children's Colony. I am very much interested in the colony and the work it is doing. Through talking with my adviser, I learned some college students are privileged to work as aids in the colony. I am a freshman here and plan to major in sociology or psychology. I hope to work with children with a problem and feel working in the colony will give me valuable experience. I understand it is possible for a student to work at the colony and attend Arkansas State Teachers College in Conway at the same time. I hope to enroll there this summer."

Using the basic concept that our world is changing rapidly, that over the years, particularly in the United States, we are much more specialized, less repetitive employment is available, and we are changing from a rural society to a highly competitive urban society, what is the role of the retarded? How can we meet their needs? What should the role of the State institutions be? What should be the role of the public schools? What should be the role of the community services, sheltered workshops, etc., be? H.R. 3869 will help find some of these answers.

So this is the challange. With over 5,400,000 mentally retarded in our country, let's develop a unified approach to meet their needs. This bill, if utilized in the proper way, will help each State to realize its responsibility for the retarded and help to create an environment where they can be accepted.

Each of you on this very distinguished committee has an opportunity to dare to be different. By being different, we find new methods of working with the mentally retarded. These new methods, from a purely economic standpoint, will save the taxpayers millions of dollars. But, more important, these

methods will give these human beings, many of whom in the past have been sadly neglected, the opportunity to live a richer life of happiness and dignity.

H.B. No. 556 (SANSON OF FAULKNER)

A bill for an act to be entitled:

AN ACT Designating the Arkansas Children's Colony as the State Agency for Carrying Out the Purposes of Any Act of the Congress of the United States of America, Now Existing or at Any Time Hereafter Enacted, Pertaining to Mental Retardation; Authorizing the Arkansas Children's Colony To Take Certain Action in Connection Therewith; and for Other Purposes.

Be it enacted by the General Assembly of the State of Arkansas:

SECTION 1. That the Arkansas Children's Colony (herein called "Colony") is hereby designated as the single state agency for carrying out the purposes of any Act of the Congress of the United States of America, now existing or at any time hereafter enacted, pertaining to mental retardation (herein called "Federal Act").

SEC. 2. That the Colony is hereby authorized to take all action of every nature whatever necessary or desirable in complying with the requirements of any Federal Act and accomplishing the purposes thereof, including, without limitation:

(a) The receiving, handling and disbursing of grants and funds appropriated by any Federal Act;

(b) The making of provisions to assure full consideration of all aspects of services essential to planning for comprehensive state and community action to combat mental retardation, including services in the fields of education, employment, rehabilitation, welfare, health and the law, and services provided through community programs for any institutions for the mentally retarded;

(c) The preparing and submitting of plans for expenditure of such grants and funds and providing the assurance required by any Federal Act as to carrying out the purposes of any Federal Act;

(d) The preparing and submitting of such reports of the activities of the Colony in carrying out the purposes of any Federal Act in such form and containing such information as may be required by any Federal Act and keeping such records and affording such access thereto necessary to assure correctness and verification of such reports as may be required by any Federal Act;

(e) The providing for such fiscal control and fund accounting procedures as may be necessary to assure proper disbursement of and accounting for grants and funds paid to the Colony in accordance with the requirements of any Federal Act; and

(f) The doing of all things and taking of all action to carry out any such plans for expenditures of said grants and funds in accordance with and for the accomplishment of the purposes of any Federal Act.

SEC. 3. This Act shall be liberally construed. The enumeration of any object, purpose, power, manner, method and thing shall not be deemed to exclude like or similar objects, purposes, powers, manners, methods or things. This Act shall be construed as being supplementary to any existing purposes and powers authorized to be accomplished by the Colony or by the Arkansas Children's Colony Board.

SEC. 4. The provisions of this Act are hereby declared to be separable and if any section, paragraph, sentence or clause of this Act shall be held unconstitutional or invalid, such holding shall not affect the validity of the remainder of the Act.

Mr. RAY. Thank you very much.

Mr. HARRIS. Mr. Nelsen, any questions?

Mr. NELSEN. Thank you, Mr. Chairman.

It has been called to my attention that in some instances, for example, a retarded child does not get the proper opportunity of training, and little guidance, and quite frequently they do wind up in a mental institution, or get into crime and into our prisons, perhaps because they can be easily led into crime. Is that your observation?

Mr. RAY. Yes. I would like to say this, in further answer to your question, that approximately 95 percent of all the retarded are really the responsibility of the community. As many as we can keep out of the State institutions we should. And I would feel that with the proper type of community services this would not only take in this daytime activity, but develop leisure time supervision.

And with this type of training, this will not be as true in the future as it is now.

Mr. NELSEN. Another point that bothers me some is, we have heard testimony relative to this bill, and some States have done a magnificent job, as I assume your State has done. Others have been backward.

Now, is it possible that some of these States have been very backward and want to get a great deal of assistance, and those of us who try to do the job are sort of put in an unequal position? De we deter some of these States from action by this Federal Government moving in? Are we going to have them leaning on us too much, or are they going to meet their responsibilities if we move in this direction?

Mr. RAY. I would think that someone else, particularly from HEW, could answer that better. But I would think that it ought to be an enrichment type practice to encourage the States. For instance, in my own State, we believe in States rights, and yet we do enjoy getting this enrichment money that we cannot possibly get otherwise. It is hard to get money just to pay for attendants, teachers, food, and other maintenance costs, and if we could get an enrichment amount of money, above regular operating budget, to help us develop new techniques, I think the States can benefit from that, sir. That is my experience.

Mr. NELSEN. Do you have any difficulty in getting personnel to staff these schools? For example, are there available to you enough personnel to do the job properly at this time?

Mr. RAY. That is a critical problem in the country, Mr. Nelsen. And this would be one of the advantages, we didn't mention this too much, but I understand these centers are to be for research and training, and we have found that the colleges and universities have not been prone to do too much in the field of training people in this area. This is also true of medical schools. And I find it is changing now. And I think that the things that we are talking about today will encourage these institutions to take their proper responsibilities in training people.

But if you ask me the question, do I have a hard time, I have a terrible time trying to find qualified people. We operate, but it is difficult, sir.

Mr. NELSEN. Thank you.

Mr. HARRIS. Tell me more about the colony at Conway. I believe you said it is a young institution, only about 3 years old.

Mr. RAY. Yes, Mr. Harris. In Arkansas, we were the 47th State to get a State school out of the original 48; the only other State that didn't have one was Nevada, and having lived out in Arizona I used to say that they weren't big enough from a population standpoint except on weekends.

I am happy to say that they have written to us to copy our law, and they are going to have a State school in Nevada.

But the bill was passed in 1955, and in 1957 we got the money for the original construction program. The first child was accepted September 1, 1959. We now have 400 capacity, it will be up to 540 about May of this year. The waiting list when I left home was 1,475. But Arkansas is not any different from other States as far as this need is concerned.

We like to feel that it is unique. We use the team approach. It is strong in education and training. It is built on a cottage plan. And it is very colorful. I wish I had brought my colored slides. I am very proud of it.

Does that answer in brief detail what you wanted?

Mr. HARRIS. It is very helpful. In other words, you can take care of about one out of every four?

Mr. RAY. That is correct, sir.

Mr. HARRIS. Are you at capacity now?

Mr. RAY. Yes, sir.

Mr. HARRIS. These funds were provided by the State legislature?

Mr. RAY. Yes, sir; except for this. We were very fortunate in the last construction program in that we did qualify for Hill-Burton funds. We built a rehabilitation center and got a Federal grant. This was two-thirds Federal money and one-third State money. We built two nursing cottages for the severely retarded, and we are able to qualify under nursing home money. We did get a little money to go into our infirmary, but it was with the Federal Government putting up some money and the State the rest.

As far as operating costs, it is all State money.

Mr. HARRIS. How many instructors or assistants do you have to take care of the 540?

Mr. RAY. For 540 the number of people counting professional and nonprofessional will be about 245 full-time people. This takes in teachers, psychologists, janitors, attendants, house parents, and all the people that it takes to operate the institution.

Mr. HARRIS. Are they all salaried people?

Mr. RAY. They are all salaried people, yes, sir. The only exception to that is some college students that we use on a part-time basis.

Mr. HARRIS. It is a substantial operation, then?

Mr. RAY. It is a substantial operation. The per capita cost is about $4.75 a day. I think the national average is about $4.65. This ranges from about $2 in some States up to about $8 in other States, for institutions for the retarded, now.

Mr. HARRIS. This provides a program, as you well know, for construction of facilities for retarded people. Are you in a position to indicate whether or not you could expand your program any further to accommodate more people who are in need?

Mr. RAY. As far as this particular bill is concerned, Mr. Harris, Governor Faubus has gone on record as supporting this. Arkansas, under Governor Faubus' leadership, has developed the support of the public for mental retardation which I believe will be continuing. I met with the legislative counsel with regard to this, and I think I can assure you gentlemen that whatever portion Arkansas can qualify for with the Federal money, we will find the money to do our matching part, even if we have to go out and raise it, we will find it.

Mr. HARRIS. The thing we are concerned with is the operation of it afterwards?

Mr. RAY. Yes, sir, that is what I am referring to, the operation part. As far as the construction part, we have no problems. At this session of the legislature, we also got this bill through which is now law, that the board of the Arkansas Children's Colony can issue revenue bonds just like a college or university, based on parents fees. And with that we could get the money to match whatever construction is available. And that is also law. It is not part of this record, I wish I had brought it.

Mr. HARRIS. You may submit it for the record if you want to.

Mr. RAY. I would like to very much.

(The document referred to is as follows:)

ACT No. 286

A Bill for an Act to Be Entitled:

AN ACT Authorizing the Arkansas Children's Colony Board to Finance Properties by the Issuance of Bonds; Authorizing the Pledging and Use of Certain Revenues for the Payment of the Principal of and Interest on the Bonds; Prescribing Other Matters With Reference Thereto; Amending Act No. 6 of the Acts of Arkansas of 1955, as Amended; and for Other Purposes.

Be It Enacted by the General Assembly of the State of Arkansas:

SECTION 1. The Arkansas Children's Colony Board, established and existing pursuant to the provisions of Act No. 6 of the Acts of Arkansas of 1955, as amended (herein referred to as the "Board"), is hereby authorized to own, acquire, construct, reconstruct, extend, equip, improve, maintain, operate, lease, contract concerning, or otherwise deal in and with any lands, improvements, buildings, furniture, furnishings, machinery, and personal property of any and every nature whatever (herein sometimes called "Properties") that can be used by the Board for the accomplishment of, or in connection with the accomplishment of, any of the purposes and powers of the Board and of the Arkansas Children's Colony, as specified by and set forth in Act No. 6 of the Acts of Arkansas of 1955, as amended, or as specified by this Act or by any constitutional provision or Act now or hereafter existing. The properties may be located on or near the present operation of the Arkansas Children's Colony at Conway, Arkansas, or at any other location in the State of Arkansas where the Board shall undertake operations to discharge its purposes and powers.

SEC. 2. The Board is hereby authorized to use any available revenues for the accomplishment of the purposes specified and referred to in Section 1 hereof, and is hereby authorized to issue revenue bonds and to use the proceeds thereof for the accomplishment of said purposes, either alone or together with other available funds and revenues. The amount of bonds issued shall be sufficient to pay all costs and sums required and necessarily incidental to the accomplishment of the specified purposes, all costs incurred in connection with the issuance of the bonds, the amount necessary to cover debt service on the bonds until revenues are available in a sufficient amount therefor, and the amount necessary for a debt service reserve, if deemed desirable.

SEC. 3. (a) Revenue bonds may be issued from time to time for any of the purposes set forth in Section 1 hereof. Each issue shall be authorized by resolution of the Board. The bonds of each issue shall be coupon bonds payable to bearer but may be made subject to registration as to principal only (except as otherwise provided in subsection (e) hereof), may be issued in one or more series, may bear such date or dates, may mature at such time or times, may bear interest at such rate or rates, not exceeding six per cent (6%) per annum, may be in such form, may be executed in such manner, may be payable in such medium of payment, at such place or places, may be subject to such terms of redemption, and may contain such terms, covenants and conditions as the resolution may provide, including without limitation those pertaining to the custody and application of the proceeds of the bonds, the collection and disposition of revenues, the maintenance of various funds and reserves, the nature and extent of the security, the rights, duties and obligations of the Board and the Trustee for the holders or registered owners of the bonds, and the rights of the holders or registered owners of the bonds. Priority as to lien on revenues between successive issues may be controlled by the resolution authorizing the issuance of each issue of bonds. The bonds shall have all the qualities of negotiable instruments under the negotiable instrument laws of this State.

(b) Each resolution authorizing the issuance of any issue of bonds may provide for the execution by the Board of an indenture which defines the rights of the bondholders and provides for the appointment of a trustee for the bondholders. Such indenture may control priority as to lien on revenues between successive issues and may contain any other terms, covenants and conditions that are deemed desirable, including without limitation those pertaining to the custody and application of the proceeds of the bonds, the collection and disposition of revenues, the maintenance of various funds and reserves, the nature and extent of the security, the rights, duties and obligations of the Board and the Trustee for the holders or registered owners of the bonds, and the rights of the holders or registered owners of the bonds.

(c) The bonds may be sold at public or private sale for such price, including without limitation sale at a discount, and in such manner as the Board may determine by resolution, but in no event shall the Board be required to pay more than six percent (6%) interest on the amount received, computed with relation to the absolute maturity of the bonds in accordance with the Standard Table of Bond Values. The bonds may be sold with the privilege of conversion into an issue bearing other rate or rates of interest, upon such terms and conditions as the Board shall specify but in any event such that the Board receives no less and pays no more than it would receive and pay if the bonds were not converted, and the conversion shall be subject to the approval of the Board.

(d) The bonds shall be executed by the Chairman and the Executive Secretary of the Board and in case any of the officers whose signatures appear on the bonds or coupons shall cease to be such officers before the delivery of the bonds of any issue, such signature shall nevertheless be valid and sufficient for all purposes. The coupons attached to the bonds shall be executed by the facsimile signature of the Chairman of the Board.

(e) In the resolution authorizing the issuance of any issue of bonds, the Board may provide for the initial issuance of one or more bonds aggregating the principal amount of the entire issue, and may, in said resolution, make such provisions for installment payments of the principal amount of such bonds as it may consider desirable and may provide for the making of such bonds payable to bearer or otherwise, registrable as to principal or as to both principal and interest, and where interest accruing thereon is not represented by interest coupons, for the endorsement of payment of interest on such bonds. The Board may make provision in said resolution for the manner and circumstances in which and under which such bonds may, in the future at the request of the holders thereof, be converted into bonds of smaller denomination, which bonds of smaller denomination may in turn be either coupon bonds or bonds registrable as to principal or registrable as to principal and interest.

SEC. 4. It shall be plainly stated on the face of each bond issued hereunder that the same has been issued under the provisions of this Act, and bonds issued under the provisions of this Act shall be general obligations only of the Board, and in no event shall they constitute an indebtedness for which the faith and credit of the State of Arkansas or any of its revenues are pledged and there shall be no mortgage or other lien executed on any lands or buildings belonging to the State of Arkansas. All agreeemnts and contracts entered into by the Board in connection with the issuance of any bonds hereunder shall be binding in all respects upon such Board and their successors from time to time in accordance with the terms and provisions of said agreements or contracts and said terms and provisions of said agreements and contracts shall be enforceable by appropriate proceedings at law or in equity, or otherwise, including, without limitation, mandamus.

SEC. 5. No member of the Board shall be personally liable on any bonds issued hereunder, or for any damages sustained by anyone in connection with agreements and contracts authorizing or pertaining to the bonds of any issue hereunder or the carrying out of any other authority conferred by this Act, unless the member involved shall have acted with a corrupt intent.

SEC. 6. Section 11 of Act No. 6 of the Acts of Arkansas of 1955 is hereby amended to read as follows:

"Section 11. CHARGES. (a) In the case of each petition for admission, the Board shall investigate and determine whether the child or its parents or its guardian can pay for the maintenance, training, education, or care of the child. The Board is hereby authorized to establish a system of charges to be based upon the ability of the child or its parents or its guardian to pay for maintenance, training, education, or care, and to impose such charges; provided, however, if the Board determines that a child or its parents or its

guardian is unable to pay for all or part of the maintenance, training, education, or care of the child, the Board may provide all or part of the same free of cost. The Board may vary such schedule of charges from time to time as circumstances warrant.

(b) If any child or its parents or its guardian shall fail or refuse to pay the charges so assessed by the Board, the Board shall have and is hereby granted the authority to institute appropriate legal proceedings in a court of competent jurisdiction for the collection of such charges. The Board is authorized to retain the services of legal counsel and pay a reasonable fee for any services furnished the Board.

SEC. 7. The principal of, interest on, and paying agent's fees in connection with the revenue bonds of each issue shall be secured by a pledge of any payable in the first instance from the gross charges, imposed by the Board pursuant to the provisions of Section 11 of Act No. 6 of the Acts of Arkansas of 1955, as Section 11 is amended by Section 6 of this Act, applicable to the particular properties financed in whole or in part by the proceeds of the bonds of the particular issue involved. In addition, the Board is authorized to pledge and to use for the payment of the principal of and interest on the bonds, of any issue, and paying agent's fees, surplus charges applicable to existing properties and any other properties operated by the Board, whether or not such other properties were financed in whole or in part by bonds issued under this Act. Surplus charges, as that term is used herein, is defined to mean gross charges which are not pledged to any bond issue and that amount of any charges that are pledged in excess of the amount necessary to meet all requirements of resolutions securing bonds to finance the particular properties to the payment of which such charges are specifically pledged. As heretofore in this Act specified, the resolution of the Board pledging specific charges can control priorities as to the lien on said charges between successive issues. In addition, the Board is hereby authorized to use, as distinguished from pledge, any available revenues and funds of the Board, including, without limitation, appropriated and cash funds, if available. All charges assessed and collected by the Board pursuant to the authority conferred by Section 11 of Act No. 6 of the Acts of Arkansas of 1955, as said Section 11 is amended by Section 6 of this Act, are hereby specifically declared to be cash funds and may be collected and deposited in such banks and depositories, as shall be determined from time to time by the Board. Furthermore, in connection with any charges which are pledged to the payment of any issue of bonds hereunder, the Board is expressly authorized to make such agreements and contracts with the bondholders, or the trustee for the bondholders, embodied in a resolution or trust indenture, referred to above, authorizing and securing the particular issue of bonds, with reference to the maintenance of the maximum possible occupancy and the maintenance of charges at a specified level, as the Board may determine to be necessary or desirable in connection with the issuance of bonds on the most favorable terms possible.

SEC. 8. Bonds may be issued hereunder for the purpose of refunding any issue of bonds theretofore issued under the provisions of this Act. When refunding bonds are issued, such refunding bonds may either be sold or delivered in exchange for the bonds being refunded. If sold, the proceeds may be either applied to the payment of the bonds being refunded or deposited in escrow for the retirement thereof. All refunding bonds issued under this section shall in all respects be authorized, issued and secured in the manner provided for other bonds issued under this Act and shall have all the attributes of such bonds. The resolution under which such refunding bonds are issued may provide that any of the said refunding bonds shall have the same priority of lien on the charges pledged for their payment as was enjoyed by the bonds refunded thereby.

SEC. 9. Bonds issued under the provisions of this Act shall be exempt from all State, County and Municipal taxes except property taxes. This exemption includes income and estate taxes.

SEC. 10. Any municipality, or any board, commission or other authority duly established by ordinance of any municipality, or the boards of trustees, respectively, of the Firemen's Relief and Pension Fund and the Policemen's Pension and Relief Fund of any such municipality, or any county, or the board of trustees of any retirement system created by the General Assembly of the State of Arkansas, may, in its discretion, invest any of its funds in the bonds of the Board issued under the provisions of this Act; and bonds

issued under the provisions of this Act shall be eligible to secure the deposit of public funds.

SEC. 11. This Act shall be liberally construed. The enumeration of any object, purpose, power, manner, method and thing shall not be deemed to exclude like or similar objects, purposes, powers, manners, methods or things. Furthermore, with the exception of the amendment to Section 11 of Act No. 6 of the Acts of Arkansas of 1955, as amended by Section 6 of this Act, this Act shall be construed as being supplementary to any existing purposes and powers authorized to be accomplished and performed by the Board and by the Arkansas Children's Colony.

SEC. 12. The provisions of this Act are hereby declared to be separable and if any section, paragraph, sentence or clause of this Act shall be held unconstitutional or invalid, such holding shall not affect the validity of the remainder of the Act.

Mr. RAY. And in Arkansas if the parents can pay, we expect them to, based on their ability to pay, but not to exceed the per capita cost.

Mr. HARRIS. What is the annual budget of Arkansas for mental health and mental retardation?

Mr. RAY. The only part I could answer, Mr. Harris, is mental retardation. As far as the institution for retardation, it is a million dollars a year. As far as special classes in the public schools, it is $400,000 a year. The State hospital is about $7 million. In Arkansas we don't have a mental health board—my board is completely separate, the mental institution has its own board.

Mr. HARRIS. That is what I have in mind, how much is the budget provided by the State legislature for the retarded program?

Mr. RAY. $1 million a year, sir.

Mr. HARRIS. And then for the next biennium it would be $2 million?

Mr. RAY. Yes.

Mr. HARRIS. Somebody have any further questions?

Mr. NELSEN. No.

Mr. HARRIS. Mr. O'Brien?

Mr. O'BRIEN. No.

Mr. HARRIS. Mr. Roberts?

Mr. ROBERTS. No.

Mr. HARRIS. Mr. Ray, I want to personally thank you for taking the time to come here and express to the committee your interest in this program, and for giving us the benefit of your experience in our State for our consideration.

Mr. RAY. Thank you very much, sir.

Mr. ROBERTS (presiding). The next witness will be Dr. Henry N. Pratt, director of the Society of the New York Hospital, American Hospital Association, 1 Farragut Square South, Washington, D.C.

STATEMENT OF DR. HENRY N. PRATT, DIRECTOR OF THE SOCIETY OF THE NEW YORK HOSPITAL, AMERICAN HOSPITAL ASSOCIATION; ACCOMPANIED BY VANE M. HOGE, M.D., WASHINGTON SERVICE BUREAU, AMERICAN HOSPITAL ASSOCIATION

Dr. PRATT. I am Dr. Henry N. Pratt, director of the Society of the New York Hospital of New York, which is closely affiliated with Cornell University Medical College, and which supports 450 psychiatric beds in close relationship with its general hospital.

I have with me Dr. Vane M. Hoge, assistant director of the Washington Service Bureau of the American Hospital Association.

I am presenting testimony as a trustee of the American Hospital Association.

Mr. Chairman, I have here a prepared statement. I believe you have copies of it. To save time I would like to submit this for the record, and then to review some of the high spots in this statement, and perhaps to make a few off-the-cuff comments about this statement.

Mr. ROBERTS. Thank you, doctor. The statement will be filed for the record, and you may proceed.

Dr. PRATT. Thank you, Mr. Chairman.

In general, the American Hospital Association is in agreement with the objectives of both of these bills. We do, however, have certain suggestions, and I would like to discuss first H.R. 3688 for the provisions of mental health centers.

It is unnecessary to tell you gentlemen that mental health is the No. 1 health problem in the United States. There are more than a million people under treatment annually in mental institutions, and approximately half of the hospital beds in the United States, some 702,000, are for mental illness. The total cost to our society must be something in excess of $3 billion a year.

Now, of those 702,000 beds for mental illness, the vast majority of them, some 670,000, are in approximately 300 large mental institutions that average over 2,000 beds each. These institutions really provide not much more than custodial care because of the lack of adequate numbers of health personnel. For example, they have approximately one-fifth of the number of registered nurses they require, and about 40 percent of the number of social workers, and one-third the number of physicians.

I think it should be made clear at this point that passage of this bill would not produce the results hoped for unless at the same time funds were made available to support the educational and training programs of doctors and paramedical personnel. And I refer more specifically to H.R. 12 which provides financial assistance in medical education.

I sincerely hope that perhaps this bill could be moved along.

Now, as you know, our population in our mental hospitals has risen steadily over the years until more recently, when new concepts of care, and particularly chemical approaches to the problems of mental health have resulted in a reversal of this increasing number of population in the mental hospitals.

Now, we feel that there are very definite advantages in the local health facilities as against the large mental institutions. The short-term acute facilities are really much more effective in curing people with mental illness.

One study that I think is extremely interesting was done in Kansas City by the Community Studies, Inc., in cooperation with the Missouri Division of Mental Diseases and the Greater Kansas City Mental Health Foundation.

Here they compare the results of treatment at two intensive care treatment centers as compared with five State mental institutions, a total of some 412 patients broken down into specific diagnostic categories. The very striking result of this was that the average length of stay in the intensive care units was only 32 days as compared with 255 days in the large mental health institutions, or a net saving of some 223 days per patient.

In addition, patients treated in the smaller acute care units had fewer readmissions, and there were longer periods of time between their readmissions. The experts tell us that the longer time a patient spends in a mental hospital, the less are his chances for recovery.

The American Hopital Association has long advocated a strong community mental health service as units of general hospitals. A recent report by the American Hospital Association, and the American Psychiatric Association, entitled "Psychiatric Services in General Hospitals" I think is pertinent, and, if I may, I would like to introduce this into the record as well.

Mr. ROBERTS. Without objections.

(The report referred to is as follows:)

PSYCHIATRIC SERVICES IN GENERAL HOSPITALS, AMERICAN HOSPITAL ASSOCIATION, CHICAGO ILL.

FOREWORD

As a result of a major change in concept in the treatment of emotional disorders during the last few years, general hospitals have been encouraged to establish psychiatric services within their confines. The Liaison Committee of the American Hospital Association and the American Psychiatric Association has prepared this manual to assist hospital's in this field of endeavor. The manual has been approved by the board of trustees of the American Hospital Association and by the Council of the American Psychiatric Association.

The endorsing organizations are of the opinion that this publication will be of considerable value as a basic guide, not only now but also in the future. The manual is not intended to be a directive; its recommendations must be adapted to the individual situation.

We wish to express our appreciation of Alston G. Guttersen, American Institute of Architects, for his assistance in the architectural considerations and in the preparation of model plans of psychiatric units in general hospitals that are embodied in the manual.

Both the American Hospital Association and the American Psychiatric Association will welcome requests for consultation and information on developing such units.

EDWIN L. CROSBY, M.D.,
Director, American Hospital Association.
MATTHEW ROSS, M.D.,
Medical Director, American Psychiatric Association.

INTRODUCTION

Many problems confront the board of trustees, administrators, and physicians of community general hospitals today. As medical needs are considered in the light of medical progress, methods of diagnosis and treatment are undergoing repeated change. But this is only one set of problems. Public awareness of the values of comprehensive medical care has led to increased utilization of hospitals. Both scientific knowledge and public acceptance have made the hospital the medical center of the community.

As a result of fundamental new concepts of the modern general hospital, we are faced with the problems of supplying public demand for care, keeping budgets balanced, and training competent medical scientists. No less important are the problems of the medical care of an aging population and the medical management of the chronically ill. In another vein, the construction of outpatient departments in or near community hospitals, the renovation of outmoded buildings and the building of new hospitals are current objectives. The question of developing the best economic program to finance the whole complex is ever present to harass the planners of medical care. These questions are even more critically focused when specific medical problems are considered, such as the needs of the patient with malignment disease, arthritic disease or mental disease.

Realizing their problems, the Federal and State governments have, in many areas, made funds available to assist communities that are endeavoring to meet these specific patient needs.

Physicians and hospitals are seldom satisfied with their standards of care; they seek constantly to do more and do it better. In time, the solution to many of these problems will, no doubt, be brought to fruition. In this manual, a more positive and vigorous approach to the early treatment of mental disease is being recommended. Realistically and idealistically, such a program must be established with appropriate orientation of the community.

The problems to be solved in the care of the mentally ill are complex, but these problems, like those of other diseases, are being studied assiduously. Diagnosis and therapy in the community and in its general hospital constitute the most logical approach. Adapting the professional staffs and the facilities of general hospitals will require purposeful development of methods and modalities of care of mentally ill patients. To this end the American Hospital Association and the American Psychiatric Association have prepared this monograph. It is not designed to present the precise details of the development of a psychiatric service or a psychiatric unit in the general hospital. Rather it is meant as a guide for the trustees, administrators, and medical staffs of general hospitals contemplating the initial steps in establishing medical care for these patients.

A program of eight principles, developed by Matthew Ross, M.D., medical director of the American Psychiatric Association, has been approved by the House of Delegates of the American Hospital Association and by the Executive Committee of the American Psychiatric Association. These principles might well guide governmental, private, and voluntary agencies concerned with the future development of services and facilities for psychiatric care. They are as follows:

1. Great economic returns come from money spent on active diagnostic and treatment programs for the mentally ill than from money spent on programs which are largely custodial. While large tax-supported mental hospitals continue as the major hospital resource, greater attention can profitably be given to the development of active diagnostic and treatment programs.

2. The training of new supplies of professional personnel in all the mental health specialties, to implement active diagnostic and treatment programs for the mentally ill, is regarded as the most profitable activity in which to invest money and other resources. To be fully effective, such an activity requires a concerted national effort.

3. Solutions to the problem of overcrowding in mental hospitals, other than building more beds, require exploration. The development of improved community services offer a promising alternative to relieve the pressure to build more beds, produced by overcrowding.

4. Many private psychiatrists with practices in cities and metropolitan areas are members of medical staffs of general hospitals and, in consequence, mentally ill patients admitted to these hospitals receive a more adequate amount of the services of professional personnel. Selected general hospitals located or being built in such areas should provide realistic amounts of bed and activity space for psychiatric care.

5. In the development of facilities and services for psychiatric care, hospitals should be aware of the importance of a well-balanced staff; they should establish activity programs for patients, and physical facilities for same; and they should prepare to avoid problems associated with closed hospital facilities by adopting the "open door" policy wherever possible. All-purpose clinics with precare and postcare programs should be part of the facilities set up in hospitals, whether tax-supported, private, or voluntary. Hospital architecture and furnishings have therapeutic importance and should be chosen with care and precision.

6. Community services for psychiatric care should be established and maintained with recognition that the supply of professional personnel in all the mental health specialties is limited. Government, which has accepted responsibility for financing large tax-supported mental hospitals, should be prepared to participate in the financing of community services. In the interest of lower costs, and in order to avoid construction of expensive facilities, consideration should be given to the use of day and night hospital facilities, family care boarding homes, and nursing homes.

7. The incorporation of adequate followup programs is essential to the success of a psychiatric treatment program and they should be included in all planning.

8. Medical and hospital prepayment and insurance plans should extend coverage to include psychiatric care. In extending such coverage, provisions established should encourage active diagnostic and treatment programs for the mentally ill rather than programs which are largely custodial.

The number of psychiatric units in general hospitals has grown remarkably in the past 10 years. As the general hospital assumes more and more of the medical responsibilities of the community, it can be anticipated that the diagnosis and treatment of mental disease will be an important part of the program.

In the following chapters an effort has been made to collate the pertinent background information on the need for and the development of psychiatric services in general hospitals.

CHAPTER 1. WHY A PSYCHIATRIC SERVICE?

Mental illness is a major medical problem and, in fact, has been called our No. 1 health problem. National Institute of Mental Health statistics show that more than 1 million patients are treated annually in mental hospitals in the United States, in addition to the substantial number of people treated in clinics and by private psychiatrists.

Estimates have been made of the total number of Americans who need treatment for some degree of mental or emotional illness. Although it is difficult to substantiate these estimates, one study showed that 10 percent of a noninstitutionalized urban population were mental ill.

The Joint Commission on Mental Illness and Health has estimated the yearly cost of mental illness in the United States at the very minimum to be upward of $3 billion (direct cost, $1 billion; indirect cost, $2 billion).

Many studies indicate that large numbers of people in the United States are in need of psychiatric diagnosis and treatment. Moreover, many of the patients who are actually hospitalized need more treatment than can now be provided.

There are approximately 300 public mental hospitals, which house some 670,000 patients. Many of these hospitals provide little more than custodial care. They have about one-fifth the number of registered nurses that would be required for adequate staffing, about two-fifths the number of social workers, a little more than one-third the number of physicians, and about three-fourths the number of psychologists. Yet the most constant factor in reducing average mental hospital stay, and the admission and readmission rates, has been the increase in number of professional personnel needed to render effective medical care.

On the other hand the 200 private psychiatric hospitals have a total of about 10,000 beds, and the 600 psychiatric units in general hospitals have a bed capacity of approximately 22,000. The psychiatric service in the general hospital is a relatively recent development, most such beds having been opened on the basis of experience gained in World War II. Many general hospitals still do not accept mentally ill patients, and few are prepared to do more than give them interim care.

A recent survey of hospitals believed to accept psychiatric patients, conducted by the joint information service of the American Psychiatric Association and the National Association of Mental Health,[1] indicated that, among the small group of hospitals confirming acceptance of such patients (844 general hospitals out of a total of 1,109 queried, and about 6,000 in the Nation), over one-fourth accept such patients only for emergency care. Many others carefully screen all psychiatric admissions in accordance with various restrictions. Furthermore, in the two States in which all general hospitals were queried, rather than those supposedly accepting psychiatric patients, only 9 percent of the hospitals indicated that such patients were accepted for treatment.

[1] The joint information service queried all hospitals believed to accept psychiatric patients. A total of 1,109 questionnaires were sent to U.S. hospitals, and replies were received from 984.

Hospital policy concerning admission of patients with a primary diagnosis of mental disorder; United States, 1958

Hospital policy	*Number of hospitals*
Total hospitals reporting	984
Admit patients with mental disorders	844
Emergency only	242
Treatment only	71
Emergency and treatment	531
Do not admit patients with mental disorder	135
No reply to question	5

Although more than half of the hospital beds in the Nation are used for mental illness, only 1 to 3 percent of them are in the general hospitals. About 200,000 psychiatric patients were discharged from about 22,000 general hospital beds in 1959. Reliable estimates indicate that nearly half of the patients on the medical and surgical services of general hospitals have emotional problems that are important factors in their illness. An anxiety reaction to physical disease is often a serious deterrent to appropriate therapy. The somatic manifestation of underlying mental illness can be exeremely difficult to diagnose and even more complex to treat.

General hospital needs psychiatric staff

The general hospital has become the medical center of the community. It is probably the only place in which expensive modern technical equipment and skilled personnel can be housed together, to provide a scientific workshop geared to complete patient care. Many pressures bear on the general hospital as it strives to meet community needs. Physicians, who have stimulated its growth through greater use of its facilities, expect it to provide the most up-to-date scientific equipment and technical procedures. The public demands and deserves excellent facilities. The trustees and the administrtors of general hospitals realize that they must provide an increasing number and variety of services: more services for patients who are living into older age groups; more preventive and rehabilitative services; more services for psychiatric patients.

The general hospital needs a psychiatric staff to help in the evaluation, diagnosis, and treatment of emotional complications, which, for the most part, can be managed on the medical, surgical, and pediatric services. The psychiatric consultant, giving advice and supervision, can help physicians and nurses gain better understanding of patients and thus provide more effective treatment. In many cases, he collaborates with other physicians in active treatment; in others, the emotional symptoms are so severe that transfer of the patient to the psychiatric unit may be necessary to achieve proper care.

It is essential to weigh the influence of both psychologic and physical factors to determine the proper solution to each patient's medical problem. Unfortunately, some physicians treat the physiological problems of patients while knowing little and doing less about emotional disturbances. Failure to recognize promptly the emotional cause of somatic manifestations can fix the patient's attitude at a point where he cannot accept a psychiatric diagnosis, let alone adequate therapy.

Psychiatrist needs general hospital facilities

Conversely, the psychiatrist requires the diagnostic facilities of the general hospital and the ready availability of other specialists for the complete care of his patients. The psychiatric unit also functions as a safety valve. Inevitably in any community there are cases of acute toxic psychoses of short duration or temporary acute behavioral disturbances, which the medical staff of the usual general hospital may be reluctant to accept for treatment. Too often there are no facilities that have a medical and nursing staff experienced in the management of such patients. The general hospital should be equipped and its personnel trained to handle such temporary problems when they occur.

Though the public has come increasingly to accept mental illness as a disease, there are still many people who believe that care in a psychiatric hospital

is stigmatizing.[2] There is less prejudice with regard to psychiatric care in general hospitals; hence such facilities encourage early diagnosis and treatment. As in all illnesses, the earlier the diagnosis is made and therapy begins, the better the prognosis.

Because the general hospital is well integrated into most communities, there is usually less disruption of the patient's life than there would be if he became a patient in an isolated psychiatric hospital. The patient's environment is acceptable to him; he is not completely apart from family and friends. Conceivably, this may help him to cooperate in his treatment program. Moreover, continuity of treatment is usually possible when it is conducted in the community general hospital. The psychiatric patient may have the continued services of his family doctor, as well as his psychiatrist, before, during, and after his illness. He does not have to break off his relationship with his physician just when he most urgently needs it.

Mental disease may occur in any person at any time. It is hoped that eventually each person may have the opportunity for initial psychiatric care and perhaps for total care in his local general hospital.

Mental patients may lack prepayment benefits

Because so much psychiatric care is given in tax-supported State mental institutions, and because of the long-term care needed for serious psychiatric illness, nonprofit and commercial insurance have tended not to cover the mental diseases. At present, establishing the presence of mental disease may even result in the patient's loss of part, or even all, of his prepayment benefits. Of 83 Blue Cross plans, 57 provide some benefits for mental illness under basic certificates, and 64 under comprehensive basic certificates. The recent joint information service survey, referred to earlier, shows the length of time patients were covered by prepaid group hospitalization insurance plans:

Length of hospitalization covered by prepaid insurance plan:	*Number of hospitals*
Total reporting length of time	284
Under 1 week	10
7 to 13 days	33
14 to 20 days	31
21 to 27 days	21
28 to 34 days	106
Over 34 days	83

As more and more psychiatric illnesses are managed in community hospitals and clinics, benefits for them will probably come to be included as part of realistic prepayment and insurance benefits. The joint information service survey indicates that 69 percent of U.S. general hospitals have the same charges for psychiatric and nonpsychiatric patients. Only 10 percent charge psychiatric patients more than nonpsychiatric patients; 21 percent charge less. Costs in 64 percent of the hospitals, for both psychiatric and nonpsychiatric patients, are between $15 and $30 per day.

Education and research are necessary

The ultimate cost of mental disease—in money and in human suffering—will be lowered and medical care will be strengthened only through education and research. We need more people professionally trained to care for mentally ill patients, and there is evidence of progress in this direction.

A psychiatric service in a general hospital has numerous educational advantages. The medical student, the intern, and the resident can gain a broader appreciation of the symptoms and signs of mental diseases and can develop experience in their management. The practitioner can further his knowledge of emotional problems and enhance his skills in diagnosis and treatment. Nurses and other personnel can develop their skills to give better care. As they watch the psychiatrist work with the internist and surgeon in the recognition and

[2] In an actual incident, the father of a young woman sought a final visit with the psychiatrist in charge of a hospital service to thank him for the care given his daughter. "Doctor," he said, "I could not take my daughter from the hospital without making a confession to you. I am a member of the board of trustees of our community hospital. When the board was considering adding a psychiatric unit, I was very strongly opposed; I felt we should not have 'crazy' people in a 'nice' general hospital. I think it was largely as a result of my objections that the proposal was turned down. I now feel that I never made a more serious mistake in my life."

treatment of emotional factors in organic disease, they are taught the effective management of any patient.

CHAPTER 2. UNIT ORGANIZATION AND CONSTRUCTION

No universal procedure in the establishment of a psychiatric service or unit in the general hospital can be outlined because of variation in local circumstances and the special purposes or functions of different hospital.[3] Certain generalizations can be made however, which will serve as guides.

Requirements in large communities

In larger communities where there are practicing psychiatrists, the unit should me tailored to their needs as well as to the overall community requirements. In this situation the administrator can meet with representative members of the psychiatric and the general medical staffs to make certain initial decisions. Fundamentally, these decisions are concerned with the function of the psychiatric unit in relationship to the total facilities for the care of mental disease in the entire community. In this respect, it is the consensus that these units are not for long-term care, but are primarily oriented to diagnosis and treatment of patients who have a good prognosis for a favorable response in a relatively short time. Three to eight weeks could be considered as an average hospitalization period, although specific limitation of time would be unwise. Accurate diagnosis and initial therapy are as important to planning the program of medical management for these patients as they are for any disease process. Provisions for continued care must be considered. This may be provided in clinics, psychiatrists' private offices, day hospitals, half-way houses, convalescent facilities, psychiatric hospitals, or other facilities.

Planning pattern for smaller hospitals

In smaller general hospitals, the planning is likely to follow a different pattern, and the unit may serve a different function. If there can be no regular attending psychiatric staff, then a consulting staff is advantageous in both planning and practice. A consulting staff can aid in establishing the unit in the hospital in much the same way as described previously. The unit might well be organized so that the patients are managed by the attending medical staff in conjunction with the consulting psychiatric staff.

Provisions for temporary care of acutely ill

All general hospitals should consider providing secure, soundproofed, air-conditioned rooms for the specific management of such problems as acute toxic reactions and acute temporary behavioral disturbances. These rooms should be constructed both in the large hospital with a psychiatric unit and in the smaller hospital where there may be no separate psychiatric unit. The purposes of these rooms would be several. They can be used for the treatment of the acutely ill until these patients are well enough to be moved to another part of the unit. They can be used for treating patients until transfer is made to a psychiatric hospital. They can be used for patients who develop temporary behavioral disturbances as complications of medical and surgical therapy.

If there is no regular psychiatrist on the staff, these patients may be managed by the attending staff with psychiatric consultation.

Certain concepts of the care of psychiatric patients will be reiterated throughout this manual. There need not be extraordinary problems in the management of these patients in the general hospital. Many of the patients who would be treated by the psychiatric service already are patients in the general hospital setting. When the psychiatric unit of the general hospital is properly equipped and staffed, only occasionally is it found impossible to manage a patient in the unit.

Ideal size of psychiatric unit

A nursing unit of 20 to 24 beds appears to be close to ideal size. It is believed that a unit of this size gives the best opportunity for close observation of patients by the medical and nursing staff, and that it seems to work best from the point of view of patient therapy. In large hospitals, where more beds can be supported in the psychiatric unit, it is recommended that two or more separte nursing units of this size be established. These separate units might be designed to receive patients of different treatment categories.

[3] Consultative assistance is available from the American Psychiatric Association and the American Hospital Association.

Details of planning are important

The foregoing paragraphs have touched on general guides in the approach to planning the unit itself. Details that will apply to most units can now be considered. When community needs have been surveyed and the types of patients have been determined, the unit can then be planned in greater detail.

Many of the features of the unit will need to be departures from the classical medical and surgical units, because of the special requirements of phychiatric patients. For the most part, the unit should be open. Men and women can be treated on the same unit, but generally speaking, younger children should not be treated in the same area. On the other hand, the adolescent can sometimes be treated most successfully on the adult unit.

Phychiatric patients of all kinds need not only special techniques of diagnosis, treatment, and rehabilitation, but also an appropriate environment, to create in them the feelings of warmth and security necessary for effective treatment. For this reason, it is important that special attention be paid to the decor of the psychiatric unit. Though completely functional, the phychiatric unit must have a pleasant atmosphere as an important part of the total psychotherapeutic setting.

Since psychiatric patients are ambulatory more than are medical and surgical patients, they need lounging areas, where they can read, chat, or watch television. They need rooms where they can participate in occupational activities, crafts, or drama therapy. They should have a recreational area where supervised exercise is possible. An outdoor recreational area is a distinct advantage in the treatment of these patients. More than most hospital patients, psychiatric patients need to associate with other people. It must be made easy for them to reach lounging and recreation areas, where they can be with other patients, staff, and visitors and participate in therapeutic activities.

Since patients' recreational and social activities are so important, it is well to separate treatment facilities from patient accommodations. In this way an appropriate environment can be better maintained. The number and type of treatment rooms should be recommended by the psychiatric staff.

Since most of the patients will be ambulatory, the lounging, recreational, and occupational facilities should be near the supervision staff area. For the same reason, the bedrooms wil not have to be equipped in the manner of medical and surgical rooms. There will be more latitude for use of bedrooms as living areas or dormitory areas, whichever is most desirable. While some private rooms are needed, the unit can be divided into two-bed and four-bed rooms. Meals are probably best served in a common dining room area rather than in the patients' rooms, and it may well be feasible to use a lounging or a recreational area for this purpose in order to conserve space.

Facilities for the staff

The staff has certain requirements in the unit also. In addition to the treatment areas and the nurses' station, offices and conference rooms are necessary. The staff will be conducting interviews with the families as well as with the patients. Offices and interviewing rooms, for the most part, can be used interchangeably. These rooms are probably best located away from the areas in which the patients will tend to congregate. The conference room may be used for staff meetings or for therapy. When X-ray, laboratory, or other technical facilities are needed, the psychiatric patient, usually ambulatory, can move to these areas; thus none of these facilities needs to be duplicated in the psychiatric unit.

Psychiatric outpatients can be managed in the regular clinic area if one exists. The principal requirement is an interviewing room where the patient and psychiatrist can talk privately. It is also possible to provide continuing outpatient care in areas set up as day hospitals. This type of facility is developed in much the same way as the psychiatric unit, except that no beds are needed. In some instances it may be possible to include some day patients in the hospital psychiatric unit.

CHAPTER 3. UNIT STAFFING AND ADMINISTRATION

The psychiatric service should be organized as a department of the medical staff of the hospital. Individual psychiatrists should be appointed in the same manner as other members of the staff, and should be given an appropriate designation, such as active, attending, or consulting, as the case may be. A chief of service should be appointed in the same manner as other department chiefs. It is expected that the psychiatrists will abide by the same staff rules and regu-

lations as other members of the medical staff. The only exceptions that can be anticipated are those pertaining to the special problems of the management of psychiatric patients. Actually these will be few and can be enumerated as the service is organized. The psychiatric staff will attend staff meetings and participate in staff functions.

During the development period the chief of the service aand other psychiatric staff members will require frequent meetings with administration. Later, this schedule can be reduced and will be no more frequent than are administrative meetings with the staffs of other departments.

Nurses need psychiatric training

Emphasis must be placed on the importance of sufficient and proper nursing care in the psychiatric unit. Nursing care provides the bulk of the daily personal contact so essential to the psychotherapeutic setting. Understanding psychiatric diagnosis and therapy is so important that all members of the nursing staff should have training in psychiatric nursing. This is especially true of the nurse in charge of the unit. When it is not possible to obtain staff nurses trained in the field, it will be essential for the head nurse to be competent to instruct all her personnel in psychiatric techniques. Further, the chief psychiatrist and the head nurse must work cooperatively in order to develop the nursing techniques that will best carry out the program of the psychiatric staff. A similar relationship is required between the nurse in charge of the unit and the director of nursing of the hospital staff. It should be pointed out that ratios of nursing staff to patients are necessarily higher in the psychiatric unit than in the general care nursing units of the hospital. The psychiatric team also requires a number of other members, such as psychologists, occupational therapists, psychiatric social workers, and ancillary therapists. These therapists can make a valuable contribution to the care of other patients in the hospital.

Staffing requirements

A hypothetical example of staffing is in order at this point. Given a nursing unit of about 20 beds, we believe there should be a minimum of 4 graduate nurses, probably 2 of them on duty during the hours of concentrated therapy and on each of the other shifts. In such a unit, a total of six attendants would be minimal. It is the function of the chief psychiatrist to mold this entire staff into a supportive team in the treatment of mentally ill patients.

An important point should be made here: After the nursing staff for the unit is obtained, its members should not be used as substitutes in other units. The special training they have received should be utilized as completely as possible. Also, substitutions for personnel on the psychiatric nursing staff should be so arranged that there is always supervision by an experienced nurse in charge.

Conferences for the psychiatric and nursing staff are important for continuing education and for adequate communication in the best interest of the patients. Because so many of the patients' problems are completely individual, it is important that every member of the psychiatric team know what is to be done for each patient and why it is being done. Other important educational responsibilities should be mentioned briefly. The psychiatric staff should participate in the educational program for the interns and residents, the senior medical staff, the nursing staff, and the school of nursing, if one exists. It is only in this manner that the psychiatric staff can make its full contribution to medical education and the quality of patient care.

Handling the medical records

Special comment should be made about the medical records of psychiatric patients. Much of the personal information the records contain is so confidential that special care in handling them is mandatory. They are usually longer and more detailed than other medical records, especially the record of the patient's history and the progress in the hospital. Entries are frequently made by the various psychiatric team members, such as the psychologist, the social worker, and the activity therapist. Nursing notes can be particularly significant and should be an integral part of the record. Regular medical forms suffice for most of the record, although some special forms will be required for such procedures as psychological testing.

Confidential notes or unusually lengthy notes probably are best summarized for the medical record. If the psychiatrist deems it advisable, the more detailed notes may be kept as part of a restricted file and this fact should be noted in the medical record. Following discharge of the patient, the medical record should be returned to the medical record department unless the staff decides that it is

necessary to restrict the entire record. In such an instance, a regular medical folder should appear in the record department files with the notation that the contents of the record are in a restricted file.

If the nursing station is open, the medical records on the psychiatric unit should be locked. This precaution is necessary to insure that only authorized individuals have access to these confidential records. Special care should be exercised in releasing information concerning any patient.

If the medical record is to be used in litigation, judgment must be used to determine the essential information that should be released. In any event, only information that has a direct bearing should be included. The psychiatric staff should appropriately counsel any hospital representative responsible for the medical record in legal proceedings, even if the record is subpenaed. In some instances the psychiatrist may need to take the record to such proceedings to present the material in the patient's best interest.

Medico-legal problems

The prospect of medico-legal problems complicating the admission of psychiatric patients to the general hospital is likely to be disconcerting to the hospital administrator and to the medical staff as well. Actually, this is not a serious problem if a sound policy is established prior to the opening of the unit. Again it is well if we remind ourselves that most of the patients already in the general hospital have emotional problems as a part or even the whole basis of their illnesses. If the possibility of medico-legal complications is a deterrent to initiating the psyhciatric unit in the general hospital it should be recognized that the problems already exist, and that establishing certain principles to avoid legal pitfalls thus only makes the present situation more secure in most hospitals.

When the psychiatric unit is being created, the staff should meet with the administrator and the hospital attorneys to set policies to minimize potential legal action. Legal suits in psychiatric cases appear to be no more frequent than in other medical cases. However, basic policies should be defined to meet the minimum legal responsibility of the institution to its patients. Consequently, good medical care, adequately documented in the medical record; good relations with the families of patients, and appropriate precautions for the welfare of the psychiatric patients become the most essential components of handling potential legal problems.

Although variations exist among the several States, for the most part there are not commitment procedures for patients admitted to the psychiatric units of general hospitals. Most States have specific laws prohibiting restraint of such patients. If the patient insists upon leaving the hospital, he must be permitted to do so, in most instances. A signed release when the patient leaves against medical advice is appropriate, as it is in other medical situations, to make sure that the family appreciates the position of the staff and the hospital. However, if medical opinion is that the patient may harm himself or others by leaving the hospital, the staff is obligated to restrain this patient as a part of good medical judgment. But the staff must act quickly to inform the relatives of the decision and to secure legal approval for further care, if not full commitment.

Deterrent to suicides

The question of suicide needs individual discussion. The possibility of suicide is present in all parts of the general hospital. The ready availability of the psychiatric consulting staff and the facilities of the psychiatric service can be invaluable aids in the prevention of suicide and in the treatment of suicidal patients.

Special consents are usually required for diagnostic and therapeutic procedures that involve some risk to the patient. These consents are obtained from the patient or, if necessary, from his relatives; every effort should be made to make the patient or his family understand the methods that are going to be employed. These consents are not unlike those used for other hospital procedures, and do not waive the patient's right to recover damages for negligence in treatment.

CHAPTER 4. DIAGNOSIS AND TREATMENT

Various studies have indicated that 50 percent or more of the patients admitted to general hospitals have an emotional problem as the major cause of illness. Few patients have physiologic disease without some kind of associated emotional conflict, and many patients need treatment for their emotional prob-

lems as well as for the physical difficulty. Such facts indicate the need for both physicians in general practice and administrators of general hospitals to recognize the responsibility of such "general" hospitals in the admission and therapy of patients with severe emotional problems.

Aid to patients in other units of hospital

The physician who first sees the patient should assume responsibility for the emotional as well as physical illness. In a general hospital with a psychiatric unit one would expect that the treatment program of such a unit would be supervised by psychiatrists. Under such circumstances, patients in other units of the hospital who develop acute symptoms of an emotional disturbance, or even a psychotic reaction, may be seen quickly by a psychiatrist, and with proper evaluation and treatment the necessity of transfer to the psychiatric unit may be avoided. An example of this kind of reaction may be seen in patients with certain deprivation syndromes associated with the loss of vision resulting from bilateral eye patches used in certain types of eye treatment. Such patients—particularly older ones—may react suddenly and seriously to such deprivation threats, but opportunity for a quick referral can result in prompt relief of the symptoms without actually having to move the patient from the service on which the difficulty developed. Should the symptoms continue, however, the patient can be transferred to the psychiatric unit.

History and physical studies first

Diagnosis and treatment in psychiatry, as in other fields of medicine, begin with a careful and extensive history, with special consideration of the patient's relationship to other members of his family and to his own problems. Symptoms should be correlated, when possible, with precipitating factors. Unfortunately, this represents a trap for the unwary; in most instances, the patient is able to describe a precipitating factor, but oftentimes it bears little if any relationship to the patient's real problem.

In the study of the psychiatric patient, a careful physical study must be made, with particular reference to those symptoms that may have a physiologic aspect. Laboratory diagnostic procedures are useful in making certain psychiatric diagnoses. In this connection care must be exercised not to overdo physical studies nor to give the patient the impression that such studies are being done because one presumes the presence of physiologic disease is an explanation of his symptoms. Such an error may very possibly crystallize an attitude on the part of the patient that makes later psychiatric treatment much more difficult. Of greater importance in the diagnostic study are various psychological studies, such as intelligence tests of various kinds, and partially structured and unstructured projective techniques, such as the Rorschach.

Major groups of psychiatric disorders

Psychiatric disorders, exclusive of the various types of mental deficiency, can be divided into six major groups:

1. *Disorders caused by or associated with impairment of brain tissue function.*—These can be subdivided into the various acute brain disorders, such as those due to infection (meningitis, encephalitis), intoxication (alcohol, drugs), trauma or metabolic disturbances. This group also includes chronic brain disorders, which may be associated with constitutional factors, infection, intoxication, trauma, circulatory disturbances (cerebral arteriosclerosis), and other diseases that result in disturbances of physiologic function.

2. *Disorders of presumed psychogenic origin or without clearly defined physical cause or structural change in the brain.*—Under this heading are usually classified the psychoses, such as the affective reactions, the schizophrenic reactions, and the paranoid reactions.

3. *Psychophysiologic disorders.*—These may actually involve any organ system or systems of the body, as for example the skin (eczema, urticaria) or the gastrointestinal tract (peptic ulcer, ulcerative colitis). These disorders are associated with physiological and structural change, in contrast to those in the next category.

4. *Psychoneurotic disorders.*—Those conditions are of psychogenic origin and without significant structural change. This and the preceding category comprise a large percentage of patients requiring psychiatric help. Under the psychoneuroses are included such conditions as anxiety reactions, conversion reactions, phobic reactions, and depressive reactions. Most of these conditions are particularly responsive to properly planned therapy.

5. *Personality disorders, sometimes described as character neuroses.*—In this group are the inadequate, schizoid, paranoid and emotionally unstable individuals, many of whom tend toward sociopathic disturbances, such as sexual deviation and addiction.

6. *Transient, situational personality disorders.*—Often these are relatively easily treated, but usually the patients require some environmental change. Falling into this group are such conditions as gross stress reaction, adult situational reaction, adolescent adjustment reaction and adjustment reaction of childhood.

As we review the various categories, we see that a large number of different types of diagnostic procedures may be required, from the conventional physical, laboratory, and X-ray determinations to and including personality studies and psychiatric examination. Furthermore, these patients require an extraordinarily careful evaluation of the history in terms of not only individual experience but also the interpersonal relationship in the family group. It should be clear that for a psychiatric service the total facilities of the modern general hospital, together with those special diagnostic tests carried out by the psychiatrist and the clinical psychologist, should be available.

Many kinds of treatment required

The keystone of psychiatric treatment is phychotherapy, but many different types of treatment are required and, as in other medical specialties, the treatment should be directed at the causal factors, whether these are physiologic or psychologic. Often it is necessary to combine various kinds of therapy for one patient. Thus it may be impossible to get the patient to accept psychotherapy until the physical symptoms are relieved or neurotic anxiety is reduced to a point at which the patient can focus upon the psychotherapeutic efforts of the psychiatrist.

Almost any kind of contact the patient has with someone who symbolizes to him the possibility of relief of symptoms may be a kind of psychotherapy.

Added to the individual psychotherapy provided for the patient by his physician are the psychotherapeutic effects that are inherent in all interpersonal relationships between the patient and members of the nursing and activity staff, as well as as in his participation in activities. These therapeutic effects may become specific because of the nature of the activity or the interpersonal relationship involved. They may be more general in nature when they are derived from the group setting and from the opportunities that the activity programs provide for progressive contact with the realities of living and improvement in morale.

Volunteers often effective

It has been found that the services of volunteers, recommended by members of the psychiatric staff and selected because of specialized skills in the arts or crafts or their ability to relate with people, can be effectively used in recreational and occupational therapy. The supervision and training of such volunteers should be the responsibility of the head of the occupational therapy department and of the psychiatric staff.

Many kinds of psychotherapy, too

If the patient recognizes that his symptoms are being carefully evaluated and that the possibility of physiologic disease is being studied through both the history and the examination process, he will develop confidence, and this in turn will lead to the kind of relationship on which psychotherapy can be based. There are many different kinds of psychotherapy. Some of these, such as reassurance, suggestion, persuasion, and support, are described as superficial psychotherapy; these can be used with relative success, in milder problems, by the nonpsychiatrically trained physician who has sufficient understanding of basic psychiatric principles to avoid an iatrogenic exaggeration of the patient's symptoms.

More specialized types of psychotherapy, sometimes referred to as deep therapy, include the so-called brief psychotherapy, intensive psychotherapy, and psychoanalysis. These forms of therapy, of course, should be reserved for the physician specially trained to carry out such procedures. They are quite as complicated and as difficult of successful execution as the more complicated procedures in other fields of medicine.

The development of more modern modalities of treatment has made it possible to care appropriately for psychiatric patients, even those who are seriously disturbed, in the general hospital setting. These modalities include the use of the tranquilizing and "psychic energizing" drugs, and the shock therapies. These

forms of therapy should be used in psychiatric treatment only in carefully-determined circumstances for which they offer the most satisfactory solution. They are not a substitute for psychotherapy but may be used in conjunction with it.

As in many other fields of medicine, more precise tools for psychiatric diagnosis and therapy and greater understanding of the psychopathology and pathophysiology of mental disease are required as psychiatry takes its proper place among the scientific disciplines of modern medicine. If psychiatry is to be readily available to those who need its help, the general hospital must provide the inpatient and outpatient facilities for the diagnosis and treatment of mentally ill patients.

CONCLUSION

Creating psychiatric services and psychiatric units in general hospitals is an important step in the diagnosis and treatment of mental disease. It represents one of the many strides that must be taken toward the solution of a serious national health problem. Recognition that mental illness must be approached as a community problem and should be a part of the program of the community general hospital and other community agencies is essential. A concerted effort by the entire medical profession to identify the early manifestations of these diseases and to start positive therapy is basic to such a program. Understanding of the symptoms and signs of these diseases, coupled with continued education and research, will bring to light new and better methods of diagnosis, treatment, and ultimately, prevention. Closer relationships of psychiatrists and other physicians, and of phychiatric and general hospitals, must have a mutually stimulating effect to further the care of mentally ill patients.

Continued discussion in staff meetings and other conferences in the general hospital must necessarily lead to better orientation in regard to the emotional problems of all patients. Experience has demonstrated that the average psychiatric patient presents no greater problems on the ward than the average medical or surgical patient. Patients are asking for psychological help and recognizing psychological needs earlier, emphasizing the need to provide these services in general hospitals.

It is with this philosophy that the American Psychiatric Association and the American Hospital Association have prepared the material in this manual. It is not the first publication on the subject, nor will it be the last. An attempt has been made here to present some of the objectives of the care of mentally ill patients that could be accomplished in general hospitals. Mainly it is a guide to those trustees, physicians, and administrators who are challenged to meet this community responsibility. In the production of the manual, the two associations have linked their forces to pursue the problems of mental disease.

APPENDIX I

ARCHITECTURAL CONSIDERATIONS

Translating the philosophies of the treatment of mentally ill patients into a functionally satisfactory architectural structure is a conceptual challenge. A detailed development is beyond the scope of this manual, although certain broad features can be discussed. The size and function of the unit will vary in different hospitals, thus influencing the final architectural design. Hospitals that are renovating older medical units and changing them to psychiatric units will be limited in altering floor plans; other hospitals will have the freedom of new construction. Thus, it is difficult to discuss all types of floor plans or facility details in this manual, and the sample plans on pages 31 and 32 are not intended for use without modification.

It is imperative for the psychiatric staff to work closely with the architect, the administrator and, when indicated, the hospital consultant, in planning the unit to create a positive treatment environment for the patient, one that will enhance his human dignity, restore his shattered feeling of self-esteem, and develop a cheerful, friendly, homelike quality for group and individual activity programs, as well as for quiet and relaxation.

PLANNING THE PSYCHIATRIC UNIT

The primary consideration in the architectural planning of the psychiatric unit lies in an examination of the differences between it and the medical and surgical areas of the hospital. This is essential whether a remodeled or a

newly constructed unit is being planned. Psychiatric patients are ambulatory and need hospital bed facilities much less than do other medical patients. They need to associate more with one another, and this requires lounging and recreational space. Dining facilities should be planned for many of the patients to eat together, although some patients may need to be served in their rooms.

In general, the treatment rooms in the unit, including interview rooms, should be set apart from the recreational and bedroom areas. The nurses' station should be centrally located to afford full view of the recreational area and to provide immediate access to the treatment area. Depending upon the size of the unit, it may be advisable to include some means of separation of the more seriously ill patients from those who are less ill. The more seriously ill patients should be located in or near the acute treatment area.

Decor is extremely important, perhaps more so than in any other unit of the hospital. The pleasanter the decor and the more "open" the construction design, the better the treatment environment.

It should be kept in mind that the units is to provide for the treatment of mentally ill patients and not to provide long-term care for the chronically ill.

PSYCHIATRIC SAFETY CONSTRUCTION

To protect patients from injuring themselves, the design of facilities in the psychiatric unit requires more consideration for safety than is commonly applied or necessary in the other units of the hospital. This is especially true in the area where disturbed patients are being treated. Walls should be built so as to avoid sharp corners or projections. Shelves and fixtures should be recessed. Heating, ventilating, plumbing, and lighting equipment should also be recessed, with specially constructed housings to make them reasonably inaccessible to patients. In the construction of floors, walls, and ceilings, attention should be paid to judicious control of noises. Ceramic tile and plaster wall finish construction is acceptable for omst psychiatric units. Radiant heating in floors and walls may be considered for the acute treatment area.

The furniture, bathroom facilities, doors, and other construction and furnishing should be simple and sturdy. Glass should be used only where necessary, and should be heat-tempered. Locks are to be provided only on specially designated doors, as recommended by the professional staff. When used, key-operating devices available only to the professional staff are advisable. Bathrooms are never to be locked. Optimally, air conditioning should be considered because it permits window construction of the sealed type, eliminating the need for protective screening while providing temperature comfort for the patient. Special hinges made it possible for doors to swing either in or out to prevent risk of barricading.

PATIENTS' ROOMS

Probably the majority of rooms in the unit should be single, but multiple rooms are also desirable for certain types of patients. Three-bed and four-bed rooms may be used, especially in the convalescent area and for depressed patients. The rooms in the acute treatment area should be designed for single occupancy. In general, two-bed rooms are seldom used and may even present certain hazards in therapy. Men and women may be treated in the same unit.

In design, the rooms should be simple and pleasant, with all parts of the room visible from the doorway. About 80 square feet per patient is minimal in the multiple rooms, and perhaps greater space should be allotted to single rooms. Beds should be simple, well-constructed, and lower than most hospital beds. Clothes closets are desirable in all rooms, but those in the acute treatment area may open onto the corridor, to be locked by the nurse. Most bathrooms should be provided with institutional type showers; tubs are to be installed only where supervision is possible.

RECREATIONAL AND OCCUPATIONAL THERAPY FACILITIES

In these areas, some patients will be reading or writing while others will engage in group discussions or recreational activities. From 40 to 50 square feet per patient will be needed. Often some of the planned occupational and recreational therapy is done in this area. Under such circumstances more space per patient, and space for storage of supplies and equipment, will be needed. For more complex activities in occupational and recreational therapy central facilities are required.

Other considerations here must include special dietary facilities, not only for a communal dining room, but also for a snack bar for use by patients permitted recreational and occupational activities.

ACUTE TREATMENT AREA

It is in this area that psychiatric safety construction is most important. Double-corridor construction is a distinct advantage in isolating this area in units with linear arrangements. In the cross type of building design, any one of the four sections can be set apart to isolate the acute treatment area. In this way the entire acute treatment area can be separated from the remaining unit and may even be locked from the inside and/or outside. This area should include the bedrooms of the acutely ill patients as well as the special treatment rooms. In another part of this general area should be the offices and/or the interview rooms of the psychiatric staff. Facilities for professional interdisciplinary conferences should be provided in conjunction with the offices. For the most part, the offices do not need to be large and require only simple office furniture. The important point is that they should afford privacy for the treatment interview.

Questions concerning installation of bathrooms, lavatories, and toilets in the rooms of this section, as well as the number of bedrooms, the design of the special treatment rooms, and other facilities in the acute area, can best be decided by the psychiatric staff.

NURSES' STATION

Within the nurses' area, charting and medication space should be similar to that in the other units of the hospital. In the psychiatric unit, however, the nurses' station should be constructed so that patients cannot enter the area. To provide supervision of patients, the nurses' station should be enclosed in heat-tempered glass. The area should be locked, and all medical charts should be kept in this area exclusively. The station should open into the acute treatment area, as well as into the other corridors of the unit. The utility rooms should be a part of the nurses' station.

Dr. PRATT. Now, with respect to provisions of H.R. 4688, if enacted as presently written, it would be an independent act. The American Hospital Association believes that title VI of the Public Health Service Act, that is, the Hill-Burton program, should be amended to include the provisions of this bill. This would permit administration by the Public Health Service, and through the same State agency that administers the Hill-Burton program. Obviously this would permit better coordination in health facility planning.

The bill also seems to give some priority to the necessity of having these acute mental health centers in close association with general hospitals. We believe that this is extremely important.

In the first place, if the psychiatrists in these acute mental care institutions are in close relationship with other disciplines of medicine, particularly internal medicine, and biological chemistry, they will be encouraged to conduct research in the area of chemistry, which is so very important. And, conversely, the other members of the medical staff, the nonpsychiatrists, they, too, will receive benefits from their day-to-day contact with the psychiatrists.

In my institution this has gone so far that there have been undertaken extensive studies on the ecology of man, the various factors that govern his actions and may relate to his physical illness, the mental factors that relate to his physical illness.

A very good example of this was a study that was recently done on prisoners of war in Japanese prison camps as compared with those in German prison camps. And it is interesting to note that even after all these years the life expectancy of those American soldiers who were prisoners of Japanese is still substantially shorter than the life expectancy of those which were prisoners under the Germans.

This comes about because of their sense of complete loss and hopelessness as prisoners, they did not believe that they ever would come home alive again.

This is a very important factor with respect to mental illness, also. The individual who is put in a large mental institution without contact or with very little contact with his friends and relatives and lack of contact with the community does feel a sense of complete loss and hopelessness. And he becomes institutionalized as a result.

Now, if these acute mental centers were closely associated with community general hospitals, the individual would not have the stigma of going to the mental institution. He would be going to the same hospital for a mental illness that he does to get his appendix out. He will have a constant association with his friends and relatives, and during the period of his rehabilitation, can actually go out into the community with which he is familiar and become a useful citizen very much earlier.

There is one additional factor for the association of general hospitals with these mental units, and that is, it prevents the necessity of duplication of a lot of equipment and supply services that a general hospital can provide to the psychiatric unit.

Now, with respect to H.R. 3689, title I provides for grants for construction of centers for research on mental retardation, and related aspects of human development—and I am glad that that phrase appears in the bill.

Title II provides grants for construction of facilities for mental retardation. I think there is tremendous need for research in this field of mental retardation, particularly in the field of genetics. I think it is quite possible that in the course of the next 10 to 15 years it will be possible to study the chromosomes of two young people who propose to marry and be able to tell them whether they might have children with some hereditary defects or mental defects. And I would hope that this type of research would be encouraged if this bill were passed.

This problem of mental retardation is a big one. A special report by the National Institutes of Mental Health reports that 126,000 babies who will be mentally retarded are born every year. By 1970, the number of mentally retarded persons in the Nation will be over 6 million, over half of which will be children.

Much progress has been made already in research in the field of mental retardation. We believe that this is not just a problem for education, training, and rehabilitation, but also a medical problem. There are diseases more recently defined, such as cretinism, and hydrocephaly—these are diseases of infants which, if recognized early enough, can be adequately treated to prevent those children from becoming mentally retarded and charges on the community.

With respect to the provisions of this bill, I have just two comments. Since more than half of the mentally retarded persons in the Nation by 1970 will be children, and since only in children can there be any real hope of significant medical improvement, we feel that the major effort should be directed toward the children. We believe that by restricting eligibility to applicants which are children's hospitals, general hospitals with well organized pediatric services, and university affiliated teaching hospitals, the best interests of these children will be served.

I do not specifically mean that facilities for the care of the mentally retarded child should be in immediate medical proximity to this type of children's or general hospitals, but that it should be an affiliate so that properly qualified pediatricians can take an interest in these children, guide their health, their training, and where medical means are available, actually to improve them. They are there to do it.

And, secondly, I would like to make the same comment I made with respect to the first bill, that title II of this bill should be an amendment to title VI of the Public Health Service Act, the Hill-Burton program, again to insure complete coordination of all community health services.

So, in general, we, the American Hospital Association, are very much in agreement with the objectives of these bills.

Our main emphasis are to the necessity of providing both mental health, research facilities for mentally retarded, and the facilities for the treatment of mentally retarded persons in close affiliation with general hospitals.

And, secondly, we believe both bills should be administered through the same channels as the Hill-Burton program.

Mr. Chairman, I appreciate very much this opportunity to present our views.

(The statement referred to is as follows:)

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. Chairman, my name is Dr. Henry N. Pratt. I am director of the Society of the New York Hospital in New York City. I appear here today in behalf of the American Hospital Association. Accompanying me is Dr. Vane M. Hoge, assistant director of the Washington service bureau of the association. I am grateful for this opportunity to express our views on H.R. 3688 and H.R. 3689.

As President Kennedy so well stated in his special message of February 5, "Mental illness and mental retardation are among our most critical health problems. They occur more frequently, affect more people, require more prolonged treatment, cause more suffering by the families of the afflicted, waste more of our human resources, and constitute more financial drain upon both the Public Treasury and the personal finances of the individual families than any other single condition."

The American Hospital Association is in general agreement with the objectives of both of these bills. We do, however, have some suggestions which I shall mention later which we feel will improve the practical application of these programs and which we hope this committee will consider during its deliberations on these bills.

H.R. 3688

I should like first to discuss H.R. 3688, for the provision of mental health centers.

Extent of the problem

Mental illness, in all its phases and manifestations, has long been and still is the No. 1 health problem in the United States. According to the National Institute of Mental Health, more than 1 million persons are treated anually in the mental hospitals in the United States, in addition to the large number treated in clinics and by private psychiatrists. Nearly half of all the hospital beds in the United States, some 702,000, are for the care of the mentally ill. The Joint Commission on Mental Illness and Health estimates that the yearly cost of mental illness in the United States is at least $3 billion.

Of the 702,000 hospital beds for the care of the mentally ill, about 670,000 are in approximately 300 public mental hospitals. Many of these provide little more than custodial care. They have about one-fifth the number of registered nurses that would be required for adequate staffing, about two-fifths the number of social workers, a little more than one-third the number of physicians, and three-fourths the number of psychologists. This shortage of trained personnel

is beyond doubt the most important single factor in the long stay of patients in large public mental hospitals. Only about 32,000 of our beds for mental illness are under nonpublic ownership. Ten thousand of these are in 200 private psychiatric hospitals and 22,000 beds are in about 600 psychiatric units of general hospitals.

For many years and up until about the end of the 1940's, the population of our mental hospitals increased steadily from year to year and there seemed to be no end in sight. Then over the past decade, due to radically new concepts of institutional care plus the discovery of psychoactive drugs, the mental hospital population increase slowed down, finally came to a halt, and now is on the decrease. To accelerate this decrease, to keep more mentally ill patients out of the large centralized institutions, and to provide for earlier diagnosis and treatment is the laudable purpose of H.R. 3688.

Advantages of local versus centralized care of the mentally ill

The advantages of short-term intensive care of mental illness in local facilities over that of the large centralized mental hospital has received a great deal of attention in recent years. The Joint Commission on Mental Illness and Health has found that the large mental hospital is not the most effective setting for the treatment of mental illness. They have found that care in short-term acute facilities is much more effective in treating mental illness and returning the patients to their homes and communities.

Striking proof of the advantages of local short-term intensive care of the mentally ill was brought out in a recent study in Missouri. This study was carried out by a research organization in Kansas City known as Community Studies, Inc., in cooperation with the Missouri Division of Mental Diseases and the Greater Kansas City Mental Health Foundation. The report presented a comparative study of the treatment results of patients admitted to two intensive treatment centers and those admitted to five State mental hospitals. The study included only first admissions to the two types of hospitals over a 2-month period, and these same patients were followed for a 3-year period. The study group included 412 patients. About one-third were first admitted to the intensive care centers, and two-thirds were first admitted to the State mental hospitals.

Four criteria of effectiveness of treatment were selected. These were: (1) Average length of stay in the hospital per admission; (2) percent of readmissions; (3) average length of stay out of the hospital for readmitted patients; and (4) the percent of patients released to the community within specified time periods.

Under the first criterion, "average length of stay," the difference in results of the two types of treatment was indeed striking. Among the 10 diagnostic categories common to both groups, the average stay in the large mental hospitals ranged from 50 to 417 days longer than in the intensive treatment centers. The average stay for all patients in the large hospitals was 237 days longer. It is clear, therefore, that in addition to the other advantages, the overall cost of care would be reduced appreciably by treatment in acute care facilities.

Under the second criterion, "readmissions," the intensive treatment centers showed up to advantage, although the difference was not so great. Nineteen percent of the patients discharged from the intensive treatment centers and twenty-four percent of those discharged from the mental hospitals returned within the 3-year period.

For those patients who must be readmitted after discharge, the length of time the patient can remain at work or at home is an important factor. Here again the intensive treatment center has the advantage. The patient discharged from the intensive treatment centers and later readmitted had remained at home for an average of over 8 months. Those discharged from and later readmitted to the mental hospitals had remained at home only 5½ months.

Mental health authorities are in substantial agreement that the longer time a patient spends in a mental hospital, the less are his chances for recovery and the longer time he spends out of the hospital after discharge, the less are his chances of having to be readmitted. In the group involved in this study, 90 percent were discharged from the intensive treatment centers within 3 months and 99 percent within 6 months. The corresponding discharges from the State mental hospitals were only 45 and 60 percent.

The study from which I have just quoted is, of course, just another bit of the already overwhelming mass of evidence in favor of the intensive, short term, community oriented type of mental health care.

The American Hospital Association has long been a strong advocate of more community mental health services, particularly as units of general hospitals. To this end we have worked closely with the American Psychiatric Association and the National Association for Mental Health. In a recent joint report by the American Hospital Association and the American Psychiatric Association entitled "Psychiatric Services in General Hospitals," the following statement appears:

"Creating psychiatric services and psychiatric units in general hospitals is an important step in the diagnosis and treatment of mental disease. It represents one of the many strides that must be taken toward the solution of a serious national health problem. Recognition that mental illness must be approached as a community problem and should be a part of the program of the community general hospital and other community agencies is essential. A concerted effort by the entire medical profession to identify the early manifestations of these diseases and to start positive therapy is basic to such a program. Understanding of the symptoms and signs of these diseases, coupled with continued education and research, will bring to light new and better methods of diagnosis, treatment, and, ultimately, prevention. Closer relationships of psychiatrists and other physicians, and of psychiatric and general hospitals, must have a mutually stimulating effect to further the care of mentally ill patients.

"Continued discussion in staff meetings and other conferences in the general hospital must necessarily lead to better orientation in regard to the emotional problems of all patients. Experience has demonstrated that the average psychiatric patient presents no greater problems on the ward than the average medical or surgical patient. Patients are asking for psychological help and recognizing psychological needs earlier, emphasizing the need to provide these services in general hospitals."

Although the number of psychiatric units in general hospitals has grown remarkably in the past 10 years, a good many general hospitals have been slow to undertake the treatment of mental illness. There are many reasons for this reluctance, but unquestionably one of the most important reasons has been the cost involved in the construction of these intensive treatment facilities. H.R. 3688 should go far to relieve this situation and further advance the treatment of mental illness in local communities.

Provisions of H.R. 3688

Mr. Chairman, I should now like to comment briefly on some of the specific provisions of H.R. 3688. H.R. 3688, if enacted in its present form, would become an independent act. The American Hospital Association believes that title VI of the Public Health Service Act (Hill-Burton program) should be amended to include the provisions of this bill. The association has been a firm supporter of the Hill-Burton program since its very beginning. We have always felt quite strongly that all federally aided community facility construction in the health field should be administered by the Public Health Service and the same State agencies that administer the Hill-Burton program. Only in this way, we feel, can coordination in health facility planning and effective use of health facilities be achieved.

The bill seems to give priority to mental health centers which are a part of, or closely associated with, a general hospital. We feel that this is a very desirable provision. The bill also would permit the construction of free-standing, independent mental health centers. We feel that this is an undesirable provision for many reasons. Not the least of these is the fact that in the mind of much of the American public, mental disease still unfortunately carries a stigma. Thus, people going to independent mental health centers come under the scrutiny of their neighbors whereas when the center is a part of the general hospital, this is not a particular problem. Also, we feel it will be more difficult to effectively staff an independent community mental health center. It is highly essential that we plan so that health personnel in very short supply can be used most effectively. It is desirable that mentally ill patients have available numerous facilities and services necessary for their treatment which are already provided in a general hospital. Their duplication in other facilities would be wasteful. Our goal should be to provide for the treatment of mentally ill persons within the main stream of medical care. We should avoid, too, returning to a program of isolation.

H.R. 3689

I would like now to address myself briefly to H.R. 3689. This bill has two titles: Title I provides for grants for construction of centers for research on mental retardation and related aspects of human development; title II provides for grants for construction of facilities for the mentally retarded.

Although the American Hospital Association has a broad general interest in title I, I shall direct my remarks primarily to the provisions of title II.

Extent to the problem

Mental retardation is a serious health problem; and from the standpoint of the family of the retarded child, certainly a most tragic one. Mental retardation is no respecter of class, wealth, or social position. It strikes all social and economic groups with equal impartiality. According to a special report on mental retardation by the National Institute of Mental Health, 126,000 babies who will be mentally retarded are born every year. By 1970, the number of mentally retarded persons in the Nation will be over 6 million, over half of which will be children.

Progress in research

Throughout the ages mental retardation had been thought to result from some hereditary defect beyond the reach of medical science. For several years, facilities for the mentally retarded were disallowed under the Hill-Burton Act on the assumption, then correct, that such facilities were primarily custodial and educational in nature rather than medical. Now, as a result of new medical knowledge, our views on mental retardation are changing. We now know that much mental retardation, instead of being a primary hereditary defect, is a symptom or the result of a specific and often remedial condition if diagnosed and treated in time.

Provisions of H.R. 3689

For these reasons we feel that H.R. 3689 has wisely been oriented to the research and medical aspects of mental retardation. We believe, however, that the bill could be strengthened even more in this direction. We are concerned that the funds available under the program may be spread too thinly to make a significant impact on the problems of mental retardation. Since more than half of the mentally retarded persons in the Nation by 1970 will be children and since only in children can there be hope of significant medical improvement, we feel that the major effort should be directed to this group. This would best be accomplished, we believe, by restricting eligibility to applicants which are childrens hospitals, to general hospitals which have organized pediatric departments, and to colleges and universities with teaching hospitals providing such services. In making this recommendation we are, of course, aware that for the foreseeable future there will be a large component of the mentally retarded that is not responsive to medical treatment. For this group, education, training and rehabilitation in long term custodial institutions must continue to be the major objective.

There is one additional point we wish to make. Title II of H.R. 3689, as now written, does not provide that a program for construction of facilities for the mentally retarded be administered through the now well established Hill-Burton organization. The American Hospital Association feel very strongly that title II should be an amendment to title VI of the Public Health Service Act (Hill-Burton program) just as title I is written as an amendment to title VII of the Public Health Service Act, in order to insure complete coordination of all community health facilities.

Mr. Chairman, as I stated in the beginning, the American Hospital Association is in general agreement with the purpose of these bills. Our main emphasis has been on our belief that the facilities to be constructed should be under the Hill-Burton agencies, and that wherever possible, they should be operated as units of general hospitals. We are pleased to note that the President in his February 5 special message has suggested that while projects may be sponsored by a variety of local organizations, "construction can follow the successful Hill-Burton pattern." He has also said that while centers could function effectively under a variety of auspices, "Ideally the center could be located at any appropriate community general hospital, many of which already have psychiatric units."

Thank you for this opportunity of presenting the views of the American Hospital Association.

Mr. ROBERTS. Thank you, Dr. Pratt. The subcommittee is very happy to have your statement. And certainly it will lend a great deal of consideration to the views you have expressed on behalf of the association.

Having listened to the other witnesses, I believe this is a little different approach from the other testimony we have had. Knowing of the long experience of the association in matters of this kind, I would certainly say that the subcommittee would give very serious consideration to your views.

I just have one question in my mind as to the mental retardation feature, as to staffing of the local facilities. There is no provision in the bill for any staffing so far as I am informed. And I am wondering if you think that the subcommittee should consider some leadership in this field other than the staffing of the comprehensive research centers which is provided for.

Dr. PRATT. I don't think I fully understand your question, Mr. Chairman. Do you mean financing of the staffing?

Mr. ROBERTS. That is correct.

Dr. PRATT. Generally speaking, the American Hospital Association takes the view that these special mental health facilities or facilities for the mentally retarded should be financed in much the same manner as are its member general hospitals, through Blue Cross, through payments by local and State governments for the care of the welfare cases, and through commercial insurance and mechanisms of this sort. I would personally see no harm in supporting the program for a few years, but I don't think it is essential.

Mr. ROBERTS. Do you think that we could do a good job initially on staffing in the mental retardation centers with the existing pool of manpower that we have?

Dr. PRATT. No, sir; it would require the training of an adequate number of individuals in this field, without any question. A lot of that, I am sure, can be done as on-the-job training in general hospitals. This is another reason that we feel that these facilities should be in relationship to general hospitals, because general hospitals are big training centers on their own, and they think in terms of training, and I think would be training the individuals to participate in these programs.

Mr. ROBERTS. Thank you, Dr. Pratt.

We, of course, are very fortunate in having on our subcommittee, the gentleman from New York, Mr. O'Brien, who does a wonderful job for your State. And I would yield to him at this time.

Mr. O'BRIEN. My only comment, Mr. Chairman, is one of gratitude to Dr. Pratt for his statement.

I would like to ask one general question. We are criticized from time to time here for Federal intervention in the State and local field. We find that after we authorize certain desirable things we are asked why we voted for investigation into the yellow fat disease of the cat, and so forth. And I would like to ask this question: Do you think it would be possible for New York State and the several States to undertake a program of this sort without Federal assistance?

Dr. PRATT. I think Federal assistance would stimulate it, and we would have a better program in the field of mental health, particularly if it were stimulated by a program of this sort. I agree that much of

the financing and initiative must come from the local level, not only governmental but through nonprofit organizations.

Mr. O'BRIEN. Then it is your position that this is a problem that cries out for solution; if it is done properly it is going to cost a certain number of dollars, and if they are not dollars at the Federal level, they will have to be dollars at the local or State level? So if an appropriation is made at the Federal level we are not just throwing money into the sea, because we would have taxpayers somewhere that money if they undertook the program, and there is no guarantee that they would undertake the program; is that correct?

Dr. PRATT. There is no guarantee. I think it would stimulate it. And I think in the long run there would be a very substantial saving to the American people if these programs are properly implemented. As I pointed out earlier, the number of days of inpatient treatment in the acute care psychiatric center is 32 compared to 255 in the large institutions. Obviously, there will be a net savings perhaps 10 or 20 years hence, but it has got to start sometime, and this seems like a good time to start it, because the attitude of the people today toward mental illness, as we said his morning, is changing.

Mr. O'BRIEN. That leads to my final question. Do you know offhand how much New York appropriates annually for its mental hospitals?

Dr. PRATT. I am not sure, Mr. O'Brien. But I am under the impression that it is the vast sum of $400 to $500 million, I think it is in that area.

Mr. O'BRIEN. And that money is spent to a great degree in a sort of a dead end, custodial treatment—in other words, they are lost souls, and the percentage that come out is very small. So you see that through a real attempt to handle this problem at the community level the possibility that this deadweight of $400 to $500 million a year around the necks of the New York State taxpayers might be reduced considerably in the next 15 or 20 years?

Dr. PRATT. I do indeed, yes, sir.

Mr. O'BRIEN. Thank you.

Mr. ROBERTS. The gentleman from Minnesota?

Mr. NELSEN. No questions, except to thank the witness.

Dr. PRATT. Thank you very much, Mr. Chairman.

Mr. ROBERTS. I will call Dr. Terrell Davis, director of mental health and hospitals for the State of New Jersey, and vice president of the National Association of State Directors; and Dr. McPheeters, director of mental health for the State of Kentucky, and secretary-treasurer of the National Association of State Directors.

STATEMENT OF V. TERRELL DAVIS, M.D., DIRECTOR OF MENTAL HEALTH AND HOSPITALS FOR THE STATE OF NEW JERSEY AND VICE PRESIDENT OF THE NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS; ACCOMPANIED BY HAROLD L. McPHEETERS, M.D., DIRECTOR OF MENTAL HEALTH FOR THE STATE OF KENTUCKY AND SECRETARY-TREASURER OF NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS

Dr. DAVIS. Mr. Chairman and members of the committee: I am Terrell Davis, director of the division of mental health and hospitals of the State of New Jersey and vice president of the National Association of State Mental Health Program Directors, a physician with 25 years' specialization in psychiatry.

I am here today representing the directors and commissioners and mental health authorities of the 50 States. We are organized as the National Association of State Mental Health Program Directors. Our president, Daniel Balin, M.D., is from California; our secretary-treasurer, Harold L. McPheeters, M.D., is from Kentucky; and our other executive committee members are from Maine, Minnesota, and Wisconsin. Our headquarters is in Washington, D.C.

I have a prepared statement which I would like to request be included in the proceedings as though read. And then I would like to make a few pertinent comments.

Mr. ROBERTS. Without objection.

(The statement of Dr. Davis is as follows:)

STATEMENT OF DR. V. TERRELL DAVIS, M.D., VICE PRESIDENT, THE NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS

Mr. Chairman and members of the committee: I am Terrell Davis, director of the division of mental health and hospitals of the State of New Jersey and vice president of the National Association of State Mental Health Program Directors, a physician with 25 years specialization in psychiatry.

I am here today representing the directors and commissioners and mental health authorities of the 50 States. We are organized as the National Association of State Mental Health Program Directors. Our president, Daniel Blain, M.D., is from California; our secretary-treasurer, Harold L. McPheeters, M.D., is from Kentucky; and our other executive committee members are from Maine, Minnesota, and Wisconsin. Our headquarters is in Washington, D.C.

THE STATES AND THE MENTALLY ILL AND RETARDED

We are the responsible heads of State government services to the mentally ill and retarded.

We are physicians (with two exceptions) who are professionally aware of, and keenly sensitive to, the enormous difficulties of providing psychiatric and neurologic treatment and special education and rehabilitation to our patients, chiefly in large, distant, and frequently antiquated State institutions of the traditional type.

We are working against nature in an outmoded system without the advantages of having available for our patients what other medical and surgical patients have—the thousand and one small and valuable resources that are present in the neighborhood in which they live—their families, jobs, doctors, health and welfare resources, and the aids for social restoration in their own communities.

THE PRESENT SYSTEM IS INADEQUATE

We have a load of human misery, hopelessness, frustration, long-term illness, and for professionals, the discouragement of knowing that better methods are available and we cannot use them.

The State mental health program directors speak to you with a great feeling of anxiety, frustration, and regret that the best of our scientific knowledge cannot be given to our patients under the present system.

I cannot imagine proposals that I could support with more sincerity, and conviction of their basic wisdom, than the bills which this committee is considering at this hearing. (H.R. 3688 and 3689.)

PROGRAM EMBODIES AMA PRINCIPLES

Those of us charged with responsibility for professional leadership at the State government level welcome the proposed legislation involving the Federal Government.

We welcome it because it embraces the principles on mental health of the American Medical Association and the program of the Council on Mental Health of that association.

Because of this it augurs well to mobilize the full constructive energies of physicians throughout the land to provide the effective leadership which is so essential.

Mr. Chairman, it seems to me that the timing of this legislation is just right.

If it had been developed any sooner there would not have been enough evidence of the soundness of the revolutionary principles in the management of the mentally ill and mentally retarded which it embodies.

Any further delay in its development of application will mean much more unnecessary expense and human misery.

THE REASON FOR URGENCY

I want to emphasize my use of the word "unnecessary." The main reason for a sense of urgency in developing a bold new approach to this problem is the prospect of unnecessary expense and human suffering.

The Congress seldom has had the opportunity of considering a proposal which is backed by such extensive practical experience at the State level.

For nearly 20 years, medical leaders in State and Federal Government and in private practice have been undertaking an agonizing reappraisal of our concepts of the care of the mentally ill and the mentally retarded.

Leaders in other professions have been contributing their knowledge and skills to these studies.

The formula grant program of the National Institute of Mental Health for community mental health services has been a beacon—encouraging further explorations in these areas since 1946.

There have been major steps of mental health program planning and development in many States.

In each instance emphasis has been on continuity of care, early detection and early treatment, minimum disruption of social and community ties, and maximum utilization of existing resources.

There have been significant advances in the combining of medical, educational, social, and occupational opportunities for the mentally retarded and mentally ill with those of the general population; and of financing these special programs in the same manner as comparable programs for the general population.

NEW JERSEY'S LONG-RANGE PLANS

In my own State of New Jersey, our plans for services to children, officially approved by our board of control in March 1962, emphasize the encouragement through planning, consultation, and financial assistance of the development on a regional basis of a variety of coordinated services to meet the needs of children.

Our current long-range plan, which has been under study since its presentation to a statewide mental health conference in June of 1962, calls for—

1. Implementation of the proposals of a legislative commission which would recodify the laws pertaining to the care of the mentally ill and retarded. These bills are currently in the State assembly as A111, 112, 113.
2. Encouragement of community mental health centers at local hospitals.
3. Exploration of methods for multiple financing.
4. Incorporation of voluntary and private services. Our State plan is predicated on the assumption that the State should not be expected to provide for all health and welfare needs of its citizens. Individuals, local governments, voluntary and private services should carry a major portion of the load; and should, in fact, set the pace for State-supported services. The role

of the State is to provide the essential services which otherwise would be unavailable, and through evocative leadership support the total effort of society.

OFFICIAL POSITION OF OUR ASSOCIATION

The National Association of State Mental Health Program Directors at its semiannual meeting, October of 1961 issued a statement regarding the report of the Joint Commission on Mental Illness and Health, entitled "Action for Mental Health." The bills before you today evolved, in a large part, from the commission's report. In part, the statement by our association said:

"This volume and the 11 separately published monographs constitute a body of collected material for which the Nation and the Congress can be proud. It places the needs of mental patients, the importance of mental health growth and development, and the maintenance of a strong and healthy citizenry in its proper perspective; it points up the great deficits which must be made up and states the direction which current knowledge and practice suggest are the important directions in which progress can be made. It brings to the attention of the Nation the obstacles to progress; namely, absence of methods of mass prevention and mass treatment methods in a field which affects a tenth of its citizens—and the lack of specific methods which will insure healthy growth and development to all citizens. It very properly accentuates the shortage of personnel and the excessive cost under present-day approaches; it rightly points to the need to consider the patient in his lifelong history and adds to older emphasis on biologic phenomena and the importance of social forces in both causation and cure of many of the mental disorders.

"The association backs most heartily the emphasis placed on public attitudes: basic, clinical and operational research; early recruitment at earlier stages and increased training in all related fields; it urges a careful transition of current treatment programs to modern methods of treatment and to proper timing, location, and organization in the establishment of new treatment facilities.

"The association particularly urges the utilization of all resources including private and voluntary organizations and individuals and governmental assistance at all levels with emphasis on authority and responsibility being kept as near the home as possible.

"The association urges the greatest possible attention and study in solving the financial problems by promotion of all available resources with proper attention to a suitable formula of Federal, State, and local responsibilities, properly balanced with private, nongovernmental and voluntary resources, including insurance, so that social and financial responsibility may be properly distributed."

You will note that the proposals in H.R. 3688 and 3689 would significantly implement these recommendations.

NO FEDERAL CONTROL—MORE LOCAL CONTROL

The President's program and these bills significantly modify the recommendations of the Joint Commission on Mental Illness and Health in the area of financing.

There is no call, in the bills we are considering today, for the Federal Government to undertake a long-term sharing of the cost of providing services and thus have a large voice in regulating services.

There is no implication that State and local governments have failed in programing or financing and that therefore the Federal Government should take over.

There is, however, clear recognition that significantly increased funds for a temporary period will accelerate the conversion of our facilities and hasten the day when we can take pride in the efficiency and effectiveness with which we are resolving today's greatest health problem.

I have looked carefully, and I do not see increased Federal control as a price of this program. On the contrary, I see significantly decreased Federal and State control by giving the responsible professionals authority as well as responsibility at the local level.

WITHOUT FEDERAL HELP THE PACE WILL BE SLOW

The question has been raised whether the States would go it alone. They have and they will continue to encourage this revolution, but the pace will continue to be agonizingly slow.

We are particularly interested in the provision for short-term assistance from the Federal Government in financing the staffing of the new centers because there are ample justifications for optimism that within a few years we will have accomplished the goal of financing the cost of services to the mentally ill and retarded in the same way as other medical and hospital costs.

In the meantime, we cannot afford the extravagance of having to use old-fashioned methods of care which have been proven more expensive per patient treated than the proposed programs.

What is being proposed here today is comparable to what our great industries do all the time—invest substantial sums to build modern plants and install new equipment and better skilled personnel, so that they can produce a better product at less expense.

RETARDATION AND MENTAL ILLNESS ARE MEDICAL CONDITIONS

House bills 3688 and 3689 (and the campanion bills introduced by Congressmen Halpern, Boland and Farbstein) give due recognition to the fact that the needs and medical problems of the mentally ill and mentally retarded, although having much in common, are not identical.

The extent that separate programing can be advantageous may be determined by the States.

Although it is clear that mental illness and mental retardation are medical conditions, ample recognition is given to the significance of adequate resources for special education, training, day care centers, guidance, and counselling services.

CONVERSION OF OLD FACILITIES

Although these bills propose the basis for a radical new approach, there is full recognition of the progress which has been made by the States in converting the large, often remote, institutions into more acceptable facilities.

We particularly like the proposals which would give aid and encouragement to those who are going to have to continue to meet the need with the old style facilities. It would be a tragic error to discredit the immense contribution which these institutions will still have to make during the period of transition.

We hope the committee will amplify certain vague sections of the bills. For example H.R. 3688, section 102, and H.R. 3689, section 202 provide that the Secretary make allotment from sums appropriated "in accordance with regulations". We are concerned about who is going to be consulted on, and review, these "regulations".

H.R. 3688, section 103 and H.R. 3689, section 203 provide that the Secretary shall, by regulation prescribe—after consultation with the Federal Hospital Council.

H.R. 3688, section 205 envisions consultations with the National Advisory Mental Health Council before prescribing regulations.

Can we assume that Congress in making annual appropriations will review the regulations governing the allotments to the several States?

OUR CONCEPTS OF THE KINDS OF SERVICE NEEDED MAY BE EXPECTED TO CHANGE

We might question whether these bills give adequate recognition to the fact that the kinds of service in mental health centers and facilities for the mentally retarded vary widely in different parts of our large country. This is caused by radical differences in population characteristics and density, and in needs and resources.

Your committee may wish to consider amending H.R. 3688, section 103, line 7, and section 205, line 4, and H.R. 3689, section 203, line 8 after the parenthesis and before the comma, by adding in each place: "and after due consideration of individual variations in needs and resources among the several States and within the several States."

PLANNING FOR STAFFING IS IMPORTANT

Experience in some States under Hill-Burton programs for aiding hospital construction has shown that it is often easier to plan and construct a building than it is to develop a staffing pattern, recruit personnel, provide the necessary supplemental training and plan for the establishment of actual services.

In short, it would be well to have assurance that planning for the administration of a program of services in a mental health center or facility for the retarded was as far advanced as the plans for construction before funds are granted to pay a part of the cost of construction.

The committee may wish to consider amending H.R. 3688, section 103(a) and 3689, section 205(a) by inserting a new paragraph (7) which would read:

"Plans and specifications for the staffing and operation of the mental health service of the center and reasonable assurance of the availability of appropriately trained professional and other personnel to enable the center, or facility, to become operational as planned upon completion of construction."

PERIODIC REVIEW OF REGULATIONS

H.R. 3688, section 104(a)(10), page 8, and H.R. 3689, section 204(a)(10), page 11, provide for a review of State plans and for the reporting of modifications in these plans at least annually.

We believe this points out the probability that as the States gain more experience through intensive planning activities and through the establishment of centers and facilities, we may expect changes in concepts and changes in needs and resources.

The present wording of 3688, sections 103 and 205 and of 3689, section 203 could be interpreted to mean that within 6 months of the passage of the bills, regulations will be prescribed which will govern for the duration of the act.

We suggest that this might be reworded to assure that the regulations of the Secretary will be reviewed often enough, in consultation with appropriate councils, to avoid unnecessary enshrinement of unworkable or outmoded concepts in the brick and mortar of mental health centers and facilities for the retarded.

LOCAL AND STATE AUTHORITY PRESERVED

We are impressed with the manner in which these bills provide for a maximum of authority at the State and local level in the determination of the center in the needs and the types of facilities to meet these needs.

We believe that this will assure a maximum of creative thinking in devising new and more effective methods of meeting our Nation's No. 1 health problem.

We recognize a valid exception to this principle in section 201 of H.R. 3689. In that bill, appropriations are authorized for grants for the construction of facilities for the mentally retarded "which are to be associated with a college or university hospital." It is important that the medical care of the mentally retarded be brought back into the main stream of medical practice and that the training and education of the retarded be brought into the main stream of education, both within the community.

SUMMARY

The State mental health program directors are solidly behind the concept of the diversion of patients from isolated mental hospitals to mental health centers in the patients' community and within the main stream of medical practice.

We are perhaps more keenly aware than any other group in the United States of the needless suffering and waste that will continue until we are able to put into full utility the skills which we now possess.

H.R. 3688 and H.R. 3689 propose a program of Federal assistance to the States which would provide aid in the place, and in a manner in which it can be most effective.

We will welcome the impetus which the proposals would give in each of our States.

We hope that the experience and present planning of the various States will be helpful to this committee in its consideration of these bills.

JUN 11 1963
MANHATTAN, KANSAS

Dr. DAVIS. I have with me a telegram from Governor Hughes of our State of New Jersey which I would like to read in which he states that he—

strongly supports passage of H.R. 3688 and 3689 which would implement significant parts of President Kennedy's program on mental health and mental retardation. The New Jersey Legislature is currently considering proposals for amendments and recodification of statutes pertaining to the mentally ill and the mentally retarded which are oriented in the directions of the President's proposals. Passage of all these bills would give impetus to new programs and planning already well underway in New Jersey as a result of the combined leadership of physicians and other mental health professionals, organized citizen groups and legislative and executive officials in our State, county, and local governments.

RICHARD J. HUGHES,
Governor of New Jersey.

This morning the question was asked, had the Governor done anything in addition or subsequent to the resolution which was passed in the special mental health conference in November of 1961.

This was a resolution at the Governors' conference in the spring of 1962 urging each of the States to pursue comprehensive planning for mental health programs. And I think it is pertinent at this time to emphasize that these two bills which we are considering today are possible, it seems to me, only on the basis that each State has undertaken and accomplished a planning for a program of mental health services in the State. And it is for this reason that the fund for the mental health centers and for the facilities for the retarded are not requested until 1965, which would give each of us time to accomplish this planning, which it seems to me represents the big revolution in the concept of the care of the mentally ill. Heretofore we have been working on a crisis-oriented administrative approach, when the crowding becomes too stinkingly unbearable, then we have a bond issue and build more facilities. And this has been what has been the program in the past, although we have begun in the last 10 years to put it on a more organized basis.

In addition, I would like to read a telegram from Governor Scranton of Pennsylvania:

The proposal for development of the community mental health centers has our hearty endorsement. The Office of Mental Health of the Commonwealth of Pennsylvania has been programing for the past several years toward a development of resources within the community for a continuium of care in the treatment of mental illness. We would like to encourage the development of more community resources for the mentally retarded as well as greater efforts in the field of prevention, but we see little hope of moving as rapidly as necessary through this transitional period from a State hospital centered program to a community centered program without financial help. The knowledge and the skills are at hand. Citizens interest and support are at their highest. And all that is needed is the means to mobilize these skills and this support to productive activity. There is a real danger of much of the existing momentum being lost by failure to act boldly and decisively.

Your effort toward favorable action in support of the development of community mental health centers is strongly urged, so that the fight against mental illness can move forward with new vigor.

We have heard questions about the availability of staff for this expanded program of mental health centers. One of the strongest arguments for the concept of the mental health centers is the fact that it will bring the patients that will be cared for in these centers back into the main stream of medical practice and back into the community

where we will have more professional resources, and where there will be more unskilled and nonprofessional personnel to provide the staff which is so necessary to care for these individuals.

The question of whether or not the States could proceed on this program alone has also been a question of interest to all of us. And I think the record on careful examination will indicate that a great majority of the States have already begun to proceed in this direction. But the pace already painfully slow, and the expense both in human suffering, and in continuing to pour good money after bad in our antiquated facilities is the thing that we hope to overcome by this assistance from the Federal Government through putting capital resources into the operation so that we can do in this facility what all of our American industries do, put new capital into new improved facilities based on newer concepts which can provide a better product at less expense to the taxpayer. And I can think of no better product than healthier American citizens.

We have, I understand, received word that 22 States have sent telegrams to the committee supporting these two bills. It don't think this is an exhaustive list, but it does indicate that this many have already sent them in.

Those of us responsible for the professional leadership at the State government level welcome this proposed legislation involving the Federal Government for many reasons. Among them we welcome the fact that the program embraces the principles on mental health of the American Medical Association, and the program of the council on mental health of that association. And because of this it augers well to mobilize the full constructive energies of physicians throughout the land to provide the type of leadership in this field which is essential.

The concepts that these bills would promote are not new. They are put together in what to us is an eminently workable program. They are different from the concepts as originally spelled out in the joint commissions' report, which was a remarkable milestone in the assembling of data and giving us essential decisionmaking data in this important field.

These proposals do not envision the Federal Government embarking on a long-term partnership in financing the care of the mentally ill in large institutions, but they envision a period of Federal Government assistance roughly for about 10 years, after which the facilities will be carried along and financed in the same manner as other medical and educational services in the community.

The question was asked of Dr. Pratt about the need for a similar program for the Federal Government to assist in the staffing of facilities for the retarded. I think it would be helpful to point out that the mental health centers, in which there is provision for such a program of assistance in staffing, will provide some basic services for the mentally retarded in addition to basic services for the mentally ill. So, by strengthening mental health centers, we are strengthening some of the professional staffing and programs for the mentally retarded.

In addition, the Federal Government has programs of assistance to the State in vocational rehabilitation and in aid to education which will have indirect benefits in improving the care of the mentally retarded.

The concept of specialized centers for the mentally retarded envisions our further progress in keeping as many of the mentally retarded in the community as possible outside of residential facilities through the provision of special education facilities in the public schools as was pointed out earlier.

I would like to comment also on another matter raised by Dr. Pratt, and indicate at the outset that I don't think there is any disagreement in principle with regard to where the Hill-Burton—where these construction funds should be administered.

I think the important point here is one of timing. In some States I would agree with Dr. Pratt that the existing Hill-Burton agency might be the most appropriate agency, and the hospital advisory council might be the most appropriate agency for the allocation of these construction funds. In other States, for reasons appropriate to those areas, another program might be better.

One of the strongest arguments in favor of these bills from our point of view is the fact that they are so designed that it leaves the authority as well as the responsibility at the State level to determine what type of a program can best meet the needs of that particular area.

And in this connection I would like to call the committee's attention to several areas where the committee might wish to consider clarifying some of the present wording, or to amplify certain vague sections. For instance, section 102 of 3688 and 202 of 3689 provide that the Secretary make allotment from sums appropriated "in accordance with regulations." We are concerned about who is going to be consulted by the Secretary in making these "regulations" which are going to apply to all 50 States.

And in contrast, we see in sections 103 and 203 and 205 that the Secretary shall prescribe after consultation with the Federal Hospital Council in the one instance, and after consultation with the Advisory Mental Health Council in the other instance. Can we assume that the Congress in making its annual appropriations will review the regulations governing the allotments to the several States and thus provide this type of a facility for consultation?

And as I suggested before, we have questions as to whether these bills give adequate recognition to the fact that the kinds of service in mental health centers and facilities for the mentally retarded will vary widely in different parts of our large country. This will be caused by radical differences in population characteristics and density, and in needs and resources.

And your committee may wish to consider amending 3688, section 103, line 7, and similarly in 3689, by adding "And after due consideration of the individual variations in needs and resources among the several States and within the several States." No one type of facility or institution in our judgment is going to be ideal for every area, and there must be provision for this variability.

One other thought that we had has to do with the problem of, when you make money available, and there is a real need for services, it is easier to build a building than it is to organize the staff and set up the administrative structure. The bills as now written propose the requirement that plans be submitted before moneys be allocated for the construction of mental health centers, and we would suggest that the committee might wish to consider inserting another proposal, that

plans and specifications for the staffing and operation of mental health centers contain reasonable assurance of the availability of appropriately trained professional and other personnel to enable a center or facility to become operational as planned upon construction, that that be included as part of the requirements.

You will note also on page 12 of my prepared statement a recommendation that the regulations of the Secretary be reviewed from time to time, because with the rapid changes in our concepts of what are "approved ways of meeting these needs," regulations that would be set up within 6 months of the passage of this legislation might not be appropriate 3, 4, or 6 years later.

Mr. Chairman, I would like to thank you for this opportunity of making these remarks. And if it is your wish, Dr. McPheeters might make his comments, and then we could both answer whatever questions the committee wishes to ask.

Mr. ROBERTS. That will be acceptable.

Dr. McPheeters.

Dr. MCPHEETERS. Mr. Chairman, I too have a prepared statement which I would like to enter as if it were read.

(The statement of Dr. McPheeters is as follows:)

STATEMENT OF HAROLD MCPHEETERS, M.D., SECRETARY-TREASURER, THE NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS

I am Harold McPheeters, graduate of the University of Louisville School of Medicine, Louisville, Ky., in 1948, and a specialist in psychiatry.

I am now and have been commissioner of the Kentucky Department of Mental Health for the past 6 years. I am here today representing the directors and commissioners of the mental health programs of the 50 States and the territories. We are organized as the National Association of State Mental Health Program Directors.

THE STATES AND THE MENTALLY DISABLED

We are the heads of State government efforts to develop and supply services to the mentally ill and retarded.

We are nearly all physicians who are keenly aware of the problems in trying to provide psychiatric and neurological treatment, and training, education, and rehabilitation to our patients in the large, old fashioned, and distant State institutions of the traditional type.

When we must serve our patients in such isolated, outmoded places, we are working against all the best clinical judgment. The patient is at once deprived of all those things which are so necessary to rehabilitation of any sick person—his family and friends, his neighborhood, his job, and all the other aids for social restoration in his home community.

Such institutions tend to be impersonal—stripping the patient of his dignity. The administratve machinery tends to be ponderous and slow so that the patent must stay away from home longer than is really necessary. We know that the sands of time quickly fill in and obliterate the patient's place in society so that for each week or month away from home, his chances of going back home are just that much less—just as a brick removed from a garden walk is easily replaced in a few days, but only with difficulty after several weeks or months.

We have today a burden of human misery, frustration and hopelessness. For professionals, there is the discouragement of knowing that better methods are available. In New York State there are presently over 130,000 persons in the mental institutions; in California, 68,000. In other States the numbers are fewer, but the problems are the same.

While we mental health program directors represent States of various political beliefs, economic and geographic conditions, we can point to the trends which our studies and experience have shown to be the guidelines for the future. It is our aim to collect scientific, clinical, and administrative information about how to provide better mental health services to the people of our States within the limits

of insufficient money and personnel. We provide this information to our members and their staffs in the various States, to their Governors, their legislators, and their people, and to the Federal Government when we are invited, as we are today.

Today, in regard to the proposed legislation being considered by this committee, our association has some facts to present.

Upon these facts the members of this committee can better judge the need for the proposed legislative program.

Here are some of the observable trends that we, who direct the State mental health programs, can demonstrate to you.

1. In the future less hospitalization will be necessary: Treatment has improved. With tranquilizing drugs, psychic energizing drugs, and more knowledge of psychotherapy and other kinds of thereapy, psychiatry is able to control and treat mental illness better than ever before. Psychiatric units in general hospitals in cities such as Philadelphia, Hartford, Dallas, Sacremento, Washington, D.C., and in my home city of Louisville, now have average patient stays of 23 to 33 days.

Back home, we have a study underway which shows clearly that even patients with schizophrenia—once thought to be the most serious mental illness of all—can be treated entirely at home. These patients have been intercepted at the point of admission to a mental hospital and are being treated entirely at home under the supervision of public health nurses working under the direction of a psychiatrist.

2. Hospitalization, when necessary, will be shorter in duration when done early and near home: Our hospitals are treating more younger patients with successful outcomes after a short period of treatment.

But the patients who go home sooner, are the ones whose homes are nearby so that aftercare services are more easily available in the convalescent stages.

3. Alternative resources have proven to be more suitable substitutes for State hospital services: These include nursing homes and boarding or foster homes for those who need only nursing or domiciliary care. Outpatient clinics, psychiatric units in general hospitals, are other alternatives.

4. The private sector of society can be encouraged to provide more services than in the past: While tax moneys have been the main support of our traditional mental health programs, there are reasons to believe that private facilities will provide more of the cost in community mental health centers.

(*a*) Average family income is rising.

(*b*) Labor-industry medical payment contracts are including psychiatric coverage.

(*c*) Other health insurance coverage is rapidly expanding to include mental disorders.

(*d*) Exclusions against the mentally ill in Federal and State public assistance programs are being relaxed and dropped.

5. State hospitals can, and in most cases, are reducing their census: There has been a drop of 1 percent to 2 percent per year in the total census of the State hospitals in the United States for the past 5 years. This drop has been faster in some States than in others.

Reduction of hospital census is related to a number of things: Increased expenditures, use of drugs, rehabilitation programs, economic conditions in the community, and the availability of treatment and aftercare services back home. But in practically all States the reduction in census has occurred in the face of rising admissions.

6. There is a great demand for psychiatric services in the local community where other medical specialties are found: The large isolated State mental hospitals came into existence just over 100 years ago as an alternative to keeping the mentally ill and mentally retarded in jails and almshouses.

No one ever thought that this was the best way to treat the sick, but the large hospitals were thought to be better than jails. In time, the distant hospitals became overcrowded, understaffed snakepits which created a general fear and rejection of mental illness.

Now that psychiatry has more effective treatment methods, the shame formerly associated with mental illness is disappearing and the people are demanding this kind of specialized treatment along with surgery, obstetrics, and internal medicine when they need it. Psychiatry is now becoming a fully accepted medical specialty in the public mind.

The community mental health centers to be provided under H.R. 3688 will enable the people to receive mental care and treatment in the community where they usually go for specialized medical services, rather than to huge, distant

State hospitals. Hospital stays will be short. Outpatient and after hospital treatment will be easily available.

The treatment of mental illness will be back in the framework of general illness. The American Medical Association has given its blessing to this plan because it does bring the treatment of mental illness into the same setting as other medical treatment, rather than isolating the mentally ill in large institutions that until recently were just custodial asylums.

Some persons have asked how we will get psychiatrists, psychologists, social workers, and others to staff these community mental health centers. This will require some effort, but I believe, that once the facilities are provided as envisioned in H.R. 3688, the mental health specialists will go to them. This is surely what happened with other medical specialists. After the Hill-Burton program provided good operating suites, hospital laboratories, and X-ray laboratories, the surgeons, pathologists, and roentgenologists quickly moved out to staff them. In fact, this is the best way I can think of to encourage a better distribution of psychiatrists who now tend to be concentrated in only a few large cities.

THE MENTALLY RETARDED

A few special words are in order for the mentally retarded. Until recently, the mentally retarded were felt to be hopelessly disabled and were sent to large institutions for life or kept under wraps at home.

Now, however, this field, too, is seeing some remarkable changes. Research is fast unlocking many secrets of the biological developmental defects that lead to mental retardation. A great deal more remains to be done in this area. We also need more study of those mentally retarded who seem to have no special biological defect, but they have not developed their mental powers because of lack of stimulation or opportunity. It appears that to develop our minds we must have mental exercise—just as our muscles must have physical exercise.

All of these causes of mental retardation as well as new methods of training and rehabilitation need more study. This study could be undertaken in the clinical research centers proposed in H.R. 3689. We surely do need them.

It is entirely appropriate that these centers be located in close relationship to universities and medical centers. This also is provided in H.R. 3689.

Throughout the country today the institutions for the mentally retarded, like the mental hospitals, tend to be too large, too isolated, and impersonal.

While the present trend is to keep the less severely retarded in their own communities for specialized training and education, and to keep the more severely retarded at home as long as possible, there is still need for more institutions.

Here, too, there is need for smaller institutions so that these youngsters can be closer to their families and homes to which we hope to rehabilitate them.

There is provision for the construction of institutions for the mentally retarded in H.R. 3689.

Our association is enthusiastic in its support of both of these bills—both would be giant steps forward for the mentally disabled.

Dr. McPHEETERS. I have a few points I would like to make.

With these large institutions that we are now operating, both for the mentally ill and the mentally retarded, we tend to work against all our best clinical judgment. We have the patient away from his family, his friends, his neighbors, all the things we are trying to rehabilitate him to. The institutions tend to be impersonal, they tend to take away the person's dignity, and the machinery moves slow, the staff has to be overcautious because of the distance and the lack of ability to follow up the patient. So it just becomes that much more difficult to get a patient back home from these large isolated institutions.

And I think we see a few trends that you folks would want to consider in deciding the appropriateness of this bill.

In the first place, it is quite apparent that there is going to be less need for hospitalization in the future. Treatment has improved, we have tranquillizing drugs, psychic energizing drugs, more knowledge

of psychotherapy and rehabilitation, and so forth. As was pointed out, the general hospital psychiatric unit has an average of 23 to 33 days compared to hundreds of days in the large mental hospitals, in fact there are some studies that indicate that much treatment can be done even on an outpatient basis.

In the second place, hospitalization when it is necessary is going to be much shorter in duration, especially when it is done closer to home. As I say, you can discharge the patient knowing that if he needs to come back in you can get him back in very quickly.

Nowadays we find more alternative resources to hospitalization. Nursing homes and foster homes are offering opportunities for nursing home and domiciliary care that formerly were handled in the large hospitals.

I think we are going to see the private resources taking a larger responsibility in supporting mental health services. Up until now it has largely been public support, but we find the average family income rising, we are finding labor and industry contracts including mental coverage, other health insurance is rapidly covering psychiatric illness, and the exclusions against the mentally ill in all kind of contracts are disappearing.

I think this indicates that in the future private resources will be able to pick up a lot of the operating costs of these programs.

Now, the State hospitals across the country for the most part have been reducing their census very slowly, about 1 to 2 percent per year, though this drop has been greater in some States than others, depending upon aftercare services and the economic conditions in the community and a lot of other things.

The other thing is, there is a great demand for psychiatric services in the local community, at the same place where we find other medical services, such as surgery, obstetric, pediatric, and so forth. The time when people are ashamed of mental illness and want to get it away from the community where most people are treated medically has come to an end, I think.

And I think all of these things indicate that if we could get just half the Federal support of a construction program to get treatment centers set up at the local community level where we now find other medical specialties, that the operating costs could much more easily be picked up by the local communities. This would ultimately reduce the State's burden, but at the present moment the States are pretty much strapped to do the job they have already got to do in the mental hospitals that we are committed to at the present time.

Now, I anticipate that in Kentucky we will have perhaps a third as many patients in our State mental hospitals 10 years from now as we do now if we have a network of community mental health centers, but we can't get there unless we have some outside help for the community mental health center construction.

As far as mental retardation is concerned, we are dealing with a somewhat different kind of problem, in that the number of mentally retarded who require institutional care is increasing each year. As we develop more effective antibiotics, we keep more of these disabled youngsters alive. As obstetrical care improves, we are keeping more pregnancies that would have ended in miscarriages going to term, and then they are delivered of live children, but they are mentally

disabled. And I think our need for institutional care is going to increase.

But we also need to know more about the biological defects, the developmental defects, and I think it is entirely appropriate and desirable that if we have these clinical research centers where we can combine the treatment and rehabilitation with research and training, we can get ahead of this problem in the long run.

Besides the States that we have heard from that you mentioned this morning, Mr. Chairman, there are a few others that we have not heard from specifically in this committee hearing. But I would like to point out that in the Senate hearings on Senate bills 755 and 756, which were the same bills essentially, we did have a telegram from Gov. Bert Combs of Kentucky stressing these ideas, which I feel sure he is still committed to. This was his telegram to Senator Lister Hill:

Kentucky is most interested in both Senate bill 755 and 756, providing for construction of community mental health centers and facilities for mentally retarded. Community mental health centers will enable better mental health care near home rather than in State hospitals. Kentucky is presently short 1,000 beds for the retarded. I join my commissioner of mental health in urging favorable consideration of this legislation.

Then at that time we also had a telegram to Senator Lister Hill from Dr. David Vail, who is the medical director of the Department of Public Welfare in the State of Minnesota. It is as follows:

Improvements in mental health facilities and programs are urgently needed in the national interest. As director of the State mental health program in Minnesota, I strongly support Senate bills 755 and 756.

I don't believe your new Governor, Mr. Nelsen, has been in office long enough to give us a statement yet.

And then also in those hearings we had a statement from Dr. Paul Hoch, who is the commissioner of the Department of Mental Hygiene in the State of New York. And this statement, I understand, was approved by Governor Rockefeller. It says:

These objectives of the President's message represent the fundamental requirements in the field of mental health today and are entirely consistent with the goals delineated in New York State's master plan for mental disability promulgated by Governor Rockefeller last year, and soon to enter its second phase of implementation. This master plan and those of other forward-looking States have contributed to the recognition by the Federal Government of the size and gravity of this problem and the important issues involved.

There is no doubt that financial contributions of the Federal Government will be welcome, but it is of utmost importance that leadership and direction remain in the hands of each State. There must be full provision for flexibility and adaptability for the specific requirements of individual States. Maximum effectiveness can be achieved only if Federal, State, and local authorities are all involved in determining and maintaining services with full provision for correlations and integration.

Thank you, Mr. Chairman.

Mr. ROBERTS. Thank you, Doctor. I thank both of you gentlemen for the appearance, and for your statements.

I particularly like your viewpoint that this would channel the patients back into the main stream of medical practice, instead of being isolated in some remote location, that is remote as far as the patient is concerned, that they would still be living in contact with everyday things that they have become accustomed to, their families, their surroundings, their environment, and that instead of indicating,

you might say, a practice by the Government personnel that you would actually be more dependent than you had been before on private practitioners. I think that is very important in consideration of this legislation. I don't know if that point has been made before, but it certainly appeals to me.

I would appreciate it very much—I think you organization is probably the best qualified to do this—if you would submit for the record a breakdown on each State of the amounts budgeted for its mental health facilities and services, and also those for the mentally retarded. I would like to have those figures for the last 10 years, if you can get them for the record. If you could without much inconvenience give us that in a per capita figure, I think it would be most helpful, rather than just a lump sum of the various States.

(The information requested follows:)

NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS,
Washington, D.C., April 16, 1963.

Hon. KENNETH A. ROBERTS,
Chairman, Subcommittee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.

DEAR CONGRESSMAN ROBERTS: During the hearings on the mental illness and retardation bills (H.R. 3688 and 3689) you asked our organization to furnish for the committee record certain data on expenditures by the various States over the past 10 years on mental illness and retardation programs.

I now have data from several States. It will give you an idea of how much effort the States have put into these programs.

Perhaps at the time we receive the data from the 50 States, I could furnish it to you, and if you deem it helpful in considering the proposed legislation, you might insert it in the Congressional Record.

I regret not being able to move faster on your request, but compiling this data in the States is a fairly exacting job and with some of the State legislatures still in session, our State mental health directors have had a heavy workload.

Sincerely,

DANIEL BLAIN, M.D., *President.*

Per capita expenditures in last decade by the States for treatment of all mental diseases

[41 States]

State	Estimated per capita expenditures for 10-year period	State population (estimated average for last decade)	State	Estimated per capita expenditures for 10-year period	State population (estimated average for last decade)
		Thousands			*Thousands*
Alabama	$27.74	3,200	Nevada	$39.62	258
Alaska	[1] 56.00	204	New Hampshire	95.13	585
Arkansas	32.11	1,800	New Jersey	96.09	5,634
California	78.84	14,270	New York	125.57	16,389
Colorado	91.91	1,672	North Carolina	51.59	4,354
Connecticut	120.22	2,353	North Dakota	59.92	625
Florida	41.99	4,278	Ohio	62.84	9,318
Georgia	[2] 11.91	3,949	Oklahoma	43.22	2,260
Hawaii	25.31	607	Oregon	78.95	1,739
Indiana	58.65	4,433	Pennsylvania	71.83	10,955
Kansas	91.36	2,070	Rhode Island	84.40	862
Kentucky	29.33	2,936	South Carolina	39.43	2,273
Massachusetts	116.07	4,911	South Dakota	48.82	682
Maine	62.54	937	Tennessee	29.50	3,455
Maryland	74.75	2,801	Texas	31.75	9,053
Michigan	83.27	7,377	Vermont	86.54	383
Minnesota	85.53	3,264	Virginia	54.96	3,664
Mississippi	39.03	2,161	Washington	70.50	2,676
Missouri	54.63	4,176	West Virginia	31.42	1,861
Montana	55.52	652	Wisconsin	82.34	3,793
Nebraska	68.04	1,384			

[1] 5 years only.
[2] 3 years only.

Source: Compiled by National Association of State Mental Health Program Directors, Apr. 30, 1963.

State expenditures in the past decade to combat mental illness and retardation

State (time period)	Expenditures on mental illness		Expenditures on retardation		Total expenditures		Total, all mental disorders	Explanatory notes
	Capital	Operating	Capital	Operating	Mental illness	Retardation		
Alabama							$82,366,063	
Alaska: 1958, estimate fiscal year 1963, expenditures, all programs (including expended transitional grants under Public Law 830, 84th Cong.):								
Capital	$582,964							
Operating	11,568,728							
Arizona [1]							12,151,692	
Arkansas: 1959–63 [2]	$3,337,441	$49,574,386	[3]$2,752,315	[3]$2,158,775	$52,911,827	$4,911,091	57,822,917	Breakdown inaccurate because "retardation" statistics reflect only treatment of children and not retarded adults who are treated with mentally ill.
California: Fiscal year 1953–54 through fiscal year 1962–63 (estimated).	80,189,812	786,614,216	40,560,281	217,786,068	966,804,028	258,346,349	1,125,150,377	Includes only hospital expenditures.
Colorado: Fiscal year 1953–54 through fiscal year 1962–63 (estimated).	19,868,521	102,690,711	6,474,938	24,642,267	122,559,232	31,117,205	153,676,437	Includes matching funds to clinics under operating costs.
Connecticut: 1953–62	43,192,520	183,835,635	15,429,583	63,963,438	227,028,155	79,393,021	306,421,176	
Delaware [1]								
Florida: Fiscal year 1952–53 through fiscal year 1961–62.	34,209,710	102,036,657	11,712,083	31,673,161	136,246,367	43,385,244	179,631,611	Does not include cost of community services for mental illness.
Georgia: Fiscal year 1959–60 through fiscal year 1961–62.	772,486	40,225,476	796,961	5,257,083	40,997,962	6,054,044	47,052,006	
Hawaii: Fiscal year 1959–60 through fiscal year 1961–62.	754,711	8,872,085	367,376	5,372,257	9,626,796	5,739,633	15,366,429	Statistics before 1959 not available because of recent statehood of Hawaii.
Idaho [1]								
Illinois [1]								
Indiana, past 10 years	28,544,044	162,543,774	8,431,585	60,497,905	191,097,818	68,929,490	260,027,308	
Iowa [1]								
Kansas: Fiscal year 1954 to fiscal year 1963	21,361,320	113,227,081	8,633,052	45,893,476	134,588,403	54,526,528	189,114,929	Mental illness operating expenditure includes State office operating costs of $2,226,089.
Kentucky: July 1, 1952, to June 30, 1962	3,472,568	74,567,130	1,239,727	8,016,749	78,039,698	9,256,476	87,296,174	
Louisiana [1]								
Maine: Past 10 years	6,651,729	39,373,213	3,911,970	81,043,397	46,024,942	21,955,367	67,980,309	

See footnotes at end of table, p. 231.

State expenditures in the past decade to combat mental illness and retardation—Continued

State (time period)	Expenditures on mental illness		Expenditures on retardation		Total expenditures		Total, all mental disorders	Explanatory notes
	Capital	Operating	Capital	Operating	Mental illness	Retardation		
Maryland: Fiscal year 1953 to fiscal year 1962	12,948,573	159,979,022	4,158,850	32,246,500	172,927,595	36,405,350	209,332,945	Includes expenditures on mentally disturbed, local health service, and preventative medical service under mental illness.
Massachusetts: Past 10 years	58,317,165	388,222,302	11,100,350	111,399,647	446,539,467	122,499,997	569,039,464	
Michigan: Fiscal year 1953 to fiscal year 1962	42,051,500	363,099,937	33,947,700	175,213,437	405,151,437	209,161,137	614,312,574	
Minnesota: Fiscal year 1952–53 through fiscal year 1961–62.	27,302,750	156,017,229	31,707,373	64,146,571	183,319,979	95,853,944	279,173,923	Expenditures for research, training, central office administration, and mental health centers included in mental illness operating expenditures ($8,647,864).
Mississippi: Past 10 years	7,620,000	49,071,543	2,594,169	7,498,615	56,691,543	10,092,784	66,784,327	
Missouri: Past 10 years, expenditures, all programs:								
Capital	25,193,013				180,851,710	44,313,152	225,164,862	
Operating		199,971,849						
Montana: 1953–62, for mentally ill	3,273,275	23,577,854	(1)	(1)	26,851,129			
Nebraska, expenditures, all programs:								
Capital $8,953,604								
Operating 85,235,174								
							94,188,778	
Nevada: Past 10 years	2,489,903	7,732,610			10,222,513		10,222,513	No separate program for retardation.
New Hampshire: Past 10 years	1,692,522	40,841,007	1,771,660	11,345,715	42,533,529	13,117,375	55,650,904	
New Jersey: 1954–63							541,347,357	No breakdown available.
New Mexico								
New York: Last 10 years	236,966,813	1,527,076,383		292,898,911	1,764,043,196	292,898,911	2,056,942,107	Capital expenditure on mental illness also include capital expenditure on retardation.
North Carolina: 1952–53 through 1961–62	42,841,448	127,830,545	21,832,858	32,124,924	170,671,993	53,957,782	224,629,775	
North Dakota: 10 years	(4)	(4)	2,145,100	5,483,861	29,822,222	7,628,961	37,451,183	Total for retardation includes some mental illness and clinics and educational services for retarded.
Ohio	67,287,327	406,785,959	14,559,498	95,924,760	474,073,286	110,484,258	584,557,544	Includes $29,804,527 in noninstitutional care in mental illness operating expense.
Oklahoma	2,471,532	77,523,703	1,651,452	15,933,429	79,995,235	17,584,882	97,580,117	
Oregon: Fiscal year 1953–62	82,960,531	12,732,840	6,226,836	35,385,441	95,693,371	41,612,277	137,305,648	
Pennsylvania	124,815,457	[5]476,822,907	69,556,759	115,769,076	601,638,364	185,325,835	786,964,199	Statistics on operating costs cover 9 yrs. (1-yr. estimate on mental illness). Capital expenditures cover 10 yrs.
Rhode Island: 1953–62	6,000,000	48,487,016	4,450,000	13,820,626	54,487,016	18,270,626	72,757,642	
South Carolina: Fiscal year 1952–53 through fiscal year 1961–62.	6,116,846	61,512,832	2,782,097	19,224,521	67,629,678	22,006,618	89,636,296	

South Dakota: Biennium 1953–55 through 1961–63	2,837,426	19,940,000	1,090,000	9,330,425	22,777,426	10,420,425	33,197,851	
Tennessee: 9 years only, fiscal year 1953–54 through fiscal year 1961–62.	27,374,402	56,813,217	7,445,071	10,286,556	84,187,619	17,731,627	101,919,246	Mental illness capital expenditures include $6,865,703 Hill-Burton funds.
Texas: 1953–62, ending Aug. 31	23,641,358	180,486,898	17,325,198	65,998,389	204,128,256	83,323,587	287,451,843	
Utah								
Vermont: 1953–62	2,905,189	22,204,335	1,455,785	6,577,200	25,109,524	8,032,985	33,142,509	
Virginia: July 1952 to June 1962	26,686,818	130,058,020	14,265,006	30,397,237	156,744,838	44,662,304	201,407,141	
Washington: 1954–63	9,191,564	114,739,653	4,907,877	59,892,033	123,931,217	64,799,910	188,731,127	Does not include community psychiatric services.
West Virginia: Retardation, fiscal year 1958–59 through fiscal year 1963–64; mental illness, fiscal year 1954–55 through fiscal year 1963–64.	2,878,266	51,879,804	353,900	3,373,671	54,758,070	3,727,571	58,485,641	Prior to 1958, retardation expense included in mental illness.
Wisconsin: Fiscal year 1952–53 through fiscal year 1961–62.	35,406,335	200,562,640	15,577,575	60,916,383	235,968,975	76,493,958	313,320,481	Statistics include also private and county funds.
Wyoming [1]								

[1] Not available.
[2] "Last 10 years" illness and retardation not separated.
[3] Expenses at Arkansas Children's Colony, 1959–63 (3 years-plus).
[4] No breakdown available.
[5] 1953–54 estimate.

SUMMARY OF EXPENDITURES BY 41 STATES IN COMBATING MENTAL ILLNESS AND RETARDATION (LAST 10 YEARS)

Total expenditures (all mental disorders)	$10,590,963,823
Mental illness:	
A. Capital expenditures	1,026,270,962
B. Operating expenditures	6,440,587,061
C. Data from States where no separation was made between capital and operating expenditures	210,673,932
Total	7,677,531,961
Retardation:	
A. Capital expenditures	374,031,504
B. Operating expenditures	1,765,033,316
C. Data from States where no separation was made between capital and operating expenditures	44,313,152
Total	2,183,377,972
Data from States where no separation was made between mental illness and retardation expenditures	730,053,890

Source: Compiled by National Association of State Mental Health Program Directors, Apr. 30, 1963.

Mr. ROBERTS. Mr. Nelsen.

Mr. NELSEN. One question. On page 4 you referred to a formula grant program of the National Institute of Mental Health for community mental health services, and you point out that it has been a beacon in encouraging further exploration in these areas. Would you give me a little information about this particular point that you make there? I am not familiar with it.

Dr. DAVIS. What I was thinking primarily there was the Federal community mental health services grant program in which an appropriation by Congress is divided among the States on the basis of a formula having to do with the population and the per capita income of the State.

In New Jersey at the moment we get some $186,000 a year. And we have been getting this since about 1949, I believe. And this has been for the purpose of developing community mental health services—in other words, we cannot use any of this money to pay for inpatient services in State hospitals.

Mr. NELSEN. Or facilities?

Dr. DAVIS. Or facilities. But we can use it for paying staff and the necessary operational expenses of community clinics, that is what it has been for the most part used for.

Mr. NELSEN. My point in asking the question is, so many times we find a vast duplication of efforts in different areas all pointing toward some central objective. And of course it is important, if this program is to be an efficient one, that you don't have an overlapping duplication in any area. And if there are any areas where we do that we would like to know it so that we can do a better job.

I thank you, gentlemen.

Mr. ROBERTS. The gentleman from New York, Mr. O'Brien.

Mr. O'BRIEN. May I say first to Dr. McPheeters, I am glad you read that telegram from New York, because that is obviously one issue we won't have to worry about in 1964.

But I am quite pleased that the chairman requested a summary of the cost in the several States of mental hospitals. That is the point I was trying to get at before. And I notice, Doctor, you said, I believe, that if this program comes into being that within a certain period of time you might reduce by one-third, was it, the population of your mental institution.

Dr. MCPHEETERS. I would hope so.

Mr. O'BRIEN. That would be translated to a national basis. And that could possibly mean as much as a billion dollars of State budget costs which could be transferred through the Federal aid end—and you will forgive me for the expression—from mental institutions into the very human cure at the community level. So the additional cost of this program to the States and communities could be minimal, and it could be actually a saving. Isn't that correct?

Dr. MCPHEETERS. That is right. We are still going to have the problem of the indigent patient. And of course a good many of our patients in the State hospitals are now indigent, at least they become so after they have been away from their jobs for several months. And I am sure the State is going to have to find some way of covering the cost of indigent patients. This is going to amount to a much higher per diem than now, but presumably for a much shorter time, to get

the patient back to his own work. How this will come out in the long run I don't know.

Mr. O'BRIEN. I am not optimistic enough to believe that we are not going to need the State mental hospitals, I just believe that there would be a substantial saving if we removed from those State hospitals the people that could be cured at the local level, and this saving would fill the financial gap in financing these things.

Dr. MCPHEETERS. I would think so.

Mr. O'BRIEN. So as I understand your testimony, and the other testimony, you are suggesting that the taxpayers of the Nation enable the States to move from the outmoded to the modern, and that in your opinion there will be a saving not only in preventing human misery, but actually in dollars and cents; is that correct?

Dr. MCPHEETERS. That is my opinion, yes, sir.

Mr. O'BRIEN. It is nice in this particular session to have before us what might be described as an economic program.

Thank you.

Mr. NELSEN. Have there been any studies made so that we would have some basic figures to prove a point, have there been any studies where there has been attention given to the mentally retarded at an early age that would show the progressive effects as compared to those that might have been neglected? Now, that may have been brought out in the testimony, I think to a degree it has been. But is there any study that would show what percentage we could expect to find in going back into the normal channels wtihout serious results, later going to a mental hospital?

Dr. DAVIS. I don't think of one right offhand. We can certainly get you this information. It would probably come more in terms of the average IQ of the patients in institutions for the retarded.

In other words, in the last 10 years we have been rehabilitating for social adaptability, shall we say, a large number of individuals who prior to that time, because of the lack of understanding of their medical and educational and social needs, were placed in institutions. They have now been returned to the communities. And this has given us a lot of encouragement.

Dr. Pratt did quote the statistics from Kansas City with regard to what we can hope to accomplish in the institutions for the mentally ill.

Mr. NELSEN. The example that was used relative to prison camps, of course, that is an example of showing how environment does have an effect, and I presume there have been experiences similar to that. That would be good information for us to have relative to the support of this particular proposal.

Dr. DAVIS. If you would like, our association will find you some information of this type and make it available for you.

Mr. NELSEN. Thank you.

Dr. DAVIS. If I may, I would like to add one other point that I overlooked.

Governor Hughes of New Jersey is chairman of the Mental Health Committee of the Governors' conference. It was one of the recommendations of the 1961 conference that they set up an ongoing committee on mental health. And I understand that he has scheduled a meeting of that committee to be held here in Washington on April

10. And they will be giving serious consideration to these bills along with other things in the field of mental health.

With regard to the breakdown of each State budget for mental health expenses, we will also try to get you capital expenses in addition to the regular appropriations. In New Jersey, for instance, we had $150 million bond issue for construction of mental health facilities in 1949 and 1951, we had another $40 million bond issue in 1958, and our average appropriation at the moment is about $66 million a year for the mentally ill and the mentally retarded programs in New Jersey.

Mr. O'BRIEN. I have a question that I may regret to ask you. Mr. McPheeters says that in New York there are presently over 130,000 persons in the mental institutions. In California there are only 68,000. I regret, of course, that California has just passed us in population, and I was wondering why we have nearly twice as many in our mental institutions.

Is there any answer to that?

Dr. MCPHEETERS. I think there are probably several things there, Mr. O'Brien. One thing, there are a great many private psychiatric hospitals in California. I think over half of all the private psychiatric hospitals in the United States are located in California. That, of course, makes a big difference.

Mr. O'BRIEN. May I interrupt at that point. Isn't that a major argument for this bill?

Dr. MCPHEETERS. It certainly is, yes.

Mr. O'BRIEN. I would not like to think that New York was twice as unbalanced as California, although some might agree.

Dr. MCPHEETERS. As a native New Yorker I can't believe that they are crazier than Californians.

Mr. O'BRIEN. Apparently they are doing something in California right now that we would like to have done for the Nation as a whole. Is that correct.

Dr. MCPHEETERS. Yes.

Mr. O'BRIEN. I have one other question. I don't want to take too much time, Mr. Chairman.

But I rather liked your reference to the patients sense of remoteness from society. Isn't it a fact that when patients remain for a long time in a State mental institution that with the passage of time there is not a desire for the return, but a desire that they not return to the family?

Dr. MCPHEETERS. This tends to happen, after a long time the patient considers the hospital home and is actually afraid of going home in many cases. Of course, this depends upon the basic personality of the patient.

Mr. O'BRIEN. I am talking about the relative, the people back home, with the passage of time they pretend that the person is dead—perhaps the person closest to them may have died, and no one wants to bother with him.

Dr. MCPHEETERS. That is right.

Mr. O'BRIEN. And if you had the community facilities you would eliminate a great deal of that, isn't that true, this would be the hope?

Dr. MCPHEETERS. That is right, there would be hope, there would be the expectation of a patient coming back just like from the local general hospital from an appendectomy.

Mr. O'Brien. Thank you.

Mr. Roberts. Thank you, gentlemen.

Our next witness will be presented by the distinguished gentleman from California, a member of our committee, Mr. Van Deerlin.

Mr. Van Deerlin. Thank you for this opportunity to present the next witness.

Just 16 years ago, as a reporter on the San Diego Daily Journal, I was assigned to do a series of articles on the mental hospitals of California which were then shamefully overcrowded. In the company of a photographer and a member of the State legislature we made a series of surprise visits to all the major mental institutions in the State. And the story that we came up with not only sold a lot of newspapers, but it helped send certain members of the legislature into action or help.

What we found out especially, though, in addition to the conditions of overcrowdedness and the dependence on custodial care at that time, was that there was a hard core of skilled, dedicated people, and devoted administrators who were already, under the governorship of Earl Warren, now our Chief Justice, beginning a program of therapy which goes a long way toward answering the question just asked by the distinguished gentleman from New York. Although California no longer yields to New York in population supremacy, I wouldn't want it suggested that we yield to New York a corner on the unbalanced. The gentleman only has to come and read any mail any morning.

But under three successive governors—Governor Warren, Goodwin Knight and now especially emphasized under Gov. Pat Brown—the State of California carried out, at considerable expense, a program of mental health. An increase in population which in the last 10 years alone has entitled us to eight new Congressmen, but it has provided us some blessings as well. Among these is a reduced population in our State mental institutions.

Dr. Daniel Lieberman has been with this program for 11 years. He is today the chief deputy director of the State department of mental hygiene. He is one of those dedicated administrators who has brought about this happy change in the trend in mental treatment in California.

It is with great pride as a Californian and as a freshman member of this committee that I present to you Dr. Daniel Lieberman.

Mr. Roberts. Thank you for your statement and introduction, Congressman.

Dr. Lieberman, we are glad to have you. I note that you have a very fine statement.

STATEMENT OF DANIEL LIEBERMAN, M.D., CHIEF DEPUTY DIRECTOR, CALIFORNIA STATE DEPARTMENT OF MENTAL HYGIENE

Dr. Lieberman. Thank you Congressman Van Deerlin, Mr. Chairman, Mr. Nelsen, and Mr. O'Brien.

It is not entirely coincidental that the enlightened newspaper reporting in 1949 went along with the beginnings of an enlightened mental health program in California. We are proud of our advances, and yet we are woefully aware of our shortcomings.

I am a medical doctor, specializing in psychiatry, and am the chief deputy director of the California State Department of Mental Hygiene. In that capacity I administer the mental health activities and facilities of the State which consist of 10 State hospitals for the treatment and rehabilitation of the mentally ill; 4 State hospitals for the care, treatment, and training of the mentally retarded; 2 neuropsychiatric institutes affiliated with the two University of California Medical Schools; 7 State mental hygiene clinics; 3 day treatment centers; 27 posthospital convalescent treatment offices; active training and research programs; and licensing of private psychiatric facilities. The Department of Mental Hygiene also administers the Community Mental Health Services Act which gives financial and professional assistance to local governments operating mental health services. Other functions of the department include public information and mental health education services, and consultation services to various public agencies such as schools. At any one time there are close to 70,000 patients for which the Department of Mental Hygiene has a direct responsibility.

My background includes working directly with mentally retarded individuals in a State hospital setting for 5 years, medical director and superintendent of a State mental hospital treating all kinds of mental disorders for 6 years, and the planning and operating of day treatment centers for the specific purpose of diverting mental patients from State hospitals in order to utilize the social forces of the community, home, and family in restoring these people to mental health. I speak therefore, not only from the theoretical framework of a psychiatric administrator attempting to develop the most efficient and economic methods of meeting the mental health needs of a large State, but also as a physician who has worked closely with severely handicapped individuals and who knows what the potentials for recovery and rehabilitation are under appropriate circumstances.

I am representing the administration of the State of California and you have a letter from our Governor, Pat Brown, soliciting your full support for H.R. 3688 and H.R. 3689 which are designed to carry out the President's recommendations for the development of comprehensive community mental health programs as described in his message on mental illness and mental retardation, presented to Congress on February 5, 1963.

THE COMMUNITY MENTAL HEALTH CENTER

You may well ask the question, "Why should the development of a particular kind of facility be so important as to materially alter the success or failure of a medical treatment program?" Psychiatric knowledge has developed to the point that we are now able to look more completely at a mental disorder in its dynamic aspects. We can assess in great measure the various sociological, genetic, cultural, physiological and interpersonal factors which enter into the development and life history of the illness. In treating these illnesses, modern psychiatry tries to use the patient's strengths and resources to help restore him to a more healthy balance. The requirements of the patient as well as his symptoms, however, tend to change from time to time as the conditions of his living change. We must be prepared to adjust quickly to these changes, and even to anticipate them. It is

obvious that the psychiatric procedures and techniques used must be changed from time to time. Furthermore, the facilities in which these techniques are carried out must have certain flexibility. Such flexibility will allow for maximum use of all available forces that can be brought to bear upon the problems of mental disorders.

The community mental health center is the kind of facility that will best meet these demands. It will be located near the patient's home, activities, and interests. It is thus readily accessible, helps to maintain family, community, and occupational ties, and is able to make use of the already established resources of the community. The scope of treatment will range from the most intensive medical and psychiatric treatments to occasional supportive outpatient guidance. The treatment spectrum and the available facilities will encompass the entire breadth of medical knowledge. The facilities and treatment procedures will be tailored to the changing needs of the patient and to the dynamics of his problems. It will provide the professional resources wherein a varied program of treatment, advanced professional training, research, and consultative services can be effectively carried out. Because such treatment may be intensive and thorough, the cost will be high. The demonstrated results, however, are so promising that the long-range cost will be less than were we to pursue a direction of large, isolated, relatively custodial institutions. We believe that one treatment bed in a community mental health center can be the focus of more service than three or four treatment beds in a custodial institution.

EXISTING STATE HOSPITALS

The kinds of services established in a community mental health center will depend upon whether it is located in a rural or urban area, the quality and quantity of existing services in the community, possibilities for mutual assistance and cooperation among various government and private agencies, and the availability of professional manpower. While basic services for a mental health center have been described, it is quite possible that a portion of them may be already available in existing facilities. Therefore, it is most important that our criteria be flexible when the standards are established.

Our State mental hospitals in recent years have been attempting to change their character so as to approach the operation of community mental health centers. There are very serious obstacles for some of them to overcome in order to develop as complete mental health centers, including tradition, location, and size. However, advances are being made to eliminate many of the difficulties encountered.

Upon embarking upon exciting and hopeful new directions, it is wise to retain the wisdom and knowledge of the past to apply to the future. Without skill and ingenuity, it is not necessary to discard existing State hospitals, branding them as obsolete custodial warehouses. Rather, let us utilize these available facilities as focuses of community mental health centers of the future. Let the large, crowded dormitories become areas for rehabilitation activities, classrooms for training professional personnel, and research units. Let the focus change from the bed to the service, and allow patients more room for all activities, including sleeping. Let the personnel concern

themselves with the needs of the surrounding community, providing services to individuals after they leave the hospital as well as providing services for the purpose of preventing hospitalization. Let there be professional consultation to the schools and other public and private agencies that deal with individuals who may have emotional difficulties of one kind or another. Who finances and administers this unit is of secondary importance. That it exists where needed is of primary importance. No one governmental source can bear the sole responsibility. Federal-State-local partnership, with formulas based upon revenue resources, is a must for the future.

THE ROLE OF PRIVATE ENTERPRISE

These bills being considered by the committee are the only health bills, to the knowledge of the witness, which have the full and complete endorsement of the American Medical Association. The medical association recognizes what we have demonstrated in California and other States; namely, that with the development of Government sponsored and financed programs for the mentally ill and mentally retarded the feasibility of treatment and rehabilitation can be demonstrated, and this encourages the private sector of medicine to increase its activities in this field. This is one Government expenditure which we recognize as being an investment to help get the Government out of the health service business and to encourage organized medicine to accept greater and greater responsibility. Even now, health insurance companies are considering the inclusion of mental disorders in their health coverage plans, and already millions of people are covered by health insurance which includes assistance for mental disorders.

In California, we are proceeding as rapidly as possible to develop broad spectrum services of the nature described. Without the stimulus of Federal assistance at this time, progress will be tortuously and agonizingly slow. We have a long-range plan which establishes a medically and fiscally sound mental health program to meet the requirements of a State growing at the rate of almost a million new people a year. The plan adheres to the widely accepted psychiatric concept that adequate "treatment should be available as early as possible, as continuously as possible, with as little dislocation as possible, and with as much social restoration as posible." We anticipate that the reponsibility for the treatment of mental illness and retardation will be the same as in other diseases, resting first with the patient, his family, and his local doctor. Government mental health services will backstop private mental health resources, taking care of individuals who cannot be assisted privately.

CONCLUSION

Gentlemen, concern for the mentally ill and mentally retarded is now deeply rooted in the public conscience. This concern has resulted in steadily increasing expenditures for mental health programs, both State and local. The private sector of medicine is beginning to accept greater responsibility for providing psychiatric services. State and local governments, for the most part, have extended themselves as far as they dare and still remain solvent. Their willingness to do

this is based upon recognition that the restoration of health to thousands of our citizens is a sound investment. We now call upon you as we reach the threshold of success to give us the assistance to keep going at the accelerated rate necessary to overcome the long years of inertia. The fate of thousands lies in your hands. Please don't let them down.

Thank you very much.

Mr. ROBERTS. Thank you, Dr. Lieberman, for a very fine statement.

I have some questions I would like to ask, but the hour is getting late, and I have other very important witnesses that I want to hear from. So I am not going to say anything except to commend you on a job well done. We appreciate your coming this long distance to give us the benefit of your fine experience, and I appreciate the help that you have given our committee on these important matters.

The gentleman from New York.

Mr. O'BRIEN. I would like to say that I compliment the doctor and the State of California.

Mr. ROBERTS. The gentleman from Minnesota.

Mr. NELSEN. Just to thank the gentleman for the statement.

I am sure that you can go back in good conscience and tell the folks back home that your Congressman is a good salesman for his State. You have made a very fine statement.

Thank you.

Dr. LIEBERMAN. Thank you.

Mr. ROBERTS. Our next witness is Jack R. Ewalt, Director, Joint Commission on Mental Illness and Health.

Dr. Ewalt, I know you have done great work in this field. You have been associated with it for a long time. I am sorry to be so long getting to you as a witness, but I hope you will understand that we have a very crowded schedule.

STATEMENT OF JACK R. EWALT, M.D., DIRECTOR, JOINT COMMISSION ON MENTAL ILLNESS AND HEALTH; BULLARD PROFESSOR OF PSYCHIATRY, HARVARD UNIVERSITY; SUPERINTENDENT, MASSACHUSETTS MENTAL HEALTH CENTER

Dr. EWALT. I am pleased to be here and have this opportunity. I feel that everybody who has spoken today has been espousing my cause.

In 1955 this very committee, I believe, first heard Congressman Priest on the Mental Health Act of 1955 (H.J. Res. 256) which started the study on which these proposed acts are based. Congress authorized a committee made up of national organizations to conduct a study and to make recommendations. There were 36 such associations with such diverse representation as the American Medical Association, the American Legion, the American Educational Association, and the American Hospital Association; quite a mixed group. But they all worked amiably on this study. They each sent representatives to form the Commission, and I was privileged to be the Director. We published the results of our study in eight books, plus the final volume, "Action for Mental Health," on which this legislation is based.

I won't repeat the recommendations here, because I want to be very brief. The theme that ran through the testimony you heard today

was that if one of our citizens becomes ill or retarded or finds himself becoming so, if he is to get adequate care under today's practices, he must know the facilities in his State and what the laws and regulations are, and then regulate his illness precisely to those needs, otherwise he receives inadequate care. If he gets a little bit sick his family doctor can treat him, or his clergyman can give him counsel. If he is a little bit sicker and needs part-time hospital care he is just out of luck, he must get sick enough so that he can qualify as a bona fide mental patient or mentally retarded person.

But then his troubles aren't over, he needs to go to court, in some cases waiting in jail for his turn. He is then taken by a court officer into a hospital with expenses for his relatives to meet, or to an institution which has too much business.

In many cases he will be placed in an institution in which one bed may be so close to the next that you can ride a bicycle across them and never hit the floor. These places are staffed by employees who are heroes in a quite desperate sort of way. You really wouldn't care to visit in some of these places because of the conditions. We find the superintendents of these hospitals being called inefficient anad ineffective, often by other hospital administrators who run hospitals which are spending $30 a day or more to care for a patient, without providing the cost of the physicians fee, and our poor inefficient administrator is supposed to provide all care plus medical care and food for somewhere between $3 and $5 a day. We need to go to a new system. The old one is not getting the job done. These bills, House 3688 and 3689 will provide care for patients when they need it—without a long wait—where they need it; that is, near their home, and of the amount needed.

They can be outpatients, part-time patients, full-time patients, according to their needs. This bill furthermore provides that the initiative for planning and saying they want such a unit comes from the local community. For the most part, these will be in regular medical facilities, but you can use facilities as the bill is now written.

I don't care much for some of the amendments offered today, I like the bill as it stands as being most likely to get the job done.

The bills also provide that the Federal Government will aid in planning if the community asks for it. They will aid in stimulating the start of these community centers, but the final decision for running them and paying for them remains in the local community.

Now, we know that Federal stimulation in these programs originally came from this committee in the Mental Health Act, establishing the Institutes of Health. A bit later you provided a program for the National Institute of Mental Health to give some aid to States. At the time you appropriated the first $3 million, the States were spending less than a million dollars a year in total on their community mental health programs. This current year the States are spending more than $100 million of their own State and local money, principally stimulated by your action.

We will make a tremendous step forward in the mental health of our Nation and in improved care for the citizens of our Nation if this bill is enacted. I speak on behalf of my colleagues on the Commission, all of whom now have gone back to their own jobs. We represented organizations with many millions of members. We beseech you to pass this bill.

Thank you.

(The statement of Dr. Ewalt is as follows:)

STATEMENT OF JACK R. EWALT, M.D., DIRECTOR, JOINT COMMISSION ON MENTAL ILLNESS AND HEALTH; BULLARD PROFESSOR OF PSYCHIATRY, HARVARD UNIVERSITY; SUPERINTENDENT, MASSACHUSETTS MENTAL HEALTH CENTER

The implementation of the program authorized by H.R. 3688 would be another major advance toward solving one of our major health problems. The groundwork was laid for this act when the Congress enacted (and by unanimous vote) the mental health act of 1955[1] which authorized a study of the services for the mentally ill of the Nation, and directed that a report and recommendation for action be made to the Congress, the Governors of the States, and certain agencies of the executive branch of the Government at National, State, and local levels.

Thirty-six professional and citizens' groups joined forces to establish the Joint Commission on Mental Illness and Health, and each organization selected one or more representatives to be members of the Commission. To the Commission was assigned the task of conducting the survey and making recommendations for action. The details of the report are in eight books. A summary of the studies plus the recommendations for services to our citizens suffering from mental illness were published in 1961 in a book titled "Action for Mental Health." The Council of State Governments, the American Psychiatric Association, the American Medical Association, the American Orthopsychiatric Association, the National Association for Mental Health plus many others devoted special meetings to studying the report.

The studies revealed a variety of services to our mentally ill persons, but services shamefully inadequate in kind and distribution. As one example of the irrational organization of services in some places I will present the plight of a hypothetical patient. A citizen becoming tense and upset over some personal problem or because of some disease must have his illness in exactly correct amounts and severity if he is to be adequately served, and these amounts must be corrected for the resources available in his town. If he can confine his symptoms to mild discontent and anxiety, his family physician may prescribe a sedative or tranquilizer, and his physician or minister give counsel. If a psychiatrist is available in his town, and has time to see him, our hypothetical patient can allow himself a few more serious symptoms, but he must not show behavior that will irritate or frighten his fellow citizens. If our patient is too ill or too troubled to confine his symptoms to either of these categories, but in fact needs hospital care for a few hours daily on some days he is out of luck. He must be sick enough to require hospital based treatment 24 hours per day every day. Why? Because the laws and regulations and policies of most hospitals, and especially mental hospitals, require that the patient adapt his symptoms to the hospital policies and rules (i.e., that he be sick enough to be confined all the time or be well enough to stay out). Our patient cannot regulate the nature and severity of his illness nor can be know the policies of his local hospital. But if his symptoms and his need for care do not conform to hospital policy and rules he will need to become more seriously ill or socially disruptive so he may qualify as a mental patient. Further, in many areas of the country, having allowed his illness to progress so he can qualify as a bona fide mental patient, he must now travel some distance from home to a large, overcrowded, understaffed institution called a mental hospital. He will find in most instances too many patients and too few employees, all trying to do the best they can with what they have. He may live in surrroundings more terrible than you can imagine. Beds may be so close together that you can ride a bicycle from one bed to another, beds entered by patients by climbing over the foot (and this, gentlemen, has none of the desirable features of "togetherness" espoused by some of our sociologist colleagues).

He will find the hospital employees for the most part devoted people, heroes in a quiet, desperate sort of way in my opinion. He will find a superintendent who is accused of being inefficient and ineffective for giving such poor care. Some superintendents are ineffective, but many do wonders with the money and resources they do have. And some of the persons who call the superintendent inefficient and lacking in business methods are those who operate hospitals in which the cost of caring for a patient is $30 or more per day, plus the phy-

[1] Public Law 182, 84th Cong., ch. 417, 1st sess., H.J. Res. 256.

sicians' fees, and the mental hospital superintendent, poor, unbusinesslike person he is reputed to be, spends from $2.50 to $5 per day caring for his patients and this sum must include the physicians' pay, not only for ordinary medical and surgical treatment of our patient, but also for treatment of the mental illness. Our hypothetical patient is fortunate indeed if he avoids any substantial part of this story.

The care of the mentally ill is a disgrace. To allow such conditions to exist challenges the very concept of democracy. Plans must be made to rectify this situation.

The President read "Action for Mental Health," the report of the Joint Commission on Mental Illness and Health, as did many Members of Congress and many Governors (about 24,000 copies were purchased by citizens). The 87th Congress made money available to plan services needed in communities. Several States have started plans, and some States have initiated portions of a new program like that envisioned in "Action for Mental Health." All States need assistance in planning and initiating the new services.

The President appointed a Cabinet level committee to study the report and to recommend what further roles should be taken by the Federal Government in coping with the mental health of our citizens. The President's message of February 7 recommends plans formulated by the President's study group on mental health, and plans prepared by a special committee on mental retardation.

These actions by Congress, a citizens' study group, and the President provide the background for H.R. 3688 which has important features that deserve emphasis, features with origins in the joint commission report and in the President's message.

The basic theme in H.R. 3688 is that services for all types of mental illness will be available when needed and in the patient's home community. The service will be as much needed but no more. For example, a patient needing 3 to 6 hours of daily treatment available in a hospital will not be required to spend 24 hours per day in the hospital to obtain these treatments as is now the case, except in a few places.

Preventive programs will be directed to the medical and social causes of mental illness and retardation. These programs of prevention, treatment and rehabilitation will be planned by each community to make maximum use of existing facilities, and to expedite the creation of additional ones needed within the health and medical facilities and resources of each community.

The Federal program is to be confined to the stimulation and facilitation of adequate plans by the communities, aid in financing construction of mental health centers, and assistance in initial staffing of the mental health centers. H.R. 3688 recommends a large amount of assistance at the beginning of the program, with a formula for decreasing the Federal share of support, and with local and State support assuming the total burden within 5-years of the opening of each mental health center.

Thus we have the desirable features of planning and operation at the local and State levels, with the Federal Government offering assistance in financing the planning and services needed in each community, and assistance in starting the program.

The Congress should be proud of its role in initiating this survey of our citizens' needs; and being informed of the shameful neglect and economic waste caused by inadequate plans and services. Congress now contemplates enactment of H.R. 3688 which if placed in full operation would represent a major step toward correcting this inequity suffered by our citizens who are, or who may become, the victims of mental illness.

On behalf of the staff and members of the Joint Commission on Mental Illness and Health—a study group formed by organizations with a membership totaling several million— I respectfully recommend and request enactment of H.R. 3688.

Mr. ROBERTS. Thank you, Doctor.

I appreciate your reference to Mr. Priest, late chairman of this committee. I had the privilege of serving with him at the time that he was the chairman of the Subcommittee on Health and Science, which later became the Subcommittee on Health and Safety, and now is known as the Subcommittee on Public Health and Safety. It was my privilege to support him in his efforts to set up the study you referred to. And I congratulate you on the fine job that you have done. I

think we can see the fruits of not only your effort but the efforts of the members of this fine commission.

I think too that I have been impressed more today by the fact that this is not a crash program, this has been in the minds of people who have known this problem for a long, long time, there has been a lot of study and a lot of planning, and I think it is evidenced also in the manner in which the States have indicated their willingness to formulate some plans. They already have plans, and they have committees that have been active for many years in this field. So we are not bringing out something on an emergency crash basis at all—maybe it should have been, I would say, 10 or 25 years ago.

Again I want to thank you for your statement, and tell you how much this committee appreciates your efforts in this field.

Mr. Nelsen.

Mr. NELSEN. No questions.

Mr. ROBERTS. The gentleman from New York.

Mr. O'BRIEN. No questions, except to say that I think you spoke for all of us in your commendatory words.

Dr. EWALT. Thank you very much.

Mr. ROBERTS. Our next witness is Dr. Francis Braceland, past president of American Psychiatric Association, and director, Institute of Living, and clinical professor of psychistry at Harvard and Yale University School of Medicine.

I am very happy to have you, Doctor. And I apologize for being late in getting to you, but I am sure you know the problems we have had.

STATEMENT OF FRANCIS J. BRACELAND, M.D., PAST PRESIDENT OF AMERICAN PSYCHIATRIC ASSOCIATION, MEDICAL DIRECTOR OF INSTITUTE OF LIVING, AND CLINICAL PROFESSOR OF PSYCHIATRY AT YALE AND LECTURER AT HARVARD

Dr. BRACELAND. Thank you very much, Mr. Chairman. I am glad to be here, and ask your permission to put the statement in the record and comment upon it briefly.

Mr. ROBERTS. Let it be included in the record.

Dr. BRACELAND. Thank you, sir.

There is a page or two in the front of my statement trying to explain me, but I have been at this for 30 years. In order that Mr. Nelsen not be alone and that he has a representative here today, I would like to tell him that I was the first psychiatrist at the Mayo Clinic, and was also a professor at the University of Minnesota.

We appeared before the committee or the counterpart of it for the first time 17 years ago, Mr. Priest in the House and Senator Pepper in the Senate. We were uniform. Dr. Felix was one, Dr. Menninger and I were the others. We were representing the services advocating sincerely the passage of the National Mental Health Act. We had been through a great deal. I was the chief of psychiatry in the Navy, Dr. Felix in Public Health, and Dr. Menninger in the Army. And we saw the waste of a great many men at a time when the Nation needed them. At that time we had no one to turn to and we had to make a lot of 90-day wonders to care for these men. We were continually worried about what would happen to our patients in the future.

Well, it was the National Mental Health Act which has enabled us to rise to the standards that we have reached today. Through the training of men, through the backing of research, and by reason of the knowledge and the level of the professional treatment that we have attained, we have made our speciality into a much more effective profession.

There was an arrest in the rise of the hospital census beginning. I believe in 1956, and by that time some of the mental illnesses had been conquered, and some others prevented from becoming chronic.

There were courses for general practitioners set up and subsidized in part by the NIMH, and in general there was a more optimistic atmosphere in mental hospitals. Before that it was as if there were a sign on the gate "All ye who enter here leave all hope behind." But when it was seen that the census did not have to continue to rise yearly—this was at the time of the advent of new drugs and various methods of treatment—then people took heart, they were expected to get well, and many of them did get well.

But still there are too many of these institutions which are custodial in nature. The Joint Commission noted that really only 20 percent of the State hospitals were really therapeutic centers. I agree with my colleague, Dr. Ewalt, however (I was on the Commission with him) that this bill is satisfactory the way it is; it is not something to be tampered with by every group which has some special cause in mind. We like the bill the way you have it, gentlemen, it will take early care of the mentally ill.

One has only to go back 30 years and realize what some of these places were and to see what we are correcting. I agree with Dr. Ewalt also in that I wouldn't denigrate my colleagues who ran these hospitals. The public got what it paid for, and many dedicated men stayed at work in them just because they had social consciousness which kept them on the job, they could have done much better outside.

We completed the first phase of our task reasonably well, gentlemen, if you please. And it is time for the next step. We return to you therefore, seeking help for the next phase. Now it is time that many of the community efforts be coordinated and worked out together. These resources are spread out at the present time, and this is wasteful of funds and of personnel. The two bills under consideration here are indeed timely for implementation of the President's plan and in addition to being a further advance toward mental health we are glad to note there is to be a serious attack on mental retardation.

We have mentioned that we would like to bring our patients back to the community. You may say to me, "Well, how did you get out of the community in the first place?" Well, a hundred years ago—and I am not going to regale you with history—when Dorothea Dix started to collect these people from the municipal asylums, which were also alms houses, and from garrets and jails and basements, she thought that if she could get them into the State institutions that being in a larger government institution they would get better care. Well, the people were glad to see them go, and the doctors were glad also, for no one knew what to do about them. But, when they got them out of the State, however, they also were out of mind, the census enlarged, the staff lessened, and we soon had the situation that we are bewailing today.

It is time therefore to bring these patients back to the community to make a start first at preventing illness, then at treating it quickly when it appears because it has been known since the time of Erasmus; that the time to start treatment is early rather than when the illness has already become chronic.

Now, family doctors and physicians in general hospitals are willing to be of help. That was not always so. But it is axiomatic that one can't be ill physically without emotions being involved, and it is just as true that one can't be sick mentally without some physical aspects of the problem manifesting themselves. This relates us solidly to medicine.

The important part of our effort for the future, then, is to render a diagnostic service quickly to treat the patient in the community, not to let him get away for too long where he is forgotten by his family, where the wife gets a job, the children grow up and perhaps become ashamed of him, where no one wants to hire him, and the only place the poor fellow will be comfortable is back in a mental hospital.

We need a center that offers a variety of treatment possibilities, close to general hospitals, but not necessarily adjacent to them. They can also be near private nonprofit institutions or even government facilities.

There are many other aspects of the problem, which will have to be worked out by the State authority which is controlling the program. The fact that private practitioners of medicine are becoming vitally interested in the program delights us. It augurs well for the future. Private mental hospitals are interested—I run one of them. We have 48 full time physicians, many of them in various stages of their training. These new centers should help to put hospital psychiatry in its proper perspective as just one of the elements in treatment and not the only element.

Heretofore, whenever a person showed even one mental symptom, away he would be sent. If he had diabetes and needed regulation, this could be done in the home or in the hospital for a short period. But let a poor fellow have one hallucination or delusion and off he went, and usually his banishment was for a long time.

We have said that these bills are timely. They come at a time when we know what to do for people who are becoming ill. We can be of help to a great many of them. The situation is very much better than we ever suspected it could be at this time. We never thought that we would live to see so much interest in this problem. It was neglected for so long. There is an incentive for people now to accept help earlier. Heretofore they have been fearful that they might be stigmatized. The construction of these centers therefore is likely to lead to closer identification with the townspeople.

In 1955, I told the American Hospital Association that we longed for the day when the community would adopt mental patients and mental hospitals like they did the general hospitals. They are proud of their general hospitals and consider them their own. Not so the mental hospitals—they are outside of the pale.

All the while we are making new improvements, however, we can't forget the people who remain in the State hospitals. There will always have to a be place for people whose illness will take a long time to heal.

There is a pressing need now for followup care and these centers should meet that need. Some patients leave State hospitals, fail to take their medicines, and where there is nobody to care for them, they neglect themselves and gravitate back to the hospital. There is no use of treating patients expertly and then casting them off. Someone must follow them in order to help them maintain what they have gained.

You have been told, gentlemen—though you already knew them very well—the essentials of the requisites of these centers. It is your hope I am sure as it is ours that various types of institutions will collaborate in these new efforts. Inpatients, outpatients, diagnostic centers, day and night hospitals are the essential elements for the centers. One can add to these but without the four elements mentioned the center would not be complete.

There are some roadblocks that will be sure to arise to complicate matters. The question will arise, Is this idea medically and psychiatrically sound? We can say unhesitatingly it is medically and psychiatrically sound. Who is going to pay for it? We are paying for it now, to the tune of about $3 billion. If you don't hold me too closely to it, I will say I believe that the situation in New York is not quite as expensive as was indicated and there are not as many as 130,000 patients. I think there are 100,000 patients, and that includes a number of retarded, too.

The bills for all of this in a State like New York come close to about $300 million. So we are paying for it now. We would like to catch the illnesses early, and put these people back into the community faster. Will we be able to gather together these various isolated center and stop the wastage of personnel? I think so.

I would like to mention one word also in behalf of title II of the bill, which helps to train the doctors and the various types of personnel needed in the centers. Now, with automation, putting people out of work, it ought to be possible for us to retain many of them and to perhaps reduce the personnel shortage which has hampered us for so long.

You have been very good to listen to me and I am appreciative. I would be glad to answer any questions that I am able to answer.

(The statement of Dr. Braceland follows:)

STATEMENT OF DR. FRANCIS J. BRACELAND, M.D., SC. D. ON BEHALF OF THE AMERICAN PSYCHIATRIC ASSOCIATION

I am Francis J. Braceland and I have been a psychiatrist for over 30 years. I graduated from Jefferson Medical College in 1930 and was an intern and chief resident at Jefferson Hospital until November 1932, when I began my psychiatric fellowship training at the old Pennsylvania Hospital in Philadelphia. I was then a Rockefeller Fellow in Psychiatry in Zurich, Switzerland, and at the National Hospital, Queens Square in London. I returned to be clinical director at the Pennsylvania Hospital until 1941 when I was appointed professor of psychiatry and dean of the School of Medicine, Loyola University.

I have since occupied the following positions:

1942–46: Special Assistant to the Surgeon General, U.S. Navy and wartime chief of the psychiatric section. I am a rear admiral, Medical Corps, U.S. Naval Reserve, retired.

1946–51: Head of the section of psychiatry, Mayo Clinic, and professor of psychiatry, Graduate School, University of Minnesota.

1951 until present: Psychiatrist in chief, the Institute of Living, Hartford, Conn., and clinical professor of psychiatry, Yale University. Since 1959, lecturer on psychiatry, Harvard Medical School.

I have been in the past: president, American Board of Psychiatry and Neurology, 1953; president, American Psychiatric Association, 1956–57; president, Association for Research in Nervous and Mental Disease, 1957; chairman, American Medical Association Section on Nervous and Mental Disease, 1956; chairman, National Health Forum, 1958; president, Board of Examiners for Certification of Mental Hospital Superintendents, 1955; vice president, World Psychiatric Association, 1961. I have served as a member of the Advisory Council to the National Institute of Mental Health.

Mr. Chairman and members of the committee, I appear here today as a representative of the American Psychiatric Association and I bring you the respectful greetings of its president, Dr. C. H. Hardin Branch, its officers and its members. In their names I am asked to register approval of House bills H.R. 3688 and H.R. 3689. Our organization, the oldest professional medical society in the Nation, has been accustomed to speak also for legions of patients whom its members have cared for down through the years, during periods when no one else seemed to bother. Therefore to say simply that we approve seems mild and not expressive enough. We feel much more strongly than that. We regard these bills as milestones in the progress of humane and scientific care and treatment of the mentally ill and the mentally retarded.

Before I continue my testimony, there is one observation that I would like to make, even though it might be considered gratuitous. You will hear a great deal of testimony, but none of it, especially mine, will be half so eloquent, so concise, so perceptive or so convincing an endorsement of these bills as the special message of February 5, 1963, from the President of the United States relative to mental illness and mental retardation. I am not dissembling—neither he nor you need encomiums from me—but the message did encompass the whole situation and showed deep understanding of the plight of our patients and the difficulties we have faced in trying to treat them. I shall not try to embellish his message but rather simply to emphasize from a professional standpoint some facts pertinent to these bills.

BACKGROUND

It was 17 years ago that my colleagues and I appeared before this Senate committee to tell of the suffering, the distress and the terrible waste of manpower we had encountered in the military services and which was occasioned by mental and nervous disorders in service personnel in World War II. I remember that we were hesitant about telling the whole story; for we feared that if we did, some might think the problem so vast and overwhelming that they would want to invest in something more hopeful and amenable to treatment. We had just learned the hard way in wartime that a man disabled by mental or emotional disorder was just as much a loss to his country as if he had been seriously wounded. This was not a pleasant bit of knowledge. It was, however, reality. We had learned also that there was precious little that we knew about effective treatment for these sick men and that there were pitifully few of us to carry out what we did know. You responded to the urgent requests of the U.S. Public Health Service, the military, the professional societies, and other citizens by passing the National Mental Health Act, the manifold benefits of which will never be completely estimated. Without this act or something akin to it, the whole problem of mental illness and the care of distressed people in this Nation would have been in chaos for another decade. By means of this legislation we were enabled to train professional and auxiliary personnel; to begin some and to enlarge other research efforts; and in general to raise the knowledge of our profession and the level of treatment of sick and distressed people to their present high planes.

RECENT ADVANCES

Things have moved rapidly since those early days; the situation, while by no means near solution, is markedly better. There has been an arrest in the climb of the State hospital census, despite the Nation's population increase. Some mental illnesses have been conquered. We have attracted to our specialty some bright young men and women from the fields of medicine and nursing, and an aura of hope pervades the whole psychiatric discipline, probably more than ever before in its history. Numerous research projects are underway, and among the people working on them are brilliant scientists from other fields, who have become interested in our problems and in the predicament of our patients. Family doctors have become much more involved in helping to care for emotional problems, for they have realized for some time that a large seg-

ment of their practice is concerned with emotional disorders masked by physical symptoms. To help prepare these physicians and to impart to them some of the knowledge which we have acquired, numerous courses have been set up for them in various parts of the country, subsidized by grants from the National Institute of Mental Health.

Attitudes inside of mental hospitals also have changed; people are now expected to get well, and, encouraged to do so, they are prone to respond. But even with all of the improvement—and it is an accepted fact that mental hospitals have markedly improved—there are still far too many of these institutions which remain custodial in nature. The Joint Commission on Mental Illness and Health notes that only 20 percent of them are real therapeutic centers and implies that, for one reason or another, the others have not taken advantage of new knowledge which is available.

In recounting our advances, I find no need to spend too much time discussing the new drugs—the tranquilizers and the antidepressants. You have heard a great deal about them, I am sure, and you will hear even more about them and their successors in the future, for chemistry and pharmacology will surely continue to contribute more of their leaven—the fruits of their constant research. Actually these drugs have been a godsend and are probably the most important single element in our recent progress.

THE NEXT PHASE

Our appearance here today, therefore, is in one sense a return visit to tell you that a portion of the mission which we set out upon with your blessing and your help 17 years ago has been accomplished, and it is now time for the next move forward. Fortunately, the initial element in that next step is embodied in the two bills which are before us today for consideration. They are the beginnings of the implementations of the President's plan for the relief of mental illness and for a serious attack upon the problems of mental retardation, conditions which have been neglected and problems which are fraught with emotional distress.

HOW WE GOT OUT OF THE COMMUNITY

I know that you have little time to listen to past history, but please let me mention briefly a period in our history when construction of institutions for mental patients was a serious consideration. In the middle of the last century Dorothea Dix was busy importuning legislatures to build State hospitals to care for the patients whom she was laboriously collecting from cellars, garrets, jails, and rundown municipal asylums. She reasoned that the State—a larger segment of government—would provide better care for these patients. The legislatures responded and did build State hospitals—big and strong, and grim and destined to last—and, whatever else they have done, gentlemen, they have lasted and patients are still being cared for in many of them.

The communities were willing, perhaps even glad, to have these patients moved, for neither they nor the doctors knew what to do for distressed, retarded, and ill people. If the patients were quiet and tractable, they were allowed to roam at large in the towns but, if they were not, they were incarcerated—and all too often, when they were incarcerated, they were forgotten. Once these individuals were out of sight and safely stored in hospitals, they were, more often than not, also out of mind. To make matters worse, when this transfer had been accomplished, the citizens voted for economy and, as the State hospital census went up, its staff and personnel ratios went down, with results which are too well known to you to elaborate here. These patients were then, as they are now, the last to benefit in good times and the first to suffer in bad times.

I have no intention, gentlemen, to denigrate the State hospital system. There have been, and are, good ones and bad ones. There is now, and always has been, a large number of men—physicians particularly—with strong social consciences who performed dedicated work in these institutions, often against frustrating odds. Basically, the community has been at fault. We, the citizens, have gotten what we paid for.

NEED FOR RETURN TO THE COMMUNITY

It is time, high time, to change all of these things, however. There is urgent need to bring the patients back to the community. We know much more about them now. We know they can be helped—not all of them unfortunately, but most of them—and that efforts can be made to prevent the illnesses of the others

from becoming chronic. Unhappily, a number of sick people will go on, and will become chronics, despite all efforts to prevent it. Even then, however, there is no need to give up. If time permitted, I would tell you many interesting stories of people who have left chronic disease hospitals and taken their places in the community long after hope that they might do so had been abandoned.

Another thing has happened in the past several decades which indicates that the time is ripe for the return of our mentally ill people to the community. This is the growing rapprochement between psychiatry and medicine. This is an important—in fact, an essential and determining—influence in any change in the direction and location of treatment efforts. To meet the mental health needs of an advancing social order it has become obvious that there must be a sustained cooperative effort to return psychiatric patients to the community medical field. Changes in the practice of medicine, like changes in the practice of psychiatry, have made this possibility much more feasible and workable.

Actually, a large part of medical practice has emotional overtones, and the new interest and willingness of the community doctors to partake actively in the care of mentally ill and retarded patients augurs well for the future of all concerned. It is axiomatic that one cannot be emotionally ill without some physical involvement, and one cannot be physically ill without his emotions being involved, for man is one, whole and entire, and any fragmentation of his treatment is artificial.

It is reasonable for us to visualize an important part of future psychiatric effort to render proper diagnostic service and alleviate emotional distress as being community based. This base should be in a center which offers a variety of treatment possibilities. It could be in a private group practice with necessary facilities, a private mental hospital which had the essentials required to carry out the mission, a general hospital or medical center, or indeed a State or Federal complex which was available and properly staffed and functional.

It has been said frequently in the past that too much dependence has been placed upon hospital phychiatry. This is partially true, but it was often so because of the low frustration tolerance of people in the community. A man might have any type of physical illness and be sure of getting both treatment and understanding in the community. But let there be any hint of mental symptoms, and there would surely be a strong suggestion that he be rapidly hospitalized. Also, it should be mentioned that for a long time hospitalization was all that we had to offer these patients. One accusation that was otfen made was that too large a portion of State hospital budgets had to be spent for maintenance and general care of patients rather than for active treatment. This, unfortunately, was often true. The construction and staffing of the comprehensive community centers should alleviate most of that difficulty, however, and put hospital psychiatry into its proper place as simply one of several possibilities for the care of sick people.

TIMELINESS OF THE BILLS

Nationwide, there is at present a growing appreciation of the need for more community clinics, guidance centers and outpatient as well as inpatient facilities. The provision of these services will be a major factor in the avoidance of long-term hospitalization and the chronicity of mental disorders. For many years psychiatry has emphasized the value of early recognition and early treatment of mental disease. With further public education and with the provision of community facilities such as those we discuss here today, and with early treatment and a variety of treatment facilities in a community center, families will be more inclined to seek help early rather than late.

Despite the fact that some patients with longstanding illnesses are recovering under modern treatment methods, sometimes to the point of social remission, it is really in the early stages of illness that the most effective treatment can be given and there is the best outlook for future stability. The old adage of Erasmus still holds good: "It is better to treat at the beginning than at the end." Brief hospitalization is desirable for many reasons other than economy, and certainly the humanitarian aspects of the early return of a loved one to the family need not be elaborated upon here.

It is reasonable to believe that the construction of these centers in the community will lead to a closer identification of the townspeople with the problem and a much more ready acceptance of responsibility for fellow citizens who become ill. Close proximity to family, family doctor, and to consultants who know the patient will in many instances make unnecessary the expensive duplication of treatment and surgical facilities, and certainly will prevent the dissipation

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of psychiatric effort on medical problems which ought to be handled by other physicians. It is hardly necessary to add, however, that, while all of these new efforts are being made, we will have to keep in mind those patients who remain in State hospitals and not let up in our efforts to restore them to family and job.

As important parts of the comprehensive mental health center, one can readily visualize the value of day and night hospitals. Only when the patient cannot be handled on an outpatient level with the help of day care would it be necessary to restore to 24-hour hospitalization. There is no doubt but that there will be a fair number of these patients; some few will even go on to longer illnesses, but not nearly in the numbers we have been accustomed to expect. The idea is to treat patients early and vigorously and so prevent chronicity.

PRESSING NEED FOR FOLLOWUP CARE

The comprehensive community centers would also be available to patients after discharge from mental hospitals; this is particularly important. In most States the readmission rates of discharged schizophrenic patients presently is 30 to 40 percent, which is much too high. The patient returns home; there is no one to direct him to take his medication; he slips backward a bit and has trouble getting a job; and before long the poor fellow, discouraged, gravitates back to the State hospital. It is the only place where he is comfortable and feels he is being cared for.

The policy of treatment in outpatient departments or of brief hospitalization cannot be expected to pay off unless the patient is able to maintain his gains in the community. It is essential, therefore, that he keep in contact with family and friends and be prepared during his hospitalization for the problems he will meet when he goes out. Equally important is the preparation of the family and community for the patient's return. There is little use in giving the patient the advantages of the best in treatment and rehabilitative procedure if the family or community will not receive him when he recovers. Hence the pressing need for community centers with their variety of inpatient-outpatient care, day centers and rehabilitation facilities, and places within, or near them, where patients can turn for help when they need it.

ESSENTIALS OF COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTERS

The essential components of a comprehensive mental health center would be inpatient and outpatient care, the day hospital, and the diagnostic clinic. No matter what else is available, these elements are necessary. Emergency service could be provided from the clinic through the person's family physician if he has one or through any clinician in practice. It will get the doctors in the community into the act, as it were. It will include them in the care of the mentally ill; they will be able to make rounds in the center and in various parts of it to take care of their patients. Treatment at the moment of crisis often is more effectual than at any time thereafter; it might be crucial and might indeed prevent long-term illness. The psychiatric clinic itself should be made flexible enough to handle emergencies as they arise on a 24-hour basis, and, certainly flexible enough to permit followup care so that the essential doctor-patient relationship may be maintained, even if briefly and intermittently. Many patterns of professional practice will emerge in the establishment of these centers and many events will transpire which will unify and coordinate the community's efforts, which now are widely scattered.

Certainly, the cause which these bills advocate is just and the purpose of these centers praiseworthy. The intent is to furnish an early defense against chronic illness. It is essential that all efforts be made to help restore patients to their families and to their fullest mental, physical, social, and vocational capabilities. We have here an excellent opportunity to utilize skills, which heretofore have been dormant, for the alleviation of conditions which have too long been neglected.

Prevention, mental health consultation, treatment where necessary, and aftercare—these are the essential duties of the personnel of the center. Diagnostic services, day and night hospitalization, 24-hour hospitalization, and transitional aftercare—all are added aids to the solution of the problems which, the President noted, "Occur more frequently, affect more people, require more prolonged treatment, cause more suffering by the families of the afflicted, waste more of our human resources and constitute more of a financial drain upon both

the Public Treasury and the personal finances of the individual families than any other single condition."

SOME POSSIBLE ROADBLOCKS

While mass education, it is devoutly hoped, will finally erase certain misconceptions which hamper progress, that utopian time has not yet arrived. People still have erroneous ideas about mental illness. They tend not to consider as mentally ill a person who shows no violent or bizarre behavior though he may be suffering from a condition which if untreated would lead to disabling chronicity, suicide, or homicide. People do not link up the human tragedies featured daily in the newspaper—premature deaths, suicide, brawls, alcoholism, etc., with emotional disorder. They do think in terms of "fate," or of "crackpots," or "people who should be locked up." All of this is an indication of widespread unwillingness to understand that some of these persons, though not all, are sick.

The emotional set of a segment of the community toward mental illness has deep historical roots. It is still equated by many people with the mysterious and the uncanny and by some with that which is evil and shameful. The logical outcome of this is the thinking by some that mental illness is something of which the patient himself is "guilty." Hence, the tendency to hide mental symptoms and be adjudged "not guilty." Thus, one misses out on hospitalization early, when treatment is most effectual. The antiquated laws on hospitalization and confinement in some parts of the country have done little to improve the situation. These are truths which psychiatrists have contended with for generations but still the lesson has not been learned. All too often precious time is lost before a psychiatric disturbance becomes florid enough to bring action; and damage is done not only to the patient but also to the family, and sometimes to the community.

Therefore, a major job of public education needs to be undertaken if these units are to be used effectively. Once the community understands that effective psychiatric treatments have been developed and that they are most effectual if applied early, this stumbling block should be eliminated. With general acceptance will come community interest and participation, which are the basic ingredients of social progress.

One thing will have to be made clear and spread broadcast. The mere building and operation of a comprehensive mental health center will not eliminate mental disease in the community. Nor will the mental hospitals empty out quickly. There has always been mental disease and as far as can be determined now, there always will be. The feasibility of reducing the present patient load in State hospitals, however, is not a figment of the imagination. It probably can be done within a decade. Early treatment in the community with an emphasis on rehabilitation will materially cut down the State hospital admission rates. Aftercare in community clinics will materially reduce readmissions. Halfway houses, day centers, nursing homes for older patients—all of these outlets for sick people who do not require intense supervision—will help to reduce the census of these institutions. Added to this there is the undoubted fact that a number of chronic patients who have been hospitalized for long periods do get well, whether under some particular drug or activation program. This is a most encouraging prospect.

A problem will probably arise in attempting to coordinate the various isolated services in communities and bring them under one aegis in order that they be able to function more efficiently. While some reluctance to give up long-held privilege and to work in close cooperation with other groups will be encountered, this difficulty should be gradually overcome. Some differences will probably never be bridged, but they will be taken care of by time and attrition. All of this indicates the necessity for laying down ground rules early in the planning of the comprehensive centers and thus forestalling many problems before they disrupt a much-needed addition to the fight against mental illness.

Questions will be asked regarding these centers. Is the concept medically sound? The answer to that question can be given without hesitation. The concept is not only medically and psychiatrically sound but it is a highly desirable step forward which in the long run will mark a great advance in treatment. It is simply the advocacy of a change in the locus of treatment, a change in the right direction and one which will prevent a patient from being alienated from his family.

The next question has already been asked: "Who is going to pay for all of this?" The answer is that we already are paying—according to the President's message—$2.4 billion a year in direct public outlays for service; about $1.8 billion for mental illness and $600 million for mental retardation. This is exclusive of the many indirect costs in anguish, wastage, etc.; the cost of these factors cannot be estimated. Here again will be a change of locus of payment and in this change I believe a much better chance of preventing long-term illness. I do not pose as an economist and my financial prognostic ability leaves much to be desired, but in my judgment this cannot prove to be a costly mistake. People are going to need treatment and if they can get it early and in the community they not only have a better chance of recovery but they also have a better chance of paying for service either individually or by means of one of the various insurance plans which must surely and hopefully become interested in these worthwhile efforts.

You will notice that I have confined most of my testimony to the cause of the mentally ill, the field which has occupied me most in my professional career. Nonetheless, I would like to espouse the cause of the mentally retarded most heartily. This group has long been neglected, and it is with all sincerity that the members of the American Psychiatric Association endorse legislation which will react to the benefit of this group.

There has been a conspiracy of silence regarding both of these afflictions. This silence has been due to misunderstanding and fear. Behind the jokes about these patients and the cartoons about psychiatrists there is wonderment and dread. These sick people are not a race apart, they are—under certain circumstances—you and I, and they and their families cry out for help. You have in your power to make the initial step toward giving that help by passing these bills.

Mr. ROBERTS. Doctor, I was just remarking to one of my colleagues that we on this subcommittee feel that we are highly privileged to have men of your caliber and your training and experience to come and tell the story of this problem.

We appreciate the fact that you gentlemen are important people in the Nation and in your community, and that you take time from your busy lives to come to Washington and try to help us work out what we believe to be very useful legislation.

I just want to say that you and the other witnesses today have the thanks of our subcommittee.

I haven't any questions except that I would like to congratulate you on a fine statement.

Dr. BRACELAND. Thank you, sir.

Mr. ROBERTS. The gentlemen from New York.

Mr. O'BRIEN. Just one question.

I take it, Doctor, that you feel that in New York if we take the $300 million cost figure—I don't know how exact that is, it might be $400 million—that we have an opportunity through these bills to reinvest a substantial part of that in a way that would do us more good, is that correct?

Dr. BRACELAND. Yes, Mr. Congressman.

And I think you have had a little sample of it already. I think that in one or two places you have tested two or three wards which would imitate what we are trying to do to see whether it would work, and it not only works and the patients get out much quicker, but it influences the rest of the hospital, and the ward upstairs will say, well, they are no better than we are, and it lifts up the tone and the morale of the whole institution.

I think you have been sampling a little bit of your own up there and have proven that this will work.

Mr. O'BRIEN. Thank you.

Mr. ROBERTS. The gentlemen from Minnesota.

Mr. NELSEN. I was curious, years ago in Minnesota I think an operation was performed, called lobotomy.

Dr. BRACELAND. Yes.

Mr. NELSEN. Is that still practiced to any degree?

Dr. BRACELAND. No, not to any degree, Mr. Nelsen, because once you cut those fibers in the brain you can't tie them together with pink ribbons.

Now, it happens occasionally in one or two types of illness, but very, very rarely, and we are reluctant to do it.

I may have said this earlier, Mr. Nelsen, but I am getting along in years and as my body gets shorter my anecdotes get longer—I was chairman of that committee of Governor Youngdahl's advisory——

Mr. NELSEN. I was in the legislature at that time.

Dr. BRACELAND (continuing). And I remember we had a great deal to do about all this.

Mr. NELSEN. Another point I would like to touch on, I think we all recognize, and I think all the committees have recognized, that the main impetus comes from the States.

This bill which is intended to provide that incentive to get things moving, in your judgment, does this protect adequately so that we don't lean too much on the Federal Government in the future, but it starts our States moving, and then we will do a better job?

Do you think there is adequate protection in this bill to guard against the possibility that too much will be expected from the Federal Government on a long-range basis in the future?

Dr. BRACELAND. I think that the committee has it nicely built into the bill.

There is a certain percentage for the construction, and only a certain time allotted for helping with the staffing.

And I think also that it has been proven, because I am afraid to have to tell you, I have been coming down for a number of years looking for funds for the NIMH—this money seeds the States, the States now have come out so much further than we ever thought they would, and the seed money has come from the seed money that has been put in.

And I think it is well protected.

Mr. NELSEN. Thank you.

Mr. ROBERTS. Thank you again, Doctor.

Our next witness is Dr. James Tramonti, of the American Optometric Association, Providence, R.I.

STATEMENT OF DR. JAMES TRAMONTI, AMERICAN OPTOMETRIC ASSOCIATION, PROVIDENCE, R.I.

Dr. TRAMONTI. Mr. Chairman, and members of the committee, my name is James Tramonti. I am an optometrist practicing my profession in Providence, R.I., having been licensed in that State in 1949.

My preoptometry education was obtained at the University of Rhode Island and my professional degree in optometry was earned at the Illinois College of Optometry.

I am a member of the Americn Optometric Association; past president and member of the Rhode Island Optometric Association; former

representative of the State of Rhode Island to the New England Council of Optometrists; chairman of the committee on visual problems of children and youth of that council; consultant to the office of Medical Service, Division of Public Assistance, Rhode Island State Department of Social Welfare since 1952; optometric consultant, Meeting Street School, Children's Rehabilitation Center, Providence, R.I.; consultant in preparation of a book by Eric Denhoff, M.D., and Isabel Robinault, Ph. D., "Cerebral Palsy and Related Disorders." Quite a task; it took about 3 or 4 years to turn out, and I have it here today, and it is a book on the developmental approach to dysfunction.

I was a staff member, outpatient eye clinic, Rhode Island Hospital, 1955–58; participated in pilot research studies at Meeting Street School, Children's Rehabilitation Center, Providence, R.I., and Bradley Hospital; Children's Neuropsychiatric Hospital, Riverside, R.I.; and am to participate in a research study on reading retardation, Child Study Center, to be conducted by the Ohio State University.

You notice I have used the word "habilitation" here rather than the word we have heard so much, "rehabilitation."

Our association is vitally interested in the two bills being considered by this committee: one H.R. 3688 to provide for assistance in the construction and initial operation of community health centers; and the other, H.R. 3689, to assist States in combating mental retardation through construction of research centers and facilities for the mentally retarded.

Our association, which includes optometrists in all 50 States and the District of Columbia, has 3 committees dealing with this area of optometric practice.

One is the committee on visual problems of children and youth, another is the committee on vision care of the aged, and the third is the committee on vision aid to the blind.

It also publishes a monthly journal which contains articles of interest to members of our profession.

The February 1963 issue contains five articles directly bearing on vision and the mentally retarded child. It was my privilege to be the author of one of these articles.

It might serve a useful purpose if these articles were included in the record of the hearings.

Accordingly, I have taken the liberty of obtaining copies of them which I trust the committee will see fit to incorporate in the record.

With your permission, sir, I would like to submit these for the record.

(The articles referred to follows:)

VISUAL PERCEPTUAL TRAINING AND THE RETARDED SCHOOL ACHIEVER

(James Tramonti, O.D.)

"Close your eyes. Pretend that you are standing across the street from your house. With your eyes closed pretend you are looking at your house. Can you tell me what your house looks like? Can you describe it to me?"

This is what you may hear in our training room during one of the early visual perceptual training sessions with a nonachieving child. He is learning to learn, and he is learning to see with his eyes closed.

There are a diversity of reasons for low school achievement and failure. The outstanding cause is intellectual subnormality. Visual, hearing, emotional, and environmental problems are some of the many additional contributing factors.

There are a great number of children with normal potential who are not achieving at school. These youngsters are sometimes referred to as "psuedo-retarded." They may score as low as 2 years below their chronological age on standardized tests. In contrast to the true retarded which include the trainable with I.Q.'s of 25 to 49 and the educable with 50 to 69 I.Q.'s, these children are capable of average school achievement and often have a potential to perform above the average.

The greater number of referred cases come from pediatricians, pediatric neurologists, pediatric psychiatrists, psychologists, and psychiatrists. The patients have usually been through medical, neurological, electroencephalogram (EEG), and psychological evaluation. The basic reasons for consulting with any of the above professions is parent or school complaints of one or more, and usually more, of the following: poor reader or inability to learn to read; poor concentration; low comprehension; inability to sit still; assigned written work never completed; poor or "sloppy" handwriting; "immaturity"; reversals in reading and writing; and inability to handle number facts or arithmetic.

Seldom have we found both reading and numbers to be a severe problem with this type of child patient. Sometimes the only evidence of a problem in the total work-up is a form perception problem; there may be only subtle neurological signs.

The earlier the child is seen, the more complete and positive diagnosis can be made; neurological and other findings do change with maturity. We want to emphasize the importance of knowing the child in order to understand his learning problem. To the inexperienced, the child is physically and mentally normal and he may have excellent verbal ability; but he is a school failure because he is not able to learn.

MEASURING IMPROVEMENT

It is not unusual after a few visual training sessions to learn of drastic improvement in school performance. The only criteria we use for determining a child's school progress resulting from visual perceptual training are school report cards and parent-teacher comments.

Regardless of the patient's advancement in the training room, there is really no progress unless the training is transferred to learning. The child has been referred because of the learning problem and unless the benefits of visual perceptual training affect this end, we have accomplished little.

What about IQ? Is the measurable increase or decrease of IQ after training a reliable means of determining success or failure of training? A longitudinal study, "Mental Growth and Personality Development" by Lester W. Sontoag, and others of the Fel Research Institute of Antioch College, notes that "* * * significant changes in intelligence quotients (IQ) do occur among many children who have been documented by data from nearly every research organization using longitudinal techniques * * * wide changes in IQ can and do occur in children of various ages * * * not only does the amount of change in IQ differ from individuals to individuals but also the ages that changes occur differ in individual cases * * * acceleration and deceleration rates of mental growth do not appear to be related to any specific areas of abilities as measured by the differences in performance on different types of items found in the Stanford Binet."

The above study, in one extreme case, found a 57.6 IQ increase in one child from age 3 to age 11 years and in another case a decrease of 32 points from age 3 to age 8 years. All children in this study started with normal IQ's. These observations and findings make two important points: The unreliability of basing prognosis of training on a single intelligence test and an increase in IQ after visual training does not necessarily mean that the visual training increased the child's IQ.

DETECTING BRAIN DYSFUNCTION

If a child's IQ is on the increase at the time of visual training, then, regardless of the training, the child will show an increase on retest. This is called a change factor. Another consideration is that a nonachiever, based on an organic factor, scores low on performance parts of tests. A difference of 10 points or more on the Wechsler intelligence scale for children (WISC) between a higher mean verbal subtest score and a lower mean performance subtest score is particularly helpful in detecting the brain dysfunction profile.

The detection of cerebral dysfunction by means of the formula verbal-higher-than-performance can be extended to younger and younger children. For exam-

ple, the 7-year-old child of average mental age can be expected to reproduce a diamond on the Revised Stanford Binet (year VII) correctly. The functionally retarded or immature child draws the diamond more like a square (year V) tilted sideways. The sides are not in the correct proportion for a diamond shape, but there is no evident distortion. By comparison, the brain-injured child draws the diamond with "rabbit ears." He is uncertain of the direction of the lines, and must reverse his direction to complete the figure. This type of performance has been shown to be diagnostic of brain damage (particularly of the occipital-parietal region as confirmed by localized EEG abnormalities) even in children who have no apparent physical disability.

If the performance abilities in these children increase, school performance increases. Clinical experience has shown that if a child is able to compensate for this low performance ability, school performance can increase in spite of the low performance score on tests. Our best reliability, therefore, is actual school achievement. When a parent requests a report on progress during the visual perceptual training period, we do not discuss training progress, instead we discuss school progress.

WORKING WITH WHAT IS AVAILABLE

The true retardate has very limited capacities. From an optometric point, we have found that a high degree of hyperopia is common among the mentally retarded. There are many cases where parents are completely unaware of a retardation problem until the child enters school. Parents sometimes refuse to accept an early diagnosis of mental retardation because at an early age the child's intellect may not be in sharp contrast with other children of the same age. But, as years pass, the gap widens and the child's chronological age goes on while his intellect remains the same or improves little.

Mental retardation may be the result of primary factors such as heredity, genetic, or endogenous, or secondary factors such as organic or exogenous during the perinatal period or later. It is essential that optometrists have competent medical-psychological diagnosis before starting any type of visual perceptual training on mentally retarded patients. We can only work with what we have: If brain cells are not present or not able to function, we cannot create new cells. Visual perceptual training may be an effective means in helping to improve IQ's and performance levels but it cannot generate brain tissue.

THE AFTER IMAGE PROCEDURE

Optometrists know that there is no one, two, three procedure in visual training. Training begins where the child is able to perform. The following procedures, therefore, are not done in the order presented, with the exception of the first procedure, which we usually do first, if possible.

To begin we try to make the child aware of his visual apparatus by demonstrating its function on a conscious and subconscious level. The child sits a few feet from a screen upon which the Ginger Bread Boy, or any similar picture of the Keystone Familiar Forms slides, is projected. He is instructed to fixate on the nose or on one of the buttons of the Ginger Bread Boy. After a few seconds, the projector is turned off and the child is instructed to continue to look at the same exact spot. We then ask him what he sees.

The important point in the demonstration of after image is to have the child explain how it happens. A common response is "I see it with my eyes." The conversation between the child and the examiner may be something like this: "Do you ever dream?" "Yes." "Are your eyes open when you dream?" "No." "Do you see in your dreams?" "Yes." "How can you see in your dreams if your eyes are closed and you tell me we see with our eyes?" At this point there is generally some hesitation. "Where do the things come from that you see if your eyes are closed?" More hesitation.

We now go on to another train of thought. "Have you ever missed seeing something when your eyes were open and you were looking straight at the object you missed seeing?" "Yes." "How can you miss seeing something if your eyes are open and you were looking at it?" Usually the child has no answer. "Well, then, it seems that sometimes you see when your eyes are closed, like in your dreams, and sometimes you do not see even though your eyes are opened."

On the other hand, children who were medically diagnosed as emotionally disturbed or anxious were not classified as having a perceptual problem. In the entire group demonstrating perceptual problems, there were nine with ocular motility problems. In the group demonstrating no perceptual problems, only two

had ocular motility involvements. All the children in the study had learning difficulties.

The neurologically handicapped group had many more ocular motility problems than the nonneurologically handicapped. Clinical observation over the last 8 years has uncovered many more ocular motility problems in children with neurological problems, and the more severe the neurological difficulty the more severe the disturbance in ocular motility. Besides the motility problem there may be sensory disorders of position and feel in hand function.

A technique blending laterality with mental imagery is the tic-tac-toe perception slides of the Keystone series. Practically every child knows the game tic-tac-toe. The No. 1 slide in this group has one circle or a cross in one of the nine spaces of the tic-tac-toe form. The No. 2 slide is so marked with two places and Nos. 3 and 4 have three places.

The child is first asked if he knows the game. We next ask him to tell us how the tic-tac-toe form is made and how many spaces the form makes. In order for the child to reply to these questions correctly, he must first have a mental picture of the form.

If the answers are correct, we make him conscious of the fact that he had to see this in his mind first. It is surprising how many children cannot tell the number of spaces within the form even though they can tell you that the form is made by intersecting two horizontal lines and two vertical lines.

In some instances, the child may know the game but cannot draw the form. We then project one of the forms. The child is orientated to the nine spaces running in groups of three in any direction: right, left, up, down.

Let us say, for instance, that the form projected upon the screen has a cross in the upper left corner. We say to the child "If I were not able to see this at all, would you be able to tell me exactly where the cross is so that I shall know exactly where it is without having to look at it?" The answers usually are like this: "In that one," "in the first square," or "on that side." There is usually no responses as to left or right, etc.

This is a summation as to the type of conversation that takes place with the child. The discussion is often carried over into succeeding training sessions. Most of the time it takes more than one exposure for the child to get the after image; we may have to work with it several times.

We have worked with children with whom after images were impossible. Progress is not good with these patients.

When the after image response and its explanation by the child is satisfactory, it is repeated at least one more time at another session in order to know if the child really understands. We do not proceed to other training procedures until we get a fairly good understanding of eyes/brain/vision concept. It is possible to work this on 5-year-olds. This is perception; without it there is no learning.

The first paragraph of this paper includes the type of conversation which takes place during our after image sessions. We may use this technique many ways. We have the child write his name or some letters or numbers on paper with his eyes closed. The tactual-kinesthetic clue will have little meaning without mental imagery.

When a child cannot at first achieve an after image, we try greater light intensity such as with the Beilschowsky after image tester for anomalous correspondence. Most children have experienced an after image from a camera flash bulb, but this is meaningless to him. In training procedures, wherever possible, we stress the "mental picture" or "brain picture"—we endeavor to bring to the child patient what vision is and what it does for him.

With some children the after image is not possible because fixation is so poor; in such cases, it becomes necessary to work in areas of ocular motility and fixation before working with after image.

READING TRAINING TECHNIQUES

Many poor readers do very well in spelling because of rote memory. Good spelling sometimes puzzles parents of nonreaders. If they know how to spell the words, why can't they read them, parents reason. We have seen children who spell every word in a book before they can say it. Many mentally retarded children have excellent memory for events or places but no learning or reasoning ability. We know retarded children who can recall every gift and from whom they received it for the last 3 years. This is not the same memory one uses in learning. Yet, parents ask "If he can remember these things, why can't he remember what he is taught?"

One reading training technique is to show the child patient a picture of a cow and ask him what it is. Then ask how he knew it was a cow and discuss the experience of seeing a cow and how he may have learned about cows.

After the discussion show him the word "cow" and ask what it is. You will have to know, of course, what words the child does know before doing this. Tie together the fact that the picture of the cow and the word "cow" denote the same thing and it will begin to relate the same information to him. Words are pictures; they represent things and places. They tell things. Talk about the alphabet and its 26 letters and how these letters arranged in a certain way gives a picture.

This is a very basic step with the nonreader or the poor reader; we know that phonics and language skills will later be necessary. It is not a matter of sight reading versus phonics; we do not believe that there is such a thing as one against the other. Optometrists, above all others, know that sight-sound-speech-touch blend as a totality. Children with learning problems have not been able to learn by conventional methods, with tutorial help, or even in special school classes. The same material presented in a different form, a new experience, a new input, will sometimes be the difference between success or failure. An investigation of the most common basic words will show you that, in most instances, these words have to be learned as sight words.

The child advances to a home program with Dolch Flash Cards. We have used these for years with excellent results. The parent—if the child can work with one of the parents—is instructed to use the cards 6 to 12 times each day for very short periods of time: 2 to 10 minutes at most depending upon the case.

The pack is sometimes kept in the office and only a few cards at a time are given to the child, five or six to start out. With the whole deck, the child sometimes gets discouraged just looking at the task he has ahead.

When the child is well on his way to knowning most of the words, the cards are presented to him upside down. This is difficult if the child has a problem in laterality, a situation often found in the neurological learning problem child. It requires considerable spacial orientation. Crossed hand/eye dominance is usually associated with laterality problems.

HAND/EYE COORDINATION TRAINING

Children as old as 10 years of age are often unable to tell their right from their left. Without question, the incidence of crossed hand/eye dominance in learning problems is extremely high. Occasionally, a child is found where the sole outward sign is crossed hand/eye dominance.

Alternating hand/eye coordination training is an effective procedure. There is no need to go into the numerous methods one can use for this training. We still prefer the old alternating illumination teletrainer technique. We hear and read much about keeping training patients away from instrumentation and train instead in a natural environment. But, these childen have been unable to learn in their natural environment. An instrument confines them to the task at hand which is sometimes very necessary for a child not able to concentrate.

Many children are very gadget conscious. Parents often tell of the child's curiosity and how he likes to tinker with things; this is another observation by parents which confuse them more with the total problem.

What parents interpret as a quest for knowledge or mechanical aptitude is generally meaningless playing; the child pokes and pulls things apart, and this is it.

Case history alone will often pick out the hyperkinetic child in need of medication. He flits from thing to thing, never stays quiet, never sits still, and can't concentrate long enough on any one thing to be able to complete a task. He is distracted by his surroundings. With an instrument he is excluded from his surroundings; the very workings of the device will often fascinate him sufficiently to stick with it.

Here again we speak with the child. We tell him that without exact fixations upon a target, pointing is impossible and we demonstrate. Hand control of the instrument rather than mechanical operation is most often necessary at first to slow down the procedure for step by step performance.

Keystone Movie Cards and the AN number star cards are the ones we prefer Two different colored pointers are used. The child knows in which hand he has each color. If his right hand holds the red pointer, he has to point with the right hand when he sees the red pointer, etc. The room is not in complete darkness; there is enough light so that he can see the cards in the instrument. We

explain that the light, when it's on, is a signal to the eye which signals the brain which signals the hand. We tell him his vision is at work, not his hands.

There are some children that cannot accomplish this task unless reinforced with auditory signals. Each time the light flashes on, we say "point" in a loud voice. After a few trials, we stop and have the patient continue without auditory signals. We often find it necessary to go back to the auditory phase until the youngster slowly begins to perform without the extra sense.

Ocular motility problems are sometimes severe. Even after a child is released from training, ocular motility skills may be subnormal.

BLENDING LATERALITY

In a visual perceptual pilot study of 41 children, we noted that the 11 spastic hemiplegics in the study were all (100 percent) classified as having visual perceptual problems. The majority of the hyperkinetic nonphysically handicapped children were likewise classified as having visual perceptual problems (87 percent).

Here again, considerable talking with the child is necessary. We discuss his relationship with the room in which we are working and his position in relation to the screen. We talk about direction. This is not as simple as it sounds, not with this type of child. When we reach the point that one place within the form can be fairly well localized, we go on to two places, and, finally, to three. All responses are oral.

The Keystone View Co. has a form upon which only the crosses and circles in the form have to be reproduced. Oral responses have been more effective for us. Flash the form; the child has to get the mental image; he then gives the oral response as "cross-top-right," "circle-bottom-left."

Each time the form is presented the child has to reorientate his space in relation to himself. The cause of the laterality problem is not known; what we see in the child's performance is the outward signs and results of the difficulty. These are revealed as poor writing primarily and associated reading problems.

THE DIGIT SPAN

Problems in laterality are also picked up in digit span. The child may always write from right to left or reverse the order of numbers. Digit span will manifest perseveration, the inability to change from one task or performance to another.

Perseveration of digit span will look something like this: Numbers flashed 24-68-98-64-70; numbers recorded 24-64-94-94-74 (in this example the digit 4 is perseverated). Imagine the difficulty when this chald perseverates while reading.

If the child's limit is two-digit span, we flash two digit numbers in rapid succession so that as the child orally responds to one number he is perceiving another. If 68-94-20 are flashed in succession, the child perceives the 94 as he recalls the 68 and recalls the 94 as he perceives the 20. Input and output must be well coordinated for performance at this level.

We use the same procedure using words and eventually phrases when the child is able to get to this level of reading. Some investigators of brain-injured children have reported that these children have poor association ideas and ability. We have not found this to be true many times. In word-flash recognition training, we have observed the following: With flashed words "grass," "sheep," "party," "mother," and the child responded "green," "lamb," "birthday," "father."

OPTOMETRY'S ROLE

The variations and problems are multiple in working with the nonachiever. Emotional situations are many. A mentally retarded child with very limited intellect does not realize his inabilities. Supply his basic needs, proper medical care, and love him and he'll love back.

The nonachiever with normal intellect, however, is well aware of his inabilities and learns about these quickly when he gets to school. Acting-out behavior and emotional problems soon work into the total problem.

If the hyperkinetic syndrome is present then medication is as necessary as any treatment or training; usually, without it, other treatment is of no value. It is almost a standard rule that if a child presents one problem or abnormality, look for others.

Optometry can play an important part in this total field, but this requires constant investigation, study and education of the practitioner, which in turn will earn respect from allied fields. We must continue to work with others who may not be completely aware of optometry's usefulness in the complex field of mental retardation and general nonachievement.

The Philosophy of Developmental Vision

(By Jerome Rosner, O.D.[1])

The purpose of this paper is to supply the reader with a general background survey of the works pertinent to the field of developmental vision. It is not our intent to treat the subject fully; this is too vast a project. Rather, we shall attempt to present the essence of the philosophy and sources of reference with the hope that some may be enticed into further investigation.

THE TERM, DEVELOPMENTAL VISION

The term "vision" does not imply "visual acuity," which is but a part of the total process we term "vision." Vision, in this paper, then, refers to that ability of the organism (individual) to receive a light stimulus, integrate that stimulus with other sensory stimuli that are concurrently being received and, with previous experiences, interpret the stimulus and be capable of responding to it (intellectually, physically, and/or emotionally) in a satisfactory manner.

The term "developmental" obviously infers that a growth pattern or learning sequence can be noted. Such is the case. The newborn infant is incapable of utilizing his visual mechanism in any but the least efficient manner. He arrives, in most instances, with the equipment more or less intact. His task then is to proceed through innumerable experiences that enable him to develop an adequately functioning visual system—one that will provide him with the ability to respond to the constant demands of his environment and culture.

It must be acknowledged that a finished product—a completely developed organization—is never achieved. Rather, new adaptations and reorganizations are constantly occurring as long as there is life.

PIAGET'S CONTRIBUTIONS

Origin of the subject of developmental vision extends in the literature back to the 19th century. Seguin's contribution, "Idiocy and Its Treatment by the Physiological Method," can be read with interest today, albeit its publication date of 1846. Also, the works of Maria Montessori, the famous physician and educator of 60 years ago, are still pertinent.

For the sake of organization in this presentation, however, we shall commence with the work of Jean Piaget and Arnold Gesell. Although they belong to different disciplines, there is an amazing correlation between their work as it pertains to the subject. Their contributions form the foundation of all that follows, their insights were phenomenal, notwithstanding the obvious fact that their accomplishments were based upon those that preceded them.

Piaget's contribution can be traced mainly to four sources: (1) Piaget's "The Origins of Intelligence in Children" (1936); (2) Piaget's "The Construction of Reality in the Child" (1937); (3) Piaget's "The Psychology of Intelligences" (1947); and (4) Hans Aebli's "The Development of Intelligence in the Child" (1950), the last a summary of the works of J. Piaget published between 1936–48.

Piaget states that "perception is influenced by motor activity from the outset, just as the latter is by the former." Distinguishing the two as separate activities (i.e., sensory stimuli and motor responses) is fallacious; and hence, he prefers to refer to a "sensory-motor" phenomenon. Piaget divides the development of sensory-motor intelligence into six stages that commence during the first 18 months of a child's life.

PIAGET'S SIX STAGES OF DEVELOPMENT

Stage I—"Exercise of the reflexes" (1st month): At birth, the child possesses a series of reflexes from which all behavior derives a continuous process of dif-

[1] Member, Advisory Council for Mentally Disturbed Children, United Mental Health Service, Allegheny County, Pa.

ferentiation and integration (e.g., sucking, grasping, etc.)." "Behavior," states Piaget, is "a life process that tends to maintain a state of equilibrium between the subject and environment."

Stage II—"First acquired adaptations and primary circular reactions" (2d to 4th months) : This implies "the formation of new patterns of behavior as a result of experience" and can be summarized as one wherein the activity patterns "consist in researches which derive from reflex activity and which still lack any intentionality, but lead to new results of which only the discovery is fortuitious, their conversation being due to an adapted mechanism of combined assimilation and accommodation" (i.e., an interaction of environment and organism).

Stage III—"Secondary circular reactions and procedures aimed at maintaining interesting spectacles" (4th to 5th months) : This level "begins with the coordination of vision and prehension; new behavior appears which represents a transition between simple habit and intelligence."

Stage IV—"Coordination of secondary patterns and their application to new situations" (5th to 12th months) : Briefly stated, "the fourth stage is characterized by the beginning of coordination of the activities between the various sensory schemata * * * there are no inventions or discoveries of new means, but simply applications of known means to unforeseen circumstances. During this stage, feedback circuits commence to become efficient; constancy of form and size develop. The child now recognizes a square even though its position is such that in perspective it looks like a rhomboid."

Stage V—"Tertiary circular reactions and discovery of new means by active experimentation" (1 to 2 years) : During the previous stage, the child produced the same result repeatedly. During the fifth stage "he experiments to see how he can vary this result so that repeated tries will be interesting and sufficiently different to avoid satiation."

Stage VI—"Invention of new means by mental combination" (2 to 8 years) : This stage "commences with the appearance of interiorized actions which, on the one hand, are at the basis of symbolic function, which, in turn, makes possible the acquisition of symbolic systems, such as language * * * by relation to his body-schema he can perceive movement which cannot be directly seen. He develops a mental space structure and spatial representations of perspective."

Piaget concludes that the sixth stage "marks the completion of the development of sensory-motor intelligence." In his argument with Gestalt theory, he states that "it is impossible not to see in the behavior of an infant at this sixth stage the end result of all the development characterizing the previous five levels."

It will serve no purpose to go further into Piaget's work at this point. Our intent in restating (in extremely condensed fashion) the early development of the child, as described by Piaget, was to illustrate the importance this researcher places upon the ever elaborating sensory-motor coordinative processes that occur during the first 2 years of life. From his study, we can readily observe the child structuring space of ever increasing complexity and concurrently, developing an adequate self-awareness. Conceptual development is, of course, dependent upon this foundation.

CONTRIBUTIONS OF GESELL

Two important works are credited to Arnold Gesell and his staff. These are "Infant Development" (the embryology of human behavior) and "Vision—Its Development in Infant and Child."

In the latter, we find such statements as "the development of human vision must be pictured as a growing complex of structured functions which change with the advancing morphogenesis of the action system." Vision must be thought of "as an act which is mediated by eye and brain, but which emanates from a growing action system.* * * Vision is a complex sensory-motor response to a light stimulus mediated by the eyes, but involving the entire action system."

Gesell presents, from studies conducted at Yale Clinic of Child Development, the visual developmental stages, as they occur in prenatal and postnatal life—up to the age of 10. He coins the phrase "developmental optics" and states that it "is concerned with the ontogenesis and the organization of visual functions in ther dynamic relations to the total action system."

As did Piaget, Gesell places emphasis upon the importance of the motor basis of visual perception. He states that "the growth of the visual functions must be interpreted in terms of a basic motor maturation" * * * the patterns of

visual behavior are configured by pervasive muscular determiners—not only by the oculomotor activators, but by the total postural mechanism and orientation."

GESELL'S THREE COMPONENTS OF VISION

Built upon a motor base, Gesell delineates the three functional components of vision. These are interdependent fields, developing conjointly but not uniformly. He terms them: (1) skeletal—"the visual system seeks and holds the image"; (2) visceral—"the visual system discriminates and defines an image"; and (3) cortical—"the visual system unifies and interprets the image."

"By image" says Gesell, "is meant any effective optical stimulus or optical cue. The visual reaction thereto results in ascending degrees and modes of attention, identification, localization, apperception, and mental synthesis."

Gesell attempts to describe the visual development of the growing child by "observing the child's patterns of ocular and postural behavior in their manifold interaction." The first 18 months of life are divided into 6 quarter-year periods, with the first month being treated separately. It is striking to note the similarity in the observations to Piaget's work—although the different approach.

This study, of course, is more concerned with the visual apparatus, per se, than was Piaget. Gesell offers us, in this work, a means of observing and evaluating the stages of development as presented by Piaget. Therein lies one of its great values to optometry. A test sequence was standardized for the age groups from 21 months to 5 years and a more complex sequence for those from ages 5 to 10.

The results of the study were organized, and it was noted that the development of this total process termed "vision" could be observed and compared at its various levels.

Maldevelopment, and its effect upon the spatial organization of vision, was also studied and found significant. Mentioned briefly, but of extreme importance, is the concept that therapy (such as training) could be effective in aiding proper visual development. The magnitude and importance of this study is not, even today, fully appreciated. In the interest of brevity, we have omitted many of the important facets of this work.

THE STRAUSS-KEPHART CONCEPT

In the past decade, there has emerged the concept of utilizing the philosophy as presented by Gesell and Piaget in the treatment of improperly developed visual abilities.

The work of Strauss, Lehtinen, and Kephart on the "Psychopathology and Education of the Brain Injured Child" must be mentioned. Volume I of this series was published in 1947. It stressed the Gestalt concept of perception. The authors suggested motor activity for the child, but basically as a means of inhibiting distractability.

Volume II, published in 1955 with N. C. Kephart as coauthor, reflects a new concept: "When we speak of the embryological development of the organism we must continually bear in mind that we are speaking of the development of this organism as a whole. We may single out certain parts and trace their specific development for the purpose of making our analysis easier. We must not forget in this process, however, that we have artificially abstracted this part from its whole. In the development of any organism, the parts subserve the whole and we cannot correctly think of the parts except in their relationship to the whole.

"When we trace the development of a part, as the nervous system, we must not allow ourselves to consider that what we observe of its development exists alone. Rather, we must at all times remember that this particular development which we are observing has only the purpose of contributing toward the whole, and its development will be modified and altered to serve the demands of the whole of which it is a part. * * * What is true of the skeletal and muscular development of the organism is likewise true of its nervous and mental development.

"There is an intimate interrelationship of parts by which changes in one are reflected in changes in all the others. Not only are the parts themselves smaller wholes in which elements combine, but the total organism is an organization of organizations. At every point the characteristics of the whole determine the characteristics of the parts as the parts in turn contribute to the development of the whole. It is this whole and the relationships of parts thereto which determines the course of development. This fact is at one and the same time a disadvantage and an advantage in our attempts to deal with an impaired organism.

On the one hand our task is more complicated since we must deal not alone with one missing part and its particular function but must deal with the effect of this missing part upon all the other parts.

"On the other hand, it is probably only this interrelationship of parts which allows us to overcome the effect of a damage by restructuring, through training, the functions of other parts so that the net effect upon the whole of a damage to one is minimized. We can in effect reshuffle the parts by changing the demands upon the organism so that a reintegration takes place."

The brilliant chapter (VIII) by Laura E. Lehtinen is overwhelming in its potential when applied to all children—not just the brain-injured.

In 1960, Kephart's "Slow Learner in the Classroom" was published. It reflected the broadening in his thinking since the publication of "The Brain Injured Child." In the newer study, Kephart describes the development of perception and spatial concepts in the child. We read statements such as "we cannot think of perceptual activities and motor activities as two different items; we must think of the hyphenated term: perceptual-motor." Again we see the influence of Piaget and Gesell and another—Darell Boyd Harmon, whom we shall mention later.

"The Slow Learner" is written for the classroom teacher. Following the excellent section devoted to the development of "vision," Kephart presents a series of tests that the teacher can administer and training procedures that he/she can utilize to correct deficiencies in development. They are more basic than those mentioned in "The Brain Injured Child"; they heavily stress the importance of gross and fine sensory-motor activities, and adequate body awareness.

If we are to accept the total philosophy at all, we must appreciate the fact that higher skills are built upon underlying, more basic, ones. In this sense, there is great merit in Kephart's book. Unfortunately, he does not go beyond this basic level of development. The volume, of course, is designed for the schoolteacher and hence, could not be too technical in its presentation.

WORK OF HARMON AND APELL

The name of Darell Boyd Harmon was mentioned above. Since 1942, he has been writing of the role of posture as it affects vision. Posture, according to Harmon, is "the position or bearing of the body as a whole, especially as that position or bearing is influenced by gravity and by tonic changes required by other stimulus forms, by attitude (tonic readiness), movement, and by the counterbalancing of movement".

Though he has not been as adequately recognized as others working in this field, it is significant to note that Harmon wrote in 1948 as follows: "The human organism depends upon modifiability of structure through function (which is the basis of learning and its accompanying ability to evaluate past experience) as its way of adaptation".

Harmon's recent publication, "Notes on a Dynamic Theory of Vision," contains a wealth of information for any practitioner interested in this topic.

Optometrists have contributed much to the subject of developmental vision. It is impossible to detail the names and work of all who have contributed so greatly. It is necessary, however to mention a few.

Richard J. Apell has been the director of the Visual Department of the Gesell Institute of Child Development since 1950. He has published many articles dealing with visual development in children. In 1959, Apell's book (written with Ray Lowry), entitled "Preschool Vision," was published. It was an important contribution. Therein is described a battery of visual developmental tests, expected visual behavior in relation to age, significant differences between achievers and nonachievers, and much more.

It was designed as a useful work manual for the practicing optometrist and serves this purpose excellently. It is, in effect, an expanded work of that published in the original vision study by Gesell. Apell and his current coworker at the Gesell Institute, John Streff, have developed brilliant concepts concerning a child's spatial organization and the effect of lenses and/or visual training upon this organization. The use of lenses as an implement to organization has proven to be an exceptionally effective device.

CONTRIBUTIONS OF GETMAN

G. N. Getman, originally involved in the Gesell vision study, later as a coworker of Kephart's, and always as a willing teacher to the interested members of his optometric profession, has been a most important contributor.

From Getman's work, we have received what is termed a doctrine for children's visual care. It condenses the philosophy of developmental vision in a most comprehensive manner.

Getman states that "visual care for children utilizes five sequential and interrelated modes of total ability development." Each mode demands that the function of vision be the "steersman for the child's actions." They are as follows:

Mode A—The development of general movement patterns for action: "Guidance in this mode assists the child to learn to use his head, body, arms, hands, legs, and feet to move about in exploring his world and assists him to learn to guide these movements by using his eyes as his steering mechanism."

Mode B—The development of special movement patterns of action: "Guidance in this mode assists the child to learn to use his body parts concurrently to control and manipulate the things in his world and assist him to learn to utilize these manipulations to develop the movements of eyes and hands in combination."

Mode C—The development of eye movement patterns to reduce action: "Guidance in this mode assists the child to learn the eye movement skills that are necessary for the quick and efficient visual inspection of his world; this assists him to learn to use vision to obtain information about his world without the movements previously needed for explorations and manipulation."

"The part played by perception in the motivation and control of behavior cannot be discovered by examination of the conscious components of the act alone, and the nature of perception can be revealed only by experimental analysis of the act while in process. In the functional approach the perception is tied to action, to the end toward which the action is directed, and to value-judgments (conscious or unconscious) that appraise the significance of the acts performed for defining the relations of the percipient to the things perceived."

APPLYING THE PHILOSOPHY

The above, in brief, is the basis of the developmental philosophy. We have, of necessity, omitted the mention of many contributors to the subject. Also, we have not attempted to elaborate upon the practical application of the philosophy. Fortunately, this is being done more and more frequently in the literature. However, most important to the practitioner is that he study, absorb, and integrate the general laws that pertain to the subject. Only thus can he adopt the viewpoint that he must adopt if he is to apply successfully the philosophy to practical purposes.

Specific diagnostic and training techniques are readily available. It must be emphatically stressed, however, that the value of a diagnostic or training procedure to the practitioner is that it enables him to observe or train a process. To observe the end result of a perceptual act is not adequate. To train a perceptual skill, solely for the sake of the skill, is insufficient. The process (and the spatial organization of the process) whereby the end result is achieved, is what we must observe with the utmost care.

It must also be noted that too frequently the developmental vision philosophy is considered applicable only to the brain damaged, the retardate, or the slow learner. This is not the case. If the concepts presented are valid, they must pertain to all humans.

As a summation, let us note that "advancing research in human function has brought with it the development of present-day concepts of the significance of the total organism in the processes of growth in development, in theories of learning, in human performance, and in applications of dynamics to problems of human behavior.

Mode D—The development of communication patterns to replace action: "Guidance in this mode assists the child to learn to use his visual and movement experiences for communication with others. This guidance will assist him to establish a visual and language relationship which permits the exchange of information through speech."

Mode E—The development of visualization patterns to substitute for action, speech and time: "Guidance in this mode assists the child to learn the visual interpretation of the likenesses and differences in numbers and words to gain further information about his world from printed materials. This guidance will also assist him to relate and understand these symbols through visualization of events in which he has, is, or will participate.

Dr. Getman concludes that "if a child's total capabilities are to be explored in a training and guidance program, the sequence and the interrelationships of the

above modes must be recognized. Overemphasis of a mode can produce imitative behavior. Omission of a mode can produce a gap in the background of information a child needs to comprehend a new learning situation. Either overemphasis or omission will result in the reduction of the experiential values that produce knowledge." The influence of Gesell and Piaget can be readily noted.

CONTRIBUTION OF HERRICK

Yet another author who adds so greatly to our knowledge of this vast and vital field is C. J. Herrick. In his book "The Evolution of Human Nature," he states: "So much of human behavior is motivated by perceptions of what is going on in our surroundings that the mechanisms of perception and their limitations must be well understood. There is ample experimental evidence that perception is not merely an indispensable instrument for the acquisition of knowledge, but is itself a behavior. Sensory stimuli as such have no significance for the organism. Their meaning is acquired only by doing something with them or about them, that is, only through experience of the results of behavior performed in response to them * * * perception may be regarded as a behavior because we know by experiment that the polarization of the perceiving self against the objects perceived must be learned by actual experience gained through the motor responses made to the setup of sensory stimuli received.

"An optical theory of vision is inadequate and inapplicable in studying the functions and operations of vision related to these and comparable areas. An optical theory is atomistic and, at times, static. These newer areas require a broader, holistic, and dynamic theory of vision." (Notes on a Dynamic Theory of Vision: D. B. Harmon.)

REFERENCES

1. Aebli, Hans. "The Development of Intelligence in the Child" (Summary of Piaget's works to 1948). University of Minnesota, 1950.
2. Apell, R. J. and Lowry, R. W., Jr. "Preschool Vision," St. Louis: American Optometric Association, 1959.
3. Gesell, A. "Infant Development: The Embryology of Early Human Behavior." New York: Harper & Bros., 1952.
4. Gesell, A., ILG, F. L. and Bullis, G. "Vision—Its Development in Infant and Child." New York: Paul B. Hoeber, Inc., 1949.
5. Getman, G. N. "How To Develop Your Child's Intelligence" (7th ed.). Published privately, Luverne, Minn., 1962.
6. Harmon, D. B. "Notes on a Dynamic Theory of Vision" (3d revision). Published privately, Austin, Tex., 1958.
7. Herrick, C. J. "The Evolution of Human Nature." Austin, Tex.: University of Texas Press, 1956.
8. Kephart, N. C. "The Slow Learner in the Classroom." Columbus, Ohio: Charles E. Merrill Books, Inc., 1960.
9. Montessori, M. "The Montessori Method." New York: Frederick & Stokes Co., 1912.
10. Piaget, J. "The Construction of Reality in the Child." New York: Basic Books, 1954.
11. Piaget, J. "The Origins of Intelligence in Children." New York: International Universities Press, Inc., 1952.
12. Piaget, J. "The Psychology of Intelligence." London: Routledge & Kegan Paul, Ltd., 1950.
13. Seguin, E. "Idiocy and Its Treatment by the Physiological Method." New York: Columbia University, 1866.
14. Strauss, A. A. and Lehtinen, L. E. "Psychopathology and Education of the Brain-Injured Child." New York: Grune & Stratton, 1947.
15. Strauss, A. A. and Kephart, N. C. "Psychopathology and Education of the Brain-Injured Child." Vol. II. New York: Grune & Stratton, 1955.

BIBLIOGRAPHY

1. Apell, R. J. and Streff, J. W. "Use of Developmental Tests in Optometric Practice." JAOA 33:6, 1962.
2. Allport, F. H. "Theories of Perception and the Concept of Structure." New York: John Wiley & Sons, Inc., 1955.
3. Goldstein, Kurt "The Organism." New York: American Book Co., 1939.
4. Hebb, D. O. "The Organization of Behavior." New York: John Wiley & Sons, Inc., 1949.

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5. Vernon, M. D. "A Further Study of Visual Perception." Cambridge: University Press, 1952.

A Discussion of Physical and Perceptual Environment in Visual Training of Mentally Retarded Children

(Harold L. Friedenberg, O.D.[1])

Mentally retarded children with visual problems are finding their way into optometric offices in an ever-increasing number, and in an ever-increasing number of optometric offices the facilities are becoming available to provide these children with superior visual care. The optometrist with a genuine desire to work with children will find this aspect of practice one which is gratifying and which provides, along with its frustrations, a richly rewarding sense of satisfaction.

In "Personality in Young Children," the author states, "Even a sick child is first of all a child, changing and growing in whatever ways still remain open to him; this change and growth give us our best hope for helping him—as long as there is movement, as long as his ideas and feelings and behavior are not deeply frozen, there is a possibility of helping this movement to go in a better direction." This statement might well be the credo of every optometrist who cares for the young mental retardate.

ONE-TO-ONE RELATIONSHIP

Once the examination and evaluation procedures have been carried out and the vision training program determined, some concrete thought must be given to the environment under which the techniques are to be administered. Depending upon the areas and extent of retardation, these children can be expected to exhibit varying degrees of hyperactivity, perserveration and a social behavior which will make it necessary to establish environmental conditions different from those under which so-called normal children operate with ease.

Hyperactivity may be defined as the behavior manifested by a child who is unable to relate to the task at hand and who is constantly in motion. This type of child has been catagorized by various investigators as a ceiling walker, a grasshopper and a jackrabbit. The child who perseverates may also be hyperactive, but in addition to his hyper activity he appears to carry out a simple task beyond reasonable limits. This child continues to perform an activity once it is begun. Faced with a new task he continues to perform the old one. The child who perseverates, therefore, encounters difficulty in shifting from one task to another.

The ease with which these children are distracted, the short attention span and the inability to adapt negatively makes it mandatory that the initial vision training be conducted on a one-to-one relationship. Once the child has learned what is expected of him and the beginning and transitional stages of training have been successfully accomplished, a second or third child or more may be introduced into the vision training room. The inference here is that the mentally deficient child should be allowed to relate to a single individual, whether it be to a skilled technician under the supervision of the optometrist or to the optometrist himself.

It is of primary importance that the child begin his training program in an uncluttered atmosphere and in the presence of one individual whose sole purpose is to relate to and establish rapport with the child who is in need of help. In the normal classroom the mentally deficient child achieves negatively in a competitive environment. It would be catastrophic to duplicate these conditions in the training room.

Because of the ease with which these children are distracted, it is desirable to remove from the vicinity of the training area as many extraneous stimuli as is possible. Illumination should be optimum, neither too bright nor too dim, and external auditory stimuli should be reduced to the barest minimum. A harshly jangling telephone, a squeaky door, a raucous voice in the reception area, a typewriter, and a myriad of other extraneous stimuli can so distract a mentally retarded child that the training program, no matter how well conceived, can become ineffective.

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PROPER TERMINOLOGY

A discussion of mentally defective children, children who lack normal intelligence, should go no further without an attempt to define intelligence. Intelligence has been defined many ways by many disciplines; agreement, even within the same discipline, is practically nonexistent. However defined, intelligence involves the following elements: the ability to learn, the ability to think or reason, the ability to deal effectively with the environment, and the ability to profit from experience.

Mental retardation is not in itself a clinical entity but is one symptom which occurs in a great number of conditions which have varying etiologies. The mentally retarded as a group is not a homogeneous one but contains many dissimilarities. The one thing in common is, however, intellectual inadequacy. The mentally defective have difficulty in reasoning and planning. They frequently have little general information and they manifest defects in foresight and judgment. They experience great difficulty in modifying behavior through experience, an axiom which must be constantly borne in mind during vision training.

In discussing the child's problem with the parents, the expressions "mental defective" and "mentally retarded" often cause the parent considerable emotional distress. It is not because they are unfamiliar with their offspring's difficulty and inadequacy; it is rather that the terminology appears to be so harsh and uncompromising. It has been suggested that the term "intellectual inadequacy" be substituted in conversations with the parents, and a Richmond psychiatrist uses an even more charitable phrase, "modestly endowed."

FIGURE-GROUND RELATIONSHIPS WITH TOYS

Materials with which these children are trained should be bright and rich in color. They should be presented to the child one at a time without clutter or disarray, so that maximum emphasis is placed upon the task at hand to the exclusion of the surroundings. The modestly endowed child with a visual problem may not be able to differentiate the whole figure. Unlike the normal child, this child cannot perceive the total figure because the integrative process is faulty. Instead, the retardate will be so mindful of one of the parts of a figure that the rest of the figure fades into the background.

Kephart feels that inadequacies in recognition of form and in separating figure from ground lead to many of the difficulties experienced by the retarded child. When the child experiences difficulty separating figure from ground, he does not react to the same perceptual images received from the stimuli as does the normal child. The child with this kind of perceptual problem is not able to separate foreground from background, or to single out the figure from its component parts.

Form perception has been stressed as being a dominant factor in the perceptual process, and mentally retarded children with visual problems have difficulty in figure-ground relationships and form perception. The training of these visual skills can be boring and monotonous both for the optometrist and the patient, or it can be conducted in an atmosphere which makes the patient eager to achieve.

The advent of television, with its minor vices, has also created among children, normal as well as retarded, an awareness of certain entertainment personalities. No child will require an introduction to Donald Duck, Huckleberry Hound, or the Flintstones. The Whitman Publishing Co., of Racine, Wis., produces a book, entitled "The Flintstones: Sticker Fun." This book consists of alternate pages of gummed, push-out stickers which are parts of the Flintstone characters and accoutrements and the opposite page represents an active phase of the story. This consists of a dotted outline of a complete picture on which the parts—the stickers—must be pasted to complete the whole. A variety of these books with a diversity of subject matter can keep the mentally deficient child fruitfully occupied for an unusually long training session.

The older child with an intellectual inadequacy presents a different problem to the optometrist because the visual inadequacy usually requires a basic technique involving symbols which the older child may reject because they are too juvenile. These children, while at an intellectual and visual developmental age which requires the use of these devices, frequently resent their application because they are designed for the younger child.

Older children can be reached for training in figure-ground relationship and the wholeness concept through, among other things, Colorforms Toys. These toys

consist of a smooth and generally solid colored board to which cutout plastic parts adhere. These parts can be attached to the board over and over again without glue or paste. The subject matter ranges from simple geometric forms to a complete circus. One of the most valuable is a sophisticated plastic manikin to "dress" by affixing parts of clothing to the doll. The youngster actually designs the costume from various parts of soft plastic clothing. Through this type of game the child learns hand-eye coordination, figure-ground relationships, contour, and the ability to manipulate parts into wholes perceptually.

ROTATIONS CAN BECOME A DELIGHT

The mental defective may experience great difficulty in performing such a simple task as monocular rotations. When the attention span and frustration tolerance is low, as it is in most of these youngsters, and when the hyperactivity and distractability color the performance, the optometrist's ingenuity might well bridge the gap between failure and success.

Simple monocular rotations can become a delight instead of a chore if the rotating disk has a picture of a treasure chest or a ship as the fixation target. The occluder can be a black patch tied over the child's eye transforming him into a one-eyed pirate. The illusion can become complete by putting a black pirate's hat with skull and crossbones on the youngster's head and placing in his hand a cardboard or rubber sword with which he is asked to follow the fixation target.

The retardate, much more than the normal child, needs affection and security. Praise his performance during training. A detachable toy as a fixation target will make a much appreciated reward after the training session, enhancing the child's sense of achievement. While the child is learning ocular motility skills, he should be made gradually aware of his surroundings and not become completely attuned to the fixation target. Ideally, the child who is being trained to perform smooth and skillful ocular movements should also be made conscious of the room and its contents in the background as the training progresses. While he is concentrating on the task at hand, he should also be cognizant of his surroundings. This should be done as a secondary perceptual act, but once the child has begun to move in training, he should never be allowed to become so fixed on the target that he is oblivious of the perceptual world around him.

PATIENCE AND UNDERSTANDING

In many cases an intensification of the near point stimulus tends to compensate for some of the hyperactivity and frequently increases the span of attention. The optometrist must remember, however, that these children are not being trained to become an island within themselves, but that one of the goals in vision training is to teach them to cope with their own immediate environment and having met that challenge, to then meet the challenge of many different environmental conditions.

The mentally retarded child may attempt to compensate for his difficulty by trying to control his environment through temper tantrums and other antisocial behavior, or by the other extreme expedient, becoming completely withdrawn. A measure of the optometrist's skill is the effectiveness with which he controls the child's attempts to manipulate the environment. In general, the retardate shows patterns of social adjustment characteristic of that of a much younger child.

Patience and understanding during the training program is of the utmost importance. The mentally inadequate child's thought processes function at a slower rate than those of the normal child. It is as though the patient were being observed functioning in slow motion. The optometrist should make every effort to control himself and at least outwardly manifest no impatience as he waits for the mentally retarded child to perform a seemingly simple task.

These children need affection, security, social recognition, a sense of achievement, and participation in new experiences. There is probably nothing so destructive to the defective child than to be assigned tasks which are beyond his power of comprehension. Vision training should be begun on a level considerably lower than the level at which the child functions and if at all possible, training devices used early in the program should consist of materials familiar to the child. The vision-training program outlined for the child must be planned in

terms of the individual capacities of the child as a whole. The cerebral palsied retardate cannot be expected to begin training on the balance board, nor can the autistic intellectually disadvantaged child be expected to verbalize freely during training.

No vision-training technique, no matter how elaborately or brilliantly conceived, can be expected to raise the IQ of a defective child. However, the elimination or diminution of the visual perceptual problem will allow the child to function more efficiently and make better and more economical use of his capabilities.

REFERENCES

1. Murphy, Lois Barclay. "Personality in Young Children." New York City; Basic Books, Inc., 1956.
2. Burton, Arthur and Harris, Robert E. "Clinical Studies of Personality." Vol. 2, New York City: Harper & Bros., 1955.
3. Fouracre, M. H. "Learning characteristics of brain-injured children." "Exceptional Children," 120, January 1958.
4. Noyes, Arthur P. and Kulb, Lawrence C. "Modern Clinical Psychiatry." Fifth edition, Philadelphia and London: W. B. Saunders Co., 1958.
5. Solley, Charles M. and Murphy, Gardner. "Development of the Perceptual World." New York City: Basic Books, Inc., 1960.
6. Strauss, Alfred A. and Kephart, Newell C. "Psychopathology and Education of the Brain Injured Child." Vol. 2, New York and London: Grune & Stratton, 1955.
7. Gibson, James J. "The Perception of the Visual World." Boston: The Riverside Press, 1950.
8. Kephart, Newell C. "Visual behavior of the retarded child." Am. J. Optom. & Arch. Am. Acad. Optom., 35 (3): 125–133, 1958.
9. Alexander, Theron. "Mental subnormality: illusions and directions." International Record of Med., 172 (2): 80–86, 1959.
10. Kugelmass, I. N. "Symposium on the mechanism and management of mental deficiency in infants and children." International Record of Med., 172 (2, 3, 4) 1959.

Vision Care of the Mentally Retarded Child: A Preliminary Report

(Harold N. Friedman, O.D.[1])

Visual analysis of a mentally retarded child should be an integrated factor in determining the evaluation and treatment of such a child. The youngster's environment might be blurred, distorted, or even suppresed in some parts of the visual field. This could so handicap the child as to prevent his response to all or part of the mental tasks given to him. In select cases, a program of vision training might greatly benefit in orientating the child to a more normal environment.

What battery of tests can be used to diagnose visual problems of mentally retarded children? Most of the usual diagnostic tests in the refractive sequence are useless. They are, in a practical sense, impossible to use. Mentally retarded children do not have the patience and, in most cases, the intelligence to respond properly to the tests. Second, at their mental level, the usual diagnostic tests would not disclose what we want to know.

What exactly do we want to know? We want an accurate determination of the child's visual acuity at near and distance as is possible to obtain. We want to know the child's general refractive error: is he myopic, hyperopic, astigmatic, anisometropic, and to what extent? We want to know as much as we possibly can about the child's ocular motility, binocular coordination, and body-hand-eye coordination. If we can determine these data and can rely on their accuracy, we can then combine our findings with those determined by the practitioners in medicine and psychology to work out a program to aid the mentally retarded child better adapt to his environment.

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BATTERY OF DIAGNOSTIC VISUAL TESTS

Our experience at the Clinic for Mentally Retarded Children have led to the adoption of several tests that are working successfully in measuring visual abilities and inabilities of mentally retarded children.

To measure visual acuity, regular and reduced Snellen picture charts are used. When examining mentally retarded children, we forget about recording results with the usual Snellen fraction. The children do not hold still long enough. With practice and keen observation, however, we get a very good determination of acuity.

Monocular acuity is very difficult to obtain because the children will not generally tolerate eye patches for any length of time. However, by playing such games as "pirate" we often succeed in getting a good determination of monocular acuity. Notations for acuity are either "adequate" or "nonadequate" for near and far. It may take from 15 to 20 minutes to come to a conclusion.

To obtain an accurate impression of the refractive error of a mentally retarded child is no small accomplishment. The task is greatly simplified with the use of a television set as a fixation target. We are not so much interested whether the child is a −1.50 or a −2.00 diopter myope; we are interested whether the child is a myopic or a hyperopic; isometropic or an anisometropic, or if there is with-the-rule or against-the-rule astigmatism. And this differentiation can be made with a retinoscope, a trial set, and a TV set.

In order to get a picture of the mentally retarded child's ocular motility, binocular coordination, and body-hand-eye coordination, many diagnostic procedures are used. Because of the erratic behavior of the mentally retarded child, examiners train themselves to catch every response.

To begin, the child's eyes are observed carefully during the "get acquainted" stage of the examination. This observation and a simple cover test will reveal obvious ocular deviations. A cover test is possible on every child.

A 15-diopter prism is next placed base down in front of one eye. The child is asked how many of a simple object he sees both near and far. This test assumes the child has a mental age capable of distinguishing 1 from 2. Where this assumption is valid, we can diagnose suppressions.

A penlight is used as a fixation target and the child is asked to fixate nine positions in the visual field. The light is then moved horizontally and vertically across the field and the child is requested to follow it. These procedures are first allowed with no restrictions of head movements; then an attempt is made to restrict head movements. Most mentally retarded children react unfavorably when head movements are restricted and it often takes considerable time to get accurate impressions of eye pursuit movement ability. Upon completion of the aforementioned procedures we have a judgment of eye fixation and pursuit responses and of limitations of extraocular excursions.

STICK AND RING TEST

After adequate demonstrations, the child is asked to hold a thin stick and put it through a ring held by the examiner. This tests the ability of the child to perceive the correct spatial location of the ring, and the ability to coordinate visual feedback with arm and hand placement. Recorded information includes: (1) which hand reaches for the stick; (2) would an attempt be made to pierce the ring when it was held by the examiner, or is the attempt made only when the child holds both the ring and the stick, or is any attempt made at all; (3) is any attempt successful; and (4) what are the relative positions of the two eyes during the test.

Attempts made only when the child was holding the ring and the stick indicate the need for tactile reenforcement to solve any complicated visual task. In the instances where unsuccessful attempts were made, eyes, as observed, did not fixate on the task indicating an inability to coordinate eyes with hands.

DETERMINING VISUAL AGE

The preceding battery of tests were attempted on 30 children. With every child we obtained an accurate determination of "visual age." By "visual age" is meant the stage of development of the whole visual process of perception.

The examination gives the following information: at what stage of development is the child's voluntary fixation and pursuit movements? Are there total or partial suppressions in the child's visual field? Is there a paresis of any of the extraocular muscles? Is the child's uncorrected refractive error hindering the natural development of vision and total learning ability?

Once we have this information we can try to go further. The first step would be, of course, to correct any adverse refractive error and note the effect on the mental and visual age of the child.

If the visual age of mentally retarded children is lower on the developmental scale than the child's mental age, we may have room to improve both. Obviously, a child with subnormal pursuit and fixation eye movements will find it extremely difficult to read. A child who cannot visually localize in space will have difficuty with locomotion. An attempt can be made by visual training to raise the visual age to the child's mental capabilities, usually far below the child's chronological age. As with the diagnostic procedures, different and unique visual training methods must be used with mentally retarded children.

If a visual training attempt is successful, we generally find an increase in the child's mental age with the child becoming better orientated to his environment. This may just be the help the mentally retarded child needs to improve his level of mental development.

The Eye Clinic Approach to the Mentally Retarded

(Elwood H. Kolb, O.D.[1])

Members of organized optometry have two community obligations to the mentally retarded: First, as professional men and women, they have an obligation to care for their visual need; second, as civic-minded individuals, they should assume an obligation to assist local units of the National Association for Retarded Children in their endeavors to better the way of life of mentally retarded children and adults.

If we are to aid in caring for the visual needs of the mentally retarded, it is necessary for us to learn where to find the patients. This should not be too difficult in view of the fact that 3 percent of the population are mentally retarded. The task, however, is made difficult by the unfortunate fact that many mentally retarded are still being hidden behind closed doors by their families. Local units of the AOA can best offer their services by contacting the nearest chapter of the National Association for Retarded Children.

Before implementing the offer of his optometric organization, the individual optometrist should familiarize himself with the general problem of mental retardation. Information on the subject can be obtained from the National Association for Retarded Children, 386 Park Avenue South, New York 16, N.Y., or from the nearest chapter;[2] or from the U.S. Department of Health, Education, and Welfare, Washington, D.C. Other articles in this issue of the Journal and an article by the author which appeared in the December 1962 issue of the Journal of the American Academy of Optometry should be of value.

The families of mentally retarded individuals want and need help, but offers of help must be above suspicion of any commercialism or paternalism.

There are but few eye practitioners who have examined any significant number of mentally retarded individuals. Until such time as our individual practitioners become more experienced in caring for these people, it is our opinion that the mentally retarded may best be handled with the following approach:

(1) Examinations should be conducted in a physical facility where other mentally retarded are present, i.e., a clinic arrangement.

(2) The clinic should be conducted by organized optometry in conjunction with a unit of the National Association for Retarded Children.

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[1] Member of faculty, Pennsylvania State College of Optometry; director, Eye Clinic, Lehigh County Chapter, Pennsylvania Association for Retarded Children, Inc.

[2] The local chapter may be found in the telephone directory under "retarded children" or under the county designation, or it may be contacted through the United Fund or the Community Chest.

(3) A team approach utilizing members of other health professions is desirable but not essential.

(4) Clinic fees, based on the ability of the individual to pay, should be charged. Fees might be distributed to any or all of the following: The local retarded children's unit; the local optometric society; the doctors doing the examining; local service groups. It should be borne in mind that the expense of caring for a mentally retarded individual is considerable, that it is a lifetime expense and not one of limited duration as in an illness.

(5) Clinic facilities should provide for the development of visual habilitative procedures that will prove themselves of value with this type of patient.

(6) A followup procedure to determine the effect of a lens correction or an habilitative technique should be available.

(7) Care should be exercised to see that the doctor-patient relationship is never violated. Clinic authorization forms should provide the examiner with freedom to discuss the results with other professionals working in the area of mental retardation.

(8) Inasmuch as many of these patients have been examined in diagnostic clinics, it must be clearly understood by the patients that such examinations often determine the presence of ocular pathology or visual problems but that these clinics do not necessarily correct for the visual problems.

The line of reasoning followed by the Lehigh County Eye Clinic is that the relief or correction of any handicap will ease the problem of retardation at least a little bit and that the correction of more than one handicap will help even more. Families concerned with the problem of mental retardation must be made to realize this. Most parents accept advice and cooperate.

The mentally retarded can be helped. And optometry has the moral responsibility and the resources to assist.

Dr. TRAMONTI. I would also like to submit a copy of the report, 1960 White House Conference on Children and Youth, "The Importance of Vision to a Creative Life in Freedom and Dignity."

(The document referred to follows:)

REPORT
to
The 1960 White House Conference on
CHILDREN AND YOUTH
from
The American Optometric Association
Committee on Visual Problems of Children and Youth

THE IMPORTANCE OF VISION TO A CREATIVE LIFE IN FREEDOM AND DIGNITY

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FOREWORD

Once a decade, since 1909, the President of the United States has met with leaders in the child health and welfare fields to consider ways and means for making this a better country for all children, and thus a happier society and a more effective democracy. The American Optometric Association is proud to participate in the 1960 White House Conference on Children and Youth as the representative of a profession whose members believe deeply in the concept of this Conference that every child deserves the fullest possible opportunity to achieve a creative life in freedom and dignity.

In company with other groups participating in the Conference, however, we are profoundly aware of the wide gap which still exists between the achievement of the goal we seek for all children and the hard realities of our society. The obstacles to the goal are economic, social, educational, psychological and physiological, varying from child to child, from family to family, and from area to area.

Fortunately, many, if not most, of the obstacles to full development of every child can be removed, if knowledge and techniques now available to us are put to full use. In the field of visual abilities, for instance, there is no longer any valid reason why millions of children handicapped by defects in vision or retarded visual development cannot be helped to achieve a better or a complete adjustment to their learning problems or to other problems caused by vision difficulties, if only professional examiners can have the opportunity to uncover the children needing help. It is truly tragic that any child should be deprived of his heritage, an opportunity for a good life, because of a correctable but neglected or undetected vision difficulty, yet this is happening to untold numbers of children throughout the country because of parental and community failure to understand and to take advantage of vision care now available.

The 21,000 members of the optometric profession, located close to the child's home in every locality in the nation, have dedicated their art and science to the goal of removing correctable vision inadequacies from among the obstacles which still bar many children's path to their full development. The progress which has been made in this field in the last few years has been heartwarming, dramatic, when children once thought hopeless from an educational standpoint have been helped into becoming contributors to society rather than "problems" to it.

In the brief 10 years since the last White House Conference on Children and Youth, optometry working closely with pediatricians, psychologists and educators helped produce the first blueprint of the development of visual performance in children, making possible the developmental appraisal of vision from 16 weeks to 10 years through a series of visual performance tests. This, in turn, has led to improved guidance programs and methods of preventive care, as well as new techniques not only in the education of children with visual deficiencies (as the result of brain injury) but in the establishment of guideposts toward improved learning procedures for all children.

At least 80 percent of all learning takes place through the visual process. A process which develops through maturation and learning experience. Yet millions of children with seemingly good eyesight, perhaps even the so-called "perfect vision" of 20/20 visual acuity at distance, have not learned to see efficiently at near-point, that is, to maintain binocular visual performance so as to make effective use of the impulses signalled by the eyes to the brain. Often, these children are scolded and humiliated as "lazy" in their school efforts when actually they desperately require professional vision training to learn how to use their eyes more effectively. It is urgent that parents, educators and the community generally recognize the existence of this all-too-common but often neglected problem in an area of vision care which optometry has pioneered and developed as a distinct and unique professional specialty.

Of great social import at this time is the startling relationship which has been found to exist between vision difficulties and the baffling problem of juvenile delinquency. Statistics reveal that more than 80 percent of delinquent and pre-delinquent children have not achieved satisfactorily in reading. Research further reveals that in 50 percent of those encountering reading difficulty, vision is a contributing factor. Certainly this does not indicate that every child with a reading problem is a potential delinquent. Rather, it does indicate that such children should always be examined promptly for the existence of a vision difficulty, and particularly those children whom society has not been able to "reach." It is not enough to know if the child can see and read a one-third-inch-high letter on a Snellen chart at 20 feet with or without correction. It must also be determined whether the child can focus readily on the printed words of a book held at 12 to 16 inches and maintain binocular vision for long periods of time. So many children with behavior problems have been discovered to be unable to accomplish this feat without special lenses and/or visual training, that their misbehavior may well have stemmed from a desperate effort to escape from an intolerable school situation.

Meanwhile, the incidence of need for professional vision care for children is increasing at a rapid pace. Extensive research is necessary to provide us with clear explanations for such phenomena as the increasing incidence of myopia, particularly at college-age levels. Optometry is pioneering in efforts for the control and reduction of this widespread problem with encouraging hope for improved preventive and corrective measures, including some promise in the new contact lenses. Furthermore, it is initiating new programs of specialized help for college students and pre-school children, supplementing its expanding and highly successful program for elementary and secondary school children.

But to be effective, new knowledge and new techniques bearing on factors affecting children in their growth and development must be shared broadly with all professions and disciplines concerned in this vital matter. They must be understood by the general public. It is particularly important for parents to become aware of early danger signs in visual growth patterns in their children so as to seek professional help promptly. Moreover, we need greater public recognition of the importance of effective and reliable mass screening programs as described in this report, to identify school children needing vision care. We need greatly expanded research into all phases of visual development. Preventively, we must determine if we can do a better job of designing classrooms, school furniture and equipment for maximum visual comfort and efficiency. We must find out whether we are attempting to teach children reading skills before many of them are visually ready for reading. These are some of the issues which we seek to explore within the context of the 1960 White House Conference.

In the preparation of this report, the optometric profession has undertaken a critical and comprehensive self-appraisal of its services to children and the public generally, of its standards of professional training, and of the degree to which it has succeeded in its conscientious efforts to achieve with other disciplines an interprofessional approach to the problems of children, even when that sometimes entails some compromise of professional prerogatives for the sake of the public good.

Optometry looks back upon the 10 years since it last participated in the White House Conference on Children and Youth as years of great progress in concepts of vision care, and in the effectiveness of its services to children and youth particularly. We regard the next 10 years as a period of even greater challenge to our profession and to every profession dedicated to the welfare of children and to service in behalf of humanity. Obviously, if the challenge is to be met, all groups working with children must keep open the channels of communication and the avenues of cooperation one with the other. We pledge our continued full efforts in that direction.

LOIS B. BING, O. D., CHAIRMAN
Committee on Visual Problems of
Children and Youth
American Optometric Association

Report to the
1960 White House Conference on Children and Youth
By the American Optometric Association's
Committee on Visual Problems of Children and Youth

THE IMPORTANCE OF VISION TO A CREATIVE LIFE IN FREEDOM AND DIGNITY

PART I. New Concepts and New Techniques—Identifying and Minimizing Visual Handicaps to the Learning Process

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"Vision is the Key to the child's whole individuality...To understand the child, we must know the nature of his vision."--Gesell

In every hospital nursery, there is tolerant amusement among the nurses at the repeated spectacle of the proud father smiling, grimacing and waving at his newborn infant through the thick glass window. The new father frequently feels let-down by the failure of the infant to at least acknowledge the affectionate greeting, let alone smile back in filial devotion. But the disappointed father soon learns that the infant cannot see him or anything else in the surroundings. In this respect, infants are like the heathen idols described in the One Hundred Fifteenth Psalm: "Eyes they have, and see not."

LEARNING TO SEE

The infant is aware of areas and patterns of light. He learns to turn toward bright spots or shadows, to attempt to follow moving lights or bright moving objects, to move the eyes without moving the head, to reach out to touch and to feel things the infant vaguely sees, to begin tentative coordination of hands and eyes.

The infant, in other words, is beginning to learn to use his eyes in order to learn to see. Thus the visual process begins in the child's life as a learned process which develops and improves with growth, development, maturation, and trial-and-error experience. The visual process he is learning to master is the same process which will in turn become his main road to the learning of other skills and of most of the knowledge he will obtain throughout his life. For authorities agree that at least 80 percent of all learning takes place through the visual process.

Millions Fail to Learn to See Effectively

Unfortunately, millions of children in the United States do not succeed in learning to use their eyes well enough to enable them to cope efficiently with the demands made upon them for successful achievement in school, or made by the culture, economy and society in which they will live. There are those children who are handicapped by injuries or malformations of the eye structure, or by brain damage, rendering them blind or partially-seeing. Blind children (those having acuity of 20/200 or less with best correction) number one in 5,000; partially seeing children (those with corrected vision ranging from 20/70 to 20/200) number one in 500. [46] These children manifest their problems in unmistakable fashion. Usually they receive prompt professional attention and are helped in school either through the establishment of special classes or by visual aids intended to enable them to continue in the regular classroom with specialized assistance.

But at least four out of every 10 children in our schools and colleges are visually handicapped in one form or another for adequate school achievement. [46]

Yet we know today, as a result of research undertaken primarily in the past 10 years, that most children with vision difficulties can be helped to overcome or helped to cope successfully with their vision problems. Obviously, therefore, to assure a creative life in freedom and dignity for every child, we must use the knowledge and techniques now available to us to search out all visually handicapped children and to give them the professional help they need to succeed in school and in life. We can no longer afford national neglect of so many children for so unnecessary a handicap.

CHANGING CONCEPTS IN VISION CARE

In its report to the 1950 White House Conference on Children and Youth, the American Optometric Association described earlier investigations into the relationship between vision and school achievement. [19] In the 10 years since then, we have come to a fuller realization of the importance of the relationships not only between vision and achievement but between vision and safety, and vision and recreation as well as the significance of vision problems themselves.

> "Your infant's eyes are very wonderful little organs—almost as wonderful as your child himself. In fact, his eyes, and the vision that results as he learns to use them to see and gain information, will have great influence upon his future performance and success. How he grows and develops and how well he learns to use these bright and shining windows to the world around him will determine the visual abilities which must carry him through his lifetime. Every experience in which he participates helps him to learn to use his eyes. These visual experiences will provide the foundations upon which vision becomes the dominant factor in his successes and achievements." [22A]

Attitudes Before World War II

Prior to World War II, the responsibility for vision care of the child was placed almost entirely on the parents, while educators and school administrators had only a slight interest in determining the visual abilities of their students. Many screening programs were in effect, but even those were of limited effectiveness. Usually only those children with extreme deficiencies of vision and those with obvious need for one or another type of corrective lenses for distance sight were uncovered as a result of screening in the schools.

As long as a child could read a one-third-inch-high letter on the Snellen chart at a distance of 20 feet (20/20 visual acuity) he was able to pass the screening examination with flying colors, taking home a note announcing to his parents he had "perfect" vision. Many such children, despite the accolade of "perfect" vision, were visually handicapped, some severely, in their ability to use their eyes together efficiently for reading the printed words in a book held at 12 to 16 inches.

We shall never know how many unfortunate youngsters have been scolded, humiliated and condemned as "lazy" in their school situations because of the failure of their parents and/or the community to discover in early school years the existence of a vision problem handicapping these children in learning the all-important reading skill. We shall never know, either, how many potential scientists, mathematicians, psychiatrists, and optometrists or other badly needed professional people have been lost to our society because undetected vision problems discouraged otherwise qualified students from undertaking the rigorous studies required. How many school "drop-outs" can be traced to ignorance of the existence of vision problems which made school work for them a daily confrontation with bitter frustrations?

Even today the problems persist, and visual inefficiencies and retarded visual development generally remain undetected because of inadequate mass screening programs. But at least we now understand better than we did a few decades ago that vision care is not achieved merely by the correction of refractive errors for distance sight.

Present-Day Concept of Vision Care

In the years since the last White House Conference on Children and Youth, new concepts and new techniques in vision care have been pioneered as a result of interprofessional research studies mady by optometrists, pediatricians, psychologists and educators, working together to achieve a better approach to the problem of uncovering learning difficulties in children. A major consequence of this multi-professional research has been optometry's present day approach to vision care.

Modern optometry is based on the concept of functional vision, which takes into account not only the shape of the eyeball (the mechanistic-physical aspect of eye care), but the entire visual process, both physiological and psychological. [58] It is not enough to determine whether the child can read the Snellen chart at 20 feet or to prescribe corrective lenses to bring him to that ability; we must also know how well the child's visual capabilities are geared for all of the normal demands made upon him particularly including the need for sustained, near-point visual performance.

Optometry's objective is to enable the patient to see clearly and comfortably and efficiently for each specific task, regardless of demand or distance; also, to assure the child's visual development through preventive as well as corrective measures.

Increasingly, the major demand upon the child's vision is made at near-point seeing tasks, and it is in this vital area of functional vision care that optometry has carved out its unique professional specialty and has made its greatest advances in recent years, providing the child with the best possible vision for his major needs. Just seeing is not sufficient. Each child must see comfortably and efficiently.

> "The total process of vision includes: refractive status, (far sightedness, near sightedness, anisometropia, astigmatism); the eye movement control mechanisms made up of six muscles controlling the movement of each eye, controlled by the voluntary nervous system, the visual pathways, and finally the visual area of the cerebral cortex in which the images received separately by each eye are fused into one image and projected out into space toward the object of regard. The total process should function with ease and efficiency." [6]

Eyes and Vision Not Synonomous

A major reason why children still go through school and into later life with undetected vision problems is a lack of understanding by some educators and even by some eye specialists as to what constitutes a "vision" problem, and how it differs from an "eye" problem. That is to say, the interior and exterior parts of their eyes are healthy; these children have the ability to see small letters clearly at 20 feet or are brought to that capacity by corrective lenses; and there are no obvious errors in the optical system of either eye. Therefore, the diagnosis is healthy eyes and "no eye problem."

In a proper vision examination, however, more than the above is involved. We must determine the child's visual "abilities": whether he can focus and point his eyes together as a team; his speed of perception; his accuracy in looking from one object to another; his power of sustaining focus at the reading distance; how he uses his eyes and hands together; and how well he performs other visual skills necessary within his school environment. [30]

When a child lacks some of these essential visual skills, he may find himself classed as a reading problem, a behavior problem, or a bored and disinterested non-achiever. He may be one or all of those things. But primarily he is a child with a problem which is serious in itself and extremely serious from a psychological standpoint.

READING FAILURE AND ANTI-SOCIAL BEHAVIOR

Many children with reading disabilities are not and never become delinquents. But many delinquents first manifest their difficulties in the development of reading disabilities.

Fabian, in a paper presented at one of the conferences of the American Orthopsychiatric Association, reported these statistical findings following a comparative study of the incidence of reading disability in several clinical settings: [42]

Sample Environment	Percent with Reading Disability
School	10%
Child Guidance Clinic	33%
Child Placement Agency	62%
Psychiatric Hospital Childrens Ward	73%
Group of Pre-Delinquent and Delinquent Children.	83%

Furthermore, a survey conducted by Roman, at the Manhattan Children's Court revealed that 84% of cases carried by the treatment clinic present the problem of reading retardation in conjunction with personality disorders and anti-social behavior. [42]

Significance of Studies to Parents, Teachers

The existence of a "reading problem" is and should be a matter of serious concern to everyone interested in the child's development toward a creative life in freedom and dignity. Every teacher is familiar with the classroom problem presented to her by the attendance of a child experiencing severe reading retardation. Such a child often becomes the classroom trouble-maker either out of sheer boredom, or perhaps out of a desire to "be somebody." He does this in some visible manner to the rest of the children in order to cover up his failure in academic achievement. Misbehavior is readily recognized as a sometimes desperate and perfectly reasonable effort to escape from a situation which is way over the child's head or beyond his visual, mental and/or emotional stage of development.

Thus, while reading difficulty is not always followed by anti-social behavior, the incidence of reading problems among those who do display behavior difficulties is impressive enough to warrant prompt remedial action. And a first step must be to determine the child's ability to get meaning and understanding from what he sees through the skillful and efficient use of both eyes. Optometry, by undertaking the kind of comprehensive functional vision examination which will uncover difficulties in pursuit and saccadic fixations, focus facility, stereopsis, lateral balance and fusion, can not only identify the child's problem if it be due to vision but also optometry can provide a regimen for correcting or minimizing it, either by prescribing of corrective lenses or by visual training or both.

A grave responsibility rests on parents, teachers and the community generally to make sure each child with a vision problem handicapping him in school achievement is examined promptly by a professional practitioner specializing in functional vision diagnosis and treatment. Resultant gains in school achievement are usually gratifying.

THE "PHENOMENON" OF READING

Reading has been described by Robinson as first of all a phenomenon of vision, and then a function of the brain. The entire brain is involved. The brain stem and cerebellum help coordinate eye movements, while the cerebrum interprets what is seen. [40] It is a marvelous and remarkable thing that in its evolution from big-muscle outdoor activity to delicate fine-muscle indoor life, mankind has developed the ability to differentiate tiny smudges of ink as meaningful letters of an alphabet, put together to form words and sentences, concepts and knowledge. Primitive man had little need for near-point visual performance during all of his

lifetime. A high degree is required each day from every school child and adult. While there are many of us with reading handicaps of various degrees of severity, the marvel of it is that so many of us can read so well.

The average student today is capable of reading at levels which the best instruction and native ability can produce. In spite of the popularity of such books as "Why Johnny Can't Read?", the facts indicate that education is doing a very creditable job of teaching the child how to read. Reading abilities, on the whole, are far better than they have been in the past. One of the reasons we have more maladjusted pupils and poor readers in the schools than we remember from a previous era, then, is that so many more children of all degrees of capability are in school now than in previous years, and are forced by law to remain in school to later age levels. Optometry's experience indicates, however, that we may be trying to teach some children to read before they are visually mature enough to succeed.

We can congratulate ourselves upon the fact that reading abilities of children are improving but we must also face the fact that our society demands from all of us significantly better performance in all skills than may have been considered adequate in the past. We face the challenging problem of preparing our youth to live in a rapidly changing world in which old concepts are under constant attack and in which science and technology are daily rewriting what we believe to be the physical realities of our universe. In a democracy, it is necessary not only that each citizen learn of the facts about his environment, but also that he develop mature judgments for exercising his influence upon decisions which must be made through the political process at local, county, state and national levels of society. As economic and technological changes have occurred, the pressures upon our youth have accelerated to acquire higher skills for employment or career, and education for a more effective role in society.

Distinctive Patterns for each Child

All of these things require a mature outlook, a broad background of experience, and a high level of competence in reading.

Yet insufficient attention has been paid to the direct relation between vision and the fundamental reading skill.

Reading is much more than perception. It requires two-way action. It is a process of getting meaning from print by putting meaning into print. For this to be possible, the youngster must be capable of seeing and reacting to the printed page without even the slightest interference in this visual process.

"Every child exhibits a distinctive pattern of development of visual performance just as in achieving the inclination and the ability to read. Considering the profound intricacy of the visual complex alone, it is not strange that there should be such an amazing range of individual differences in reading performances both before and after the age of six." [40]

"We do great injustice to individual children by overlooking and combatting these individual differences." A developmental approach to the diagnosis of child vision is essential for a better understanding of the cultural art of reading in all its aspects. "There could well be more emphasis on perceiving as opposed to looking and on sincere thinking as opposed to mere reading." [40]

VISION IS A LEARNED SKILL AND CAN BE TAUGHT

As we have noted, vision is a learned skill, not something solely dependent on the physical condition of the eye. Skills that are learned can be taught. This fact is the basis of scientific visual training in which optometry has pioneered.

Visual training has long been recognized as an effective method of correcting some types of squint (crossed eyes). The child who has difficulty in making his two eyes work together may turn one out of the way and use only the other. Through visual training (orthoptics)

however, such children can be taught in many instances to restore binocular skill, and, when the eye straightens, the child usually sees with both eyes simultaneously.

There are many other children, and adults as well, who merely suspend vision in one eye, without turning the eye out of the way as in strabismus or squint (crossed eyes). Intermittently or continuously, however, they have only one-eyed vision. Just as visual training may restore the binocular skill in the crossed-eyes, it may also restore binocularity where the lack of it is not obvious, or help to maintain it in cases where the individual has difficulty prolonging it.

Categories of Visual Training

By the use of visual training, optometrists have learned to solve a number of visual problems in addition to those of restoring or maintaining binocularity. Through visual training, a child can be taught to see several words at once, instead of only a few letters or syllables, and to perceive what he reads more quickly. Visual training can teach accuracy in seeing, by overcoming a tendency to reverse letters or figures, for example. Visual training can also help the child to overcome fatigue resulting from sustained close work activity.

Visual training was found to be the only successful method of training airmen in World War II to instantly distinguish enemy from friendly aircraft.

As practiced today by optometry, visual training has many uses for school children who, for some reason, have failed to develop necessary visual skills. [4] [24] There are three broad categories of visual training:

(1) For the pre-school child it is directed toward giving the child learning experiences to help achieve the most efficient use of his vision and to assure that the child is made visually ready for school, and for life;
(2) For correction of visual problems it is an effective program which has had gratifying results for many children with reading problems growing out of vision difficulties;
(3) For visual enhancement it is a program to enhance the vision abilities of those desiring to increase their levels of reading capabilities, or visual abilities for occupational, recreation or other purposes.

All three types of visual training have been developed by optometry as organized, professionally guided programs backed by continuing and extensive research and by frequent postgraduate instruction for the individual practitioner.

THE SERIOUS PROBLEM OF PROGRESSIVE MYOPIA

Myopia (nearsightedness) is an especially serious problem for thousands of school children. According to old theories, these nearsighted children were doomed to follow a pattern of increasing difficulty in seeing beyond arm's length. Evidence is mounting, however, which indicates that a more hopeful outlook about myopia may be justified. [3] [20] [25] [44]

While the cause and exact mechanism of progressive myopia eludes researchers, some progress has been made in the management of the myopic patient. Some of the more encouraging results have been indicated from the carefully supervised use of bifocals and the new tiny contact lenses developed in recent years. But the problem of myopia is far from solved, and extensive research will be necessary in the coming years to identify the factors which lead to such a high incidence of myopia among school age children.

Effects of School Work upon Vision

Over a period of years, observations of many cases indicate that "educational" myopia occurs frequently among individuals who are engaged in excessive near-point work, particularly among individuals who are physically and emotionally immature. [28] [34] [29] On the other hand, researchers have found a direct relationship between the incidence of myopia and normal classroom activity, suggesting that there is a possibility that the school environment and/or methods of teaching may be at fault. These results do not rule out the possibility that myopia

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represents a normal developmental stage of vision which in many children is part of the growth process.

There are three major studies especially worth noting of the harmful effects of school work upon children's vision.

A United States Public Health Service survey of the vision of 1,860 children in Washington, D. C., showed that the frequency of myopia and astigmatism tends to increase between the seventh and eleventh years of childhood. Myopia, for example, increased from two percent at ages 7-9 to nine percent at age 12, with constant increase during the intervening years. There was no apparent increase in ages 11 to 16. [13]

A second survey done a few years later, also by officers of the U. S. Public Health Service, found a much more rapid increase in the percent of myopic persons during school ages than the early years of industrial life (ages 20-45). These results were based on the Snellen testing of about 5,000 boys and over 6,000 male industrial workers.

This apparent increase in defective vision during school age does not per se prove that school life is visually harmful. Some authorities attribute uncomplicated myopia to the normal elongation of the eye during the process of growth from birth to late adolescence. They believe that this development then becomes static and in most cases is easily correctible.

However, Kephart of Purdue offers some evidence that seems to support the belief in a direct relationship between increasing myopia and school work. A group of 84 children tested by an optometrist in May at the close of school and again in September when school reopened showed a decrease in the extent of myopia from 49 to 30 percent, apparently as a result of the freedom from close work during the summer vacation. And other studies indicate that whereas the rate of myopia's progression remains fairly constant among myopic children until the age of 17, medical students who study long hours often continue to become more myopic even though they may be 35 years of age. [35]

Is myopia, then, a natural inevitability for some children or the fault of close-work activity in school before the child's vision is ready for it? These are important unanswered questions of vision care for children.

Reports on Myopia Control

While the experience of optometry established the fact that the structure of the eye mechanism does not constitute the only, or even the main factor in the child's ability to achieve good functional vision, there is no denying the additional fact that science has still failed to explain the process of progressive myopia requiring ever-greater corrective lenses for distance seeing. Nevertheless, encouraging strides have been made in recent years in the "containment" of myopia, even while its cure, or completely effective prevention, escapes us. [20] [3] [26]

Several studies show that bifocal lenses may stop the progress of myopia. Tait, in his "Textbook of Refraction" [51] wrote:

> "While it has not been conclusively demonstrated—there is probably some truth in the general conviction of refractionists that excessive ciliary activity, especially in younger individuals, should be avoided in order to reduce the possibility of a rapid increase in the refractive error. In a number of individual cases of children, the prescription of bifocals was promptly followed by a decrease in the rate of progression, but when the bifocal additions were removed for a time, the former rate was resumed. I, therefore, consistently prescribe bifocals, with a full concave lens correction for distance and an arbitrary addition of Plus 1.00 or Plus 1.50 in all myopic cases in which there is real evidence of untoward progression."

Pascal, in his "Studies in Visual Optics," agreed with Tait.

In 1957, Miles, [35] reporting on data taken from a control study of 50 children followed over a period of 20 years, stated that nearly all myopic children increase in myopia at a rate remaining fairly constant until the age of 17, with the rate of myopization and the age of onset generally determining the final degree. To test the conclusions of Tait and Pascal on the effectiveness of bifocal lenses in curbing this progression, Miles investigated a number of cases from his own practice, and made the following statement on his findings in an article in the December 1957 issue of Missouri Medicine:

> "Average rates of myopization were determined over a period of years by studies of clinic cases. The final degree of myopia depended on the age of onset and on the rate. It was shown that the rate of myopization is fairly stable, diminishing gradually until about the age of 17. Exceptions occurred in 14 percent of the 50 control cases, in that before the age of 13, myopization slowed abruptly. Similar decrease in myopization rate occurred at the time bifocal lenses were provided in 60 percent of 10 myopic children reported here. The series is, of course, too small for statistical analysis. However, of the four children whose myopization rate did not change, one could not overcome his habit of reading at seven inches distance, and another had a serious physical disability. Most significant was the fact that the change in myopization rate in the six cases followed exactly the use of bifocals. Case 3, W.N., is significant in that his bifocals were removed for four months during which myopia increased 1.25 diopters. They were then replaced, and the myopia has not increased in two months."
>
> "I postulate, therefore, that myopia may depend not only on heredity, but also on other factors. I assume that there is a myopic growth mechanism which under certain conditions will stop myopization prematurely. This stop mechanism may depend on heredity, but it may also depend on some biochemical event in the body, or on some change in visual habits or mechanical device such as a bifocal segment."

Expanding Popularity of Contact Lenses

As recently as 10 years ago, only about 200,000 persons in the United States were wearing contact lenses. Today, between 6,000,000 and 7,000,000 persons are reported to be wearing them, with teen-agers particularly taking to the new and virtually invisible devices. Contact lenses, up to about 1947, could be worn by most persons only a few hours at a time. Since then, the larger lenses have been largely replaced by tiny acrylic plastic lenses. Teen-agers requiring corrective lenses have found contact lenses a cosmetic and psychological boon.

While 98 percent of all youngsters wearing contact lenses are in the 13 to 19 age grouping, many children below the age of 13, including babies as young as 9 months, have been fitted with contact lenses, the very young usually as part of post-operative care. Furthermore, there are some types of vision problems for which contact lenses provide the only possible correction. [59]

Contact Lenses and Progressive Myopia

Contact lenses are providing some new and perhaps dramatic data on the problem of containing myopia, and the optometric profession is guardedly excited about the implications of these data. Clinicians from all parts of the world are reporting varying successes in the containment of myopia by fitting children with contact lenses beginning at the age of eight. Results are by no means conclusive.

Whatever the explanation for the encouraging results in the containment of myopia, the fact is that, 78 percent of the practitioners prescribing contact lenses believe they play an important part in many youngsters' emotional development. Thus, they cannot be depreciated as a fad.

VISION PROBLEMS AT THE COLLEGE LEVEL

Vision problems at the college level require far more concern than has been given them up to this time. As college populations have expanded, and as the number of students taking advanced work has increased, more and more students are finding they cannot adjust satisfactorily to the reading demands made upon them.

A recent study at Bradley university in Peoria, Illinois, reveals that nearly two-thirds of all of the freshmen (61.9 percent) had (corrected or uncorrected) vision problems on entering college, and more than a third of these (23.9 percent of all freshmen) had unsuspected vision problems. [38]

McClennand, on the basis of work with students over a period of several years in three colleges, has reported data showing that some 60 percent of all students of the college level might well be in need of vision care as a prerequisite to improvement in their studies, health, and/or emotional stability.

And, as previously cited in this report, the progressive myopia characteristic of myopic children up to the age of 17 has been found to be continuing at an alarming rate for college-age students, including medical students 35 years old.

All of these facts point up the need for a more aggressive visual care program for the serious-minded young adults in our colleges and universities who are engaged in a daily battle to read and understand the vast library of knowledge they are expected to master. The optometric profession has been increasingly concerned over the expanding need for visual care for the students of college level.

Optometry's Preventive Care Program

Optometry feels that adequate preventive eye care programs drafted by optometry for children of all ages (discussed in detail in Part II of this report) should go a long way, if widely adopted and properly supported, to establish and maintain good visual habits among the elementary and secondary school children which will carry over with these children into the college level and thus avoid the vision difficulties now so common on our national campuses.

SPECIAL VISION PROBLEMS

Squint or Strabismus (Crossed Eyes)

During the past 10 years progress has been made in the non-surgical treatment of crossed eyes through orthoptic training (visual training).

Examinations of large numbers of the school population show that strabismus occurs in at least one case in every 100 pupils. The majority of cases is found to have a convergent strabismus--esotropia. When the eyes diverge, the condition is called exotropia. Both conditions are found in many individual cases to result from an attempt on the child's part to avoid discomfort experienced from the hard work of trying to focus both eyes together on the same near object. The child unconsciously seeks to overcome the discomfort or simplifies the task by seeing the object through only one eye, either suppressing the other one or turning it inward or outward.

The theory that crossed eyes is a functional disorder is not new. MacKensie, in his "Practical Treatise on Diseases of the Eye" stated in 1854 that: [52]

> "The cause of ordinary strabismus, then, must lie deeper than the muscles of the eye, and deeper even than the retina, namely, in the brain and nerves, the organs which govern the associated actions of the muscles of both eyes."

While surgical procedures are sometimes necessary for strabismus, surgery is not always effective. Of course, each child's needs are different and the facts in each case must determine the course of action to be followed.

Investigation of Lenses and Visual Training—(Orthoptics)

However, based on experience with children suffering from strabismus, it is optometry's opinion that before an operation is undertaken, every effort should be made by the parents to investigate all possibilities for help through visual training and glasses. As is often the case in visual care, if the strabismic response is one which has been learned by the child as a compensation rather than existing as an organic defeat, it is possible that the cause can be discovered and the child taught to use his eyes simultaneously.

Frequently, after an operation, single binocular vision cannot be maintained and deviations occur again within a few months after the surgery unless visual training is given. Some children make excellent progress if they receive visual training both before and after the operation reduces excessive deviation.

Encouraging Progress in Helping Crossed-Eye Condition

Parents should certainly not take the chance of hoping for the child to outgrow the condition. When they first observe or think they observe a squint in a very young child, they should have the child's eyes examined immediately. Optometrists, in addition to prescribing lenses when indicated, will often find it advantageous to the child to begin some type of visual training at a young age--prior to 5 or 6.

A large percentage of cases with convergent or divergent strabismus can learn single binocular vision through visual training combined with lenses, even cases previously written off as hopeless. No child's case should be considered hopeless until all possibilities are investigated. The vocational, educational and social consequences of uncorrected strabismus are often such that no child should suffer them needlessly and particularly so in a nation which seeks to provide the full opportunity to every child for a creative life in freedom and dignity.

There is no sure, easy solution for strabismus. There has been encouraging progress. There is a basis for strong conviction that many such children not now being helped can be helped to overcome their difficulty. Optometry will continue its efforts in this direction.

THE PARTIALLY-SEEING CHILD

Not so long ago, we approached the problem of the partially-seeing child by protecting him as much as possible from using his limited vision. We were "conserving" his precious sight by not letting him use it. We have since learned that a more effective philosophy is one which enables the child to use to the fullest advantage in his daily life the residual vision he still possesses. Properly supervised and guided, a partially-seeing child does not wear out his limited vision; he enhances and develops it and thereby his own role in life as well.

The Committee on Visual Problems of Children and Youth of the American Optometric Association has prepared a "Manual on the Partially-Seeing Child" which states:

> "Education is believed to be preparation for living, from the economic, sociological, cultural, and emotional points of view. In accordance with this principle, methods of educating children with special educational problems are changing rapidly. This is unquestionably true of the partially-seeing child as well as the other types of special problems."

A Normal Environment

These new concepts have led educators to keep the partially-seeing child in a normal school environment as much as possible, thus leading a normal school life, learning and playing

with his normally-seeing classmates as well as with exceptional children with handicaps of a different nature. This heterogenous school situation echoes the kind of life situation the child will later encounter as an adult. In this way he learns as a child to understand his handicap and what it means, how to compensate for it, and how to make the most of his total abilities in a normal environment.

What can we do about improving the vision of the partially-seeing child? Often, mere vestiges of vision can be utilized with unexpected effectiveness. Usually this involves the use of magnifying aids, including telescopic and microscopic types of eyeglasses which have made it possible for people with low residual vision to read even the small type of newspapers.

Merely furnishing the magnifying aid is not enough. In most cases the patient needs a carefully developed program of vision care.

The optometric profession has evolved a program of low vision rehabilitation which adheres to the following philosophy for the partially-seeing:

(1) To integrate, as effectively as possible, remaining vision with other senses in a normal environment.
(2) To utilize, rather than "conserve", the visual sense; to venture behavior on the basis of reduced visual clues.
(3) To avoid a sheltered and often limited education as preparation for a non-sheltered, unlimited, competitive world.
(4) To provide visual aid in the form of special vision training, visual education, experience and optical aids.

Need For Team-Approach By Several Professions

Such a program of rehabilitation ideally calls for more skills than are found in any one profession or discipline. Consequently, it is optometry's view that only a team can achieve the desired maximum goal in rehabilitating the partially-seeing child and providing him with his deserved opportunity in life. Among the skills needed are:

(1) Teachers--the regular classroom teacher and the itinerant or resource room teacher--the primary members of the team.
(2) Ophthalmologist to judge the significance and prognosis of the pathological cause of the partial loss of sight.
(3) School nurse.
(4) Educational psychologist.
(5) Social worker, if possible.
(6) Optometrist--to provide developmental vision care to the fullest extent possible through visual training and special devices to enable the child to use his limited vision resources to the utmost.

The child who can read only by holding the book or paper within a few inches of his eyes has a handicap. Undoubtedly he cannot read at the pace of normal children of good vision habits. However, with proper understanding of their problems, many of these children aided by modern optometric techniques may be taught in a normal school environment.

On the other hand, many Americans who visited the Senate of the United States in the days when the late Alben Barkley was Majority Leader, and watched from the galleries as Senator Barkley, in debate, cited chapter and verse of the bill under debate, might have seen the Kentucky senator then pick up the bill and hold it two inches from his face, find the line he was searching for and read it out. Anyone who saw this frequent incident in the Senate of the 1940's can attest to the fact that a vision-handicapped person who has the motivation to read can often learn to do it well enough for any normal need.

VISUAL CARE FOR THE BRAIN-INJURED OR RETARDED CHILD

Partly as a result of the work of the Mid-Century White House Conference on Children and Youth, remarkable progress has been made in this country since 1950 in caring for and providing new opportunities for handicapped children of all types. The educational systems of most of our states have been expanded to provide school experience for those exceptional children requiring either a special environment, or specialized teaching within the regular classroom. Previously, such children received little or no formal education.

It has been only within the last five years, however, that much has been done for the brain-injured or severely retarded child; thus we are still in the earliest pioneering stage of providing educational or training opportunities for such children. Optometry is proud to have had the opportunity to play an important role in the teamwork approach to the needs of the brain-injured.

As a special supplement to this report, we have persuaded one of the leading specialists in the United States in the field of brain-injured children, Dr. G. N. Getman of Luverne, Minnesota, to prepare a statement for submission to the White House Conference on "Optometric Visual Care for the Brain-Injured Child," and we present it in the Appendix of this document. We urge that educators and other professionals interested in, or working with brain-injured children read the Getman paper for encouraging facts on how children once relegated to the level of "human vegetable" are being made into productive members of society.

Progress in the training or education of brain-injured children has come about only through the combined efforts of psychiatry, psychology, education, pediatrics and optometry. It has been a teamwork project in a field of extraordinarily challenging difficulty. The results, while limited, have nevertheless been remarkable in some instances, and rewarding in nearly all cases.

New Testing Technique

The work of Gesell, Getman, Apell, Strauss, Simpson, and others in the literature relating to vision developments and characteristics of brain-injured children has been the foundation on which much of the later progress was built. [32]

As the visual development of the brain-injured child has become better understood, a logical sequence of visual development is now being utilized as a yardstick in the care of brain-injured children. Optometry has now devised testing techniques which can be applied to brain-injured children of all degrees of severity, measuring their visual development against a predictive developmental scale.

In many cases, it has been found that when children have been assisted in the development of their visual skills and the related skills which are essential to visual development, they show less evidence of the characteristic mannerisms of the brain-injured. Their injury, of course, remains; they can often learn, however, to overcome the jerky motions, the necessity to turn the head instead of moving the eyes and other characteristic mannerisms of the brain-injured. As they improve visual skill they are on the road to learning to become contributors to society rather than problems to it.

RESEARCH IN VISION CARE—GAPS IN OUR KNOWLEDGE

A great deal has been accomplished in the field of vision care research in the past 10 years. A great deal more, however, remains to be done. Past research, while encouraging, has been scattered, uncoordinated, and financially neglected. Results have been due almost entirely to the initiative and determination, and personal sacrifices, of dedicated individuals rather than of institutional or governmental guidance or endowment. In fact, public funds have been virtually non-existent in this field.

In our country, each year, we spend several millions of dollars for physical and medical eye research, both clinical and laboratory and these needs, of course, should continue to be met. They are urgent. At the same time the several millions now spent would make only a

tiny ripple in the pool of needed financing for a balanced program of vision research in the developmental, recreational, social, psychological, educational and administrative areas of the vision needs of children and youth.

Areas In Which We Need More Information

There is a special need for studies to be made in all areas of vision care which are designed to evaluate functional vision.

A research project is needed involving all professions concerned with the important developmental years of a child from birth to school age.

A great deal of research is needed on the vision problems of brain-damaged children. The start optometry has made in this field is only a very tiny beginning, in view of the scope of the problem and the increasing population of such children.

On the vital educational problem of reading achievement, we need research answers to such questions as these:

(1) What factors affect visual perception and its development?
(2) Are we starting near-point activities in school too early? Are children visually ready to read by this time?
(3) How can we best help the schools to determine when a child is visually ready to learn to read?
(4) How can we improve our training of visual readiness for reading?
(5) What can the schools do to help children learn to see before trying to teach them to read?
(6) Are we requiring too much use of the eyes in sustained near-point activities during the early school years? Is this an important factor in progressive myopia?
(7) How can materials and methods be better adjusted to the vision needs of school children?
(8) What are the symptoms of poor vision ability which children display in class?
(9) How much is the classroom environment, the furniture design, the lighting and the materials contributing to vision difficulties?
(10) Can we establish the reliability of present indications of myopia containment by use of special devices such as bifocal lenses, or contact lenses, combined with visual training?
(11) What are the factors contributing to the reported increase in the incidence of strabismus?
(12) Can visual training by itself correct strabismus in a larger percentage of cases?
(13) What is the incidence and relationship of functional vision to emotional disturbance and delinquency?
(14) What are the factors in the development of visual performance which contribute to incidence of visual problems at college level?

The Challenge of the Next Decade

As in all sciences, optometry has found in the past 10 years since the last White House Conference on Children and Youth that new concepts and new techniques, while greatly advancing our knowledge and our services to children and youth, also bring with them new problems, new challenges, and the need for vastly more research. This is the price of progress in all fields as solutions to older problems inevitably bring new ones. It is optometry's conviction that the tremendous strides made in these past 10 years in assuring better vision care for our children and youth are but the prelude to much greater progress in the coming decade.

We look for our greatest accomplishments in the coming decade in the field of preventive vision care, a field in which the need for improvement is urgently demanding, if we do achieve our goal of a creative life in freedom and dignity for every child.

THE IMPORTANCE OF VISION TO A CREATIVE LIFE IN FREEDOM AND DIGNITY

PART II: The Prevention of Vision Problems in Children and Youth

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"Your eye is the lamp of your body. When your eye is sound, your whole body is light, but when it is unsound, your body is dark."--Luke 11:34

The 1960 White House Conference on Children and Youth occurs at a time when America's long supremacy in science and technology is being impressively challenged by a country only four decades removed from national illiteracy, and by a people who have never known in all of their long history the meaning of freedom of the concept of the dignity of the individual in matters involving the State. Soviet successes in space rocketry out-distancing our own efforts and achievements have therefore come as a shock to American complacency and have led to an increasingly critical re-examination not only of missile and space programs but of American educational methods and the motivation of our youth.

It is certainly not the purpose of the American Optometric Association in this report to seek to assess the reasons for our failure as a nation to achieve the first artificial satellite or to reach or circle the moon before the Russians. Certainly, however, it was not the fault of today's youth in schools and colleges, although one could easily be led to think from the discussions which have been publicized on this issue that America's space failures in relation to Russia's successes could be blamed on high school students electing "co-ed cooking" in preference to chemistry or physics courses.

Nevertheless, we are all now painfully aware of the fact that the end-product of American education in terms of total number of college graduates trained in the advanced skills our society requires, is far from adequate to meet the defense or other needs of our nation, or the challenge of world-wide shortages and scarcities of trained technicians in all fields. Moreover, an alarmingly high per centage of our youth is dropping out of school uneducated, untrained, unmotivated, undirected. It is joining an already large reservoir of aimless unemployed in an economy in which a high school diploma is now demanded for almost any type of industrial or commercial employment.

Utilizing Preventive Vision Care Knowledge

Thus, whether or not American educational policies are at all at fault for this nation's failure to win the race into Space, the fact is that we are not making the most of the educational opportunities now available for our children and youth. We can do much better.

The optometric profession believes that we could improve tremendously on educational end-product and that we could cut down drastically on the number of non-achievers and drop-outs in schools and cut the cost of our public education. We could encourage more students to study harder and learn more if we were to put to broader use in the United States the knowledge now available to us in preventive vision care. Do we have the vision as a people to meet this challenge?

Part I of this report described the incidence of vision problems and the techniques for identifying and minimizing them among children and youth. Equally important, however, is to prevent common visual problems from arising in so many of our youth, and to give all children the advantages of current information on vision health and efficiency.

ENVIRONMENTAL FACTORS IN PREVENTING VISION DIFFICULTIES

Now that television is no longer the novelty it was a decade ago, and is well established in almost every home in most of the populated areas of the nation, fewer children are coming to school each day with the red rimmed bloodshot eyes, and tired minds and bodies so prevelant in the classrooms a few years ago when TV was so irresistibly new. However, excessive viewing still persists among many children, and bad television viewing habits are contributing to some degree, at least, to vision difficulties.

This is only one of the many aspects of the environmental effect upon vision. In schools, where children spend so many hours of each day they can be helped or hindered in their vision abilities and thus in their learning abilities by the classroom's physical characteristics, such as colors, lighting, furniture design, etc.

For instance, children react to glaring lights, bright sunlight streaming through windows or bright sunspots. They are affected by "light-robbing" dark colors, glossy finished walls, harsh shadows and dark corners in their rooms. Adult-sized desks, tables and chairs, and other ill-fitting over-sized or under-sized furniture adversely affect not only the child's vision and posture but also his general health, growth and learning.

"Vision-Conditioning" the Classroom

The importance of "Vision-Conditioning" of the classroom was underscored by the work of the Texas Interprofessional Commission on Child Development under Harmon in studying the effects of improper lighting, decorations, and seating upon the well-being of 160,000 children.

Intensive research indicated that three-quarters of the children had signs of chronic infection, 71 percent had nutritional problems, 53 percent had vision problems, and 30 percent had posture handicaps. Following inexpensive changes in classroom lighting, decoration and seating, the improvements were marked and dramatic. The percentage of children with chronic infection dropped from 75 to 42; those with nutritional problems dropped from 53 percent to 18 percent; those with posture handicaps comprised 22 percent instead of the previous 30 percent.

Moreover, the children demonstrated in the changed surrounding an ability to learn as much in six months as they had previously learned in a full academic year of 10 months. [27]

Harmon's success in improving the over-all well being, as well as the learning skills, of the children involved in this study grew out of a recognition of the complex nature of the visual process and the interrelationships of many factors in the child's environment and his visual and learning abilities. It was found that well-planned, evenly distributed light and brightness, with properly fitted furniture, will help the child to "focus" in his numerous activities.

On the other hand, severe contrasts in brightness, harsh shadows and posture-distorting furniture (the much-too-common environment for home television viewing, by the way) sap the child's reserves of bodily energy and, in school situations, distract the child and interfere with learning tasks. [49]

PREVENTIVE VISION CARE BEGINS IN INFANCY

Ideally, a program of developmental vision care would begin at birth, when the nascent reflex patterns of eyes, hand, touch, balance, hearing, taste and smell are beginning to organize within themselves and in relation to each other. Actually, vision development has already gone through many stages, before birth. Thus, shortly after birth, specific vision activities may be

set up for the baby, and the child will welcome and respond to appropriate visual stimulation. [22A]

Undoubtedly, the first year is vital to the healthy development of vision. Ample opportunities should therefore be provided by the parents to help the child learn to see efficiently and effectively.

The battery of infant vision tests which an optometrist can use as early as 16 weeks of age can provide several clues as to the developmental stages of the baby's vision behavior. Thus, an immediate professional vision examination is essential where a recurrent deviation of either eye is noted or any indication exists that the infant is not using his eyes properly.

First Examination Before Kindergarten

For normal youngsters evidencing no sign of visual difficulties, the first professional eye examination and vision analysis can be scheduled for the third or fourth year, depending, among other things, on the examiner's skill in handling young children. As a practical matter, four is usually the best age for the first vision examination. The four year old is more stable and cooperative, and there is less danger of fatigue or of an incomplete examination. In any case, however, the first vision examination should be done before the child enters kindergarten.

This initial examination not only serves an important purpose in itself, but it lays the ground work for the examination that should then follow at yearly intervals. From this starting point, the parents and the optometrist can begin planning the type of activities that will best encourage normal, efficient vision development.

Pre-school evaluation of vision and corrective program when needed will do much to prevent vision problems from developing or increasing. Regular examinations thereafter can chart the manner in which the child is developing the vision skills necessary for the complex act of deriving meaning from the printed page. Such regular examinations, furthermore, will uncover in early stages any danger signs indicating the need for special vision aid.

SCHOOLS MUST PLAY A KEY ROLE IN PREVENTIVE VISION CARE

Many parents arrange for periodic vision examinations for their children as a regular and routine matter, just as they arrange for periodic dental check-ups and overall physical examinations. If all parents did so for all children, undoubtedly we would have far fewer problems among children and youth today, and much suffering and unhappiness could be averted. Unfortunately however, too many children have been neglected by parents who failed to see any need for a vision examination in time to prevent vision damage from occurring, or to correct it promptly.

But while we must exert every effort to educate parents to the vision needs of their children, the fact is that many parents will continue to remain unaware of the problem, or will persist in ignoring it despite all warnings, just as many parents have tragically failed to arrange for Salk vaccine shots for their children.

Thus our approach to the problem of reaching all children for vision health and well-being must be primarily through the schools: 1) in teaching all of today's youngsters how to be tomorrow's more responsible parents so that their children will not in turn suffer vision neglect; 2) in alerting the child, and through him, his parents, to the importance of obtaining regular professional vision care; 3) finally, and perhaps most important of all, in school-based vision screening programs designed to uncover in early stages the vision care problems of children whose parents have not fulfilled their duty to arrange for periodic professional examinations. Such vision screening programs are discussed in detail further on in this section of the report.

What the Schools Should Teach About Vision Care

But within the school's regular course of instruction, the following facts about vision care should be stressed and emphasized in all hygiene or health courses:

1. Children do not "outgrow" vision problems. A child with uncorrected or untreated vision problems is going to get worse, not better with the passage of time.
2. Difficulties in binocular coordination persisting to the age of six generally require long-term therapy. Prompt diagnosis and attention therefore are important to the solution of this serious learning problem as early in the child's school life as possible.
3. While mass-screening programs are vitally important in uncovering the existence of many unsuspected or neglected vision problems, not all such problems may be discovered in this fashion. Thus, each person should learn to recognize subtle signs of vision difficulties in himself or in children under his care or supervision.
4. Any departure from the normal which would indicate the possibility of trauma or inflammation should receive prompt professional care and treatment.

Vision care specialists are frequently amazed by the extent of vision difficulties of children who have given neither parents nor teachers any clear indication of the existence of the problem. The child may have been placed regularly in the front seats of the classroom and thus have had no occasion to complain of difficulty in seeing the blackboard. Furthermore, he never complained of difficulty in seeing at distance because he just didn't know that the fuzzy and indistinct outlines of objects he looked at were not the normal appearances of those objects to everyone else. And he may have unconsciously "covered up" poor visual adjustment to motion pictures or television programs by indicating he wasn't "interested in" or "just didn't like" movies or TV. At some point, however, the child will eventually become consciously aware that his schoolmates are seeing things he does not.

Such experience indicates that only a school-based program of adequate instruction in visual health coupled with effective vision screening can successfully prevent the unfortunate, widespread and completely unnecessary wastage of vision resources which deprives so many children of their full opportunity to live a creative life in freedom and dignity and which deprives our society and economy of the greater contribution such children could make to our over-all national goals.

AN EFFECTIVE SCREENING PROGRAM FOR VISION HEALTH

The "perfect" vision screening program in the schools would be one which, at small expense and by inconsequential demand for teacher and pupil time, would automatically and reliably single out every child needing any special vision aid, attention or training, while not causing a single "over-referral", that is, recommending a child for professional attention when he was not in need of it. The "perfect" vision screening program as several surveys of screening programs now in effect have indicated just does not exist, any more than does any "perfect" quick-screening, one hundred percent reliable, inexpensive, assembly-line mass screening program for say tuberculosis, or cancer, or other diseases or malfunctions.

This does not mean, however, that mass screening for tuberculosis, for instance, is useless because some suspects are not uncovered while occasional healthy persons are referred for further investigation. Yet some studies into vision screening programs have implied that little is to be gained by any mass examination which goes beyond the traditional Snellen test of visual acuity at 20 feet. [15]

> "The misconception that the Snellen chart will do an effective job of screening out children who need visual care is a major block in the road of those who are trying to establish good school visual screening programs. The fact is that any school which relies on the Snellen chart alone as a screening method will fail to detect large numbers of children in urgent need of visual care." [31]

Regarding the subject of over-referrals and under-referrals, Blum, Peters, and Bettman state:

"The most significant over-all cost in a vision-screening program will be the expense to the individual families, or to the community resources, for clinical examinations of the children screened out as needing professional attention. If there is significant over-referral, the cost will be increased needlessly. In addition to wasting community resources, over-referrals may well destroy confidence in the program. If there is significant under-referral, many children needing professional attention will not be detected, although screening costs will be minimized. In terms of visual health and welfare, the hidden costs of under-referrals are inestimable." [9]

Effective Screening Methods Can Be Devised

Regardless of the admittedly controversial pros and cons of the methods and procedures used in the various evaluation studies which have been conducted into vision screening, the fact is that better results can be achieved in vision screening if there is a willingness on the part of all professions and disciplines concerned in this matter to join together in a determined attack on the problem. The optometric profession is sincerely anxious to help foster such an inter-professional approach, similar to the type of approach it has fostered in the care of brain-injured children in cooperation with educators, pediatricians and/or ophthalmologists, as well as psychologists, social workers, nurses and other groups. Experience in these joint efforts has proved to our satisfaction that effective procedures can be worked out cooperatively, even though it may occasionally entail some compromise of professional prerogatives for the sake of the common good.

In any discussion of the problem of establishing a more effective vision screening program, the major consideration must be, as it always must be in any matter affecting the lives and futures of our children, how can we do the job which has to be done?

Any statement which implies that it cannot be done well enough such as, "Even the best vision screening program will not be 100 percent 'perfect' so why bother with anything more than the common Snellen test," ignores the responsibility upon all professions concerned with children to do the best job possible within the admitted limitations of vision screening techniques. Meanwhile we should bend all of our joint efforts constantly toward improving the results obtained.

Anything less than that is a confession of futility to which optometry refuses to subscribe.

American Optometric Association Screening Policy

The Committee on Visual Problems of Children and Youth of the American Optometric Association realizes, and readily concedes, that the problem of developing better screening programs for the schools is a complicated one. Many factors make for this complexity. Some of the elements which must be considered are the variation in laws governing vision screening for school children in the various states, the number of school children to be screened, personnel available to do the screening, the instrumentation available, the cost of vision screening, the funds available to the school or community, facilities available for followup, and the level of professional services available in the various communities.

Vision screening should be a part of a larger vision conservation program which has as its aim prevention of visual difficulties which keep a child from achieving. It is therefore important that all of the various groups concerned with a child's welfare in school should be included in such a program: the teacher and parents (to observe symptoms of vision difficulty); parents (for parent education as to the importance of vision to a school child, and for facilitation of follow-up care); the vision and eye specialists in the community; the school nurse; and school administrative personnel. [6]

If a school vision screening program is to be practical in terms of cost, administrative ease, time and number of children referred, it is of utmost importance that the vision special-

ists practicing in the community agree at the very beginning on the types of tests to be administered and on the criterion to be used in referring children for professional help. Too often, vision screening programs are caught between divergent professional approaches to eye and vision care as if there were only one acceptable method of uncovering children with vision difficulties, or as if one-eyed distance sight at 20 feet were the only criterion of seeing ability.

As Dr. Martha Eliot, former Chief of the U. S. Children's Bureau, recently stated: "There is no more important subject to which we can address ourselves than the essential need for a multi-professional approach to the problems of children." Disagreements and discord among professional groups working in the field of eye care and vision care must be and certainly can be subordinated to the need for better methods of vision screening in the schools.

Limitations of Screening Must Be Understood

It is of utmost importance that all groups and individuals participating in the screening programs understand the limitations of the program. This is particularly important for parents, who must be made aware of the fact that passing a screening test or even of a battery of tests is no guarantee that a child does not have defective vision or malfunction serious enough to require treatment. Whenever a family uncritically should accept a report from school that the child has "perfect vision" at distance and fails as a result to watch for any signs of vision difficulty or fatigue in the child, the screening program has done the child a great disservice. Or, rather, the utilization and interpretation of the test has been abused.

GUIDEPOSTS TO BETTER VISION HEALTH

1. If we can discover more children, even if not all children, needing vision assistance through a practical school vision screening program, it is well worth the expense, time and effort of teacher, child, school administration staff, school nurse, volunteer PTA helpers. And, if the community had the foresight to engage them, the school optometrist and the school physician. Screening programs should always include tests of vision efficiency at the reading distance.

2. Professionals in vision and the eye care field must "get together" and jointly work out constructive programs for vision conservation of school children which can be utilized in the schools throughout the school year. Architects, decorators, psychologists and pediatricians can augment this work by vision-conditioning and posture-conditioning the classroom environment.

3. More avenues of communication must be opened up between all professional groups working with children and youth, for a wider sharing of research knowledge and of new techniques. This is as true for the groups working with so-called normal children as it has been proved to be true among the professions which have cooperated so splendidly in recent years in the care and advancement of brain-injured, partially-seeing and other "exceptional" children. Optometry is proud to have played a satisfying and significant role in this interprofessional teamwork approach which has resulted not only in optometry sharing its knowledge with other disciplines but in reciprocal benefits of invaluable assistance to optometry in serving the vision needs of millions of Americans.

THE IMPORTANCE OF VISION TO A CREATIVE LIFE IN FREEDOM AND DIGNITY

PART III: Optometry's Specialized Role in Service to Children and Youth

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Vision is a child's most precious sense. A child with good vision performance at near and far is usually a good student for he can spend his efforts and energy in mastering written concepts, rather than mastering the problem of seeing words. Optometry is dedicated to enhancing the child's operational vision.

As early as 1910, shortly after the first White House Conference on Children and Youth, it was recognized that vision care required a type of education which could not be assimilated in, or made adjunct to, any existing professional curriculum. It was obviously necessary to combine knowledge from many diverse sciences if the science of vision care was to emerge as a practical discipline. Consequently, leading universities began setting up specialized optometric courses for professional education in vision care, combining physics, optics and mathematics with psychology and such health subjects as anatomy, physiology and pathology. Today accredited courses require a minimum of 5 years (some require 6 years) of study at the college level.

Today, moreover, about 35 percent of all students entering optometry colleges have already completed four-year undergraduate courses of study with bachelor's degrees. If they have concentrated on science subjects in college, they can thereupon finish optometry requirements in three or four additional years, receiving customarily the degree of O.D. (doctor of optometry). Some schools grant degrees of bachelor of science in optometry and master of science in optometry, doctor of optometry and doctor of philosophy degrees in physiological optics. The accredited colleges and universities offering optometric courses include: Illinois College of Optometry; Indiana University; Los Angeles College of Optometry; The Massachusetts College of Optometry; The Ohio State University; Pacific University; The Pennsylvania State College of Optometry; Southern College of Optometry; University of California and the University of Houston.

The optometric curriculum, in addition to concentrating on subjects directly related to vision care, also devotes about one-fourth of the student's work to a broad study of the human body, with particular emphasis on eye diseases and symptoms of other diseases which can be detected in the eyes. Optometrists, of course, do not treat patients medically; however, the long study devoted to eye and other diseases enables the optometrist to refer for appropriate professional care patients whose eyes reveal evidences of possible disease.

Availibility of Vision Care

Every year more than 30,000,000 Americans obtain vision care. Millions more who need such care neglect to seek it. If all who needed vision care were to seek to make appointments with qualified practitioners, they could not all be served. At present, there are about 21,000 optometrists or one to every 8,000 persons, (the ratio of certified ophthalmologists to population is 1 to every 45,000 persons). To serve 10 years from now merely the same percentage of the population now receiving vision care, we would have to double the present number of optometrists.

The greater need for more professional optometrists is in the Southern States, where the existing ratio is as low as 1 to 15,000. (See Appendix Exhibit C for numbers and ratios of licensed optometrists and certified ophthalmologists by states.)

Nevertheless, there are today members of the optometric profession located in almost every rural community, and town, and in every city in the United States, and in nearly all instances these professional men and women devote a major share of their practices to the special vision problems of children and youth with particular emphasis on preventive care. Just as a conscientious dentist strives to save a child's permanent teeth and keep them strong for a lifetime, rather than later try to remedy the ravages of dental neglect, so the optometrist strives to prevent damage to the child's vision in preference to correcting it later in the child's life.

Functional Vision Care

In this connection, optometry has pioneered in functional vision and developmental vision, with emphasis on effective near point performance, and has developed such innovations as con tact lenses, visual training, and the use of bifocal lenses for children in improving classroom visual performance. Often bifocal lenses contain a prescription lens only in the lower segment and merely plain glass in the upper segment, for children needing no assistance in distance sight, but requiring appropriate lens prescription for nearpoint tasks. The bifocal technique has replaced the older practice of prescribing a single lens where the child needs help only in nearpoint sight but not at distance or greater help at near than at distance. This is but one illustration of optometry's development of the functional vision concept, to help the child perform better in all of his vision tasks.

The American Optometric Association, and the state associations affiliated with it, are constantly seeking new insight on means of strengthening the profession's services to the public and particularly to children and youth by disseminating new knowledge in this field. In addition, numerous post-graduate courses to keep practitioners up to date on new developments are being offered to the members of the profession through the Schools and Colleges of Optometry, through state and national associations, and by two ancilliary organizations, the American Academy of Optometry, and the Optometric Extension Program Foundation, both of which devote full time efforts to continuous research and to the further education of the practicing, licensed optometrist.

OPTOMETRY'S ORGANIZED SERVICES IN BEHALF OF THE CHILD

The continuing work of the American Optometric Association in relation to the welfare of children from birth through college is centered in the activities of the Committee on Visual Problems of Children and Youth, which is also charged with responsibility for organizing the American Optometric Association's participation each decade in the White House Conference on Children and Youth.

In the 10 years since the last White House Conference, the Committee on Visual Problems of Children and Youth has sponsored an annual multiprofessional forum on vision problems of children and youth in Cleveland. Each year since 1950 the attendance at these conferences has grown as educators, psychologists, optometrists and others have recognized in the annual forum an excellent opportunity for the exchange of information, techniques and methods for aiding and enhancing the developmental vision of children.

As the annual Cleveland conference of the American Optometric Association's Committee on Visual Problems of Children and Youth has become more and more successful, regional groups have found it worthwhile to establish similar meetings. Thus, in three successive years, such forums have been held for the Middle West in Chicago; two such annual events have occurred for the West Coast in Los Angeles, and this year the first Southern Forum is being sponsored by the Florida Optometric Association.

On the state level, most of the state optometric associations affiliated with the American Optometric Association have conducted similar forums, with subsequent report sessions at the local society level to disseminate broadly the new knowledge developed at national, regional and state meetings.

Active Sponsorship of Multi-Professional Approach

In every possible way, organized optometry has sought to sponsor or encourage a multi-professional approach to the vision and related problems of children and youth. As a profession, and through the dedicated work of many individual vision care specialists, optometry has participated in a variety of programs set up to aid various types of exceptional children, with particular emphasis on the partially-seeing, the retarded, and the brain-injured, but covering also all other categories of exceptional children for whom special programs are being undertaken on the local, regional, state or national level.

In the field of vision screening in the schools, optometry has found that the multiprofessional approach, in which optometrists, ophthalmologists, school administrators, public health officials, teachers and parents cooperate in the development of a program, provides the best hope of achieving a successful and effective and practical result. [9] In practical operation, such an approach is being used with encouraging success in Euclid, Ohio schools, where children are tested not only by Snellen chart for visual acuity at 20 feet but by additional tests which reveal difficulties in using the eyes together with ease and efficiency for boardwork, deskwork and reading.

In furtherance of their objective of integrating vision care programs into school health services, State Committees on Visual Problems of Children and Youth are cooperating not only with the public agencies concerned but with civic and fraternal groups such as Lions, Kiwanis, Rotary and others to establish voluntary vision testing programs where the states are unable to provide official programs.

AOA Publications To Help Parents, Teachers

A variety of publications and an authoritative new book have been published by, or underwritten by, the optometric profession, to help parents, teachers and all groups working with, and interested in, the visual welfare of children to understand the processes by which children learn to see more efficiently. These materials may be obtained from the American Optometric Association, 4030 Chouteau Avenue, St. Louis 10, Missouri.

The book referred to, PRE-SCHOOL VISION, by R. J. Apell and R. W. Lowry, Jr., published in 1959, was prepared under a research grant from the American Optometric Foundation to the Gesell Institute of Child Development at the request of the American Optometric Association's Committee on Visual Problems of Children and Youth. [1] It describes a battery of visual tests developed for pre-school children not only to detect errors of refraction but also to appraise the child's visual performance in relation to others of his own age, thus indicating, from the child's visual behavior, whether he may need special vision help to become an achiever in the school environment.

A leaflet published by the American Optometric Association, YOUR BABY'S EYES, is intended to help parents to encourage the child's visual development in the right direction from the earliest days of infancy.

Another pamphlet, MOMMY AND DADDY, YOU CAN HELP ME LEARN TO SEE, (referred to earlier in this report) has been published by the Association under the sponsorship of the Woman's Auxiliary of the AOA, as a guide for parents on observation and application of developmental principles in vision guidance of infants. And to guide parents further in observing the child's visual performance, the Association has also published a folder CHECK YOUR CHILD'S VISION.

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Other useful publications issued by the American Optometric Association in a continuing and determined effort to increase public understanding of vision problems and of the need for preventive vision care include:

MANUAL ON VISION CARE OF THE NON-ACHIEVING CHILD, which, besides providing the optometrist with background technical information, has been found to be particularly useful to educators, especially those connected with reading clinics. [18]

TEACHER'S GUIDE TO VISION PROBLEMS WITH CHECKLIST, which discusses symptoms of a child's visual difficulty while using his eyes "on the job" of learning in the classroom. [53]

STUDENT VISION REPORT FORMS, which enable the optometrist to provide parents and teachers with a readily understandable outline of the elementary or secondary school student's visual abilities.

CLINICAL GUIDE TO AMBLYOPIA THERAPY, to assist in the early detection and subsequent care of children with strabismus or amblyopia (a dimness of vision not fully corrected with lenses). [37]

MANUAL ON THE PARTIALLY SEEING, to be released during 1960.

In addition reprints are available of numerous articles on the vision problems of children and youth written by members of the optometric profession for various publications. These, and other materials—including monographs, posters, and a filmstrip ADVENTURES IN SEEING (of which more than 15,000 prints have been distributed on request to elementary schools within the past two years)—are available to groups or individuals interested in more information on the importance of vision to a creative life in freedom and dignity for America's millions of children and youth.

OPTOMETRY LOOKS AHEAD CONFIDENTLY TO 1970

Each White House Conference on Children and Youth since the first one a half-century ago has served humanity in two important ways:

1) as a device for assembling together in understandable terms and workable dimensions the sum total of all new knowledge of the preceding decade in matters involving the welfare of children; and,

2) in inspiring all of the professions, disciplines and lay groups participating to exert renewed efforts to solve in the succeeding decade the unanswered questions, the riddles and dilemmas inherent for children in the dynamics of community and national life in a constantly changing American society and economy.

The 1950 White House Conference was an outstanding success from the standpoint of both criteria, and the 1960 White House Conference promises to match and exceed the contributions of its predecessor. In the field of vision care, the 1950 Conference set off an explosive charge of scientific curiosity leading into new paths of research, with often remarkable results.

In fact, so much has been accomplished in the field since the 1950 Conference that the optometric profession is encouraged to believe the next 10 years will bring even greater progress in conserving and improving the visual abilities of America's youth, thus making possible a tremendous upsurge in educational achievement and assuring a better life for millions of Americans, and a sounder, firmer basis for our freedom.

In the concluding section of Part 1 of this report, the American Optometric Association's Committee on Visual Problems of Children and Youth outlined in detail the many existing gaps in our knowledge about vision care and vision problems and the research goals which we must pursue diligently in the coming decade. There is, therefore, no necessity for repeating that material here. These are goals not only of optometry but of all groups which recognize the

close and direct relationship between a child's visual capabilities and his opportunities for achievement in school and in later life.

Optometry as a profession takes great pride that its efforts and its cooperation have played a key role in the research in vision care undertaken so successfully in the past 10 years. This research has created a broad new pattern of knowledge in vision care which now constitutes the foundation on which future research efforts can optimistically be erected.

Challenge of Future CAN and WILL be Met

As a comparatively new discipline itself, optometry has had the necessary flexibility in outlook to enable it to strike out inquiringly into new and uncharted fields of research without fear of disturbing encrusted doctrines and grimly held dogmas inherited from another era.

In concluding this report, the Committee on Visual Problems of Children and Youth, of the American Optometric Association, on behalf of the 21,000 licensed optometrists now practicing in every State of the Union, wishes to assure the delegates to the 1960 White House Conference on Children and Youth of optometry's determination as a profession to continue to search, probe, inquire, challenge old theories and test new ones. To this great goal; we pledge:

That every means will be sought by optometry, working in our own practices and in sincere cooperation with other disciplines, to solve more of the vision problems of America's youngsters. This will assure better vision for children and youth and thus a more creative life in freedom and dignity for the boys and girls who, more than missiles or armadas of ships or stone and mortar and steel, represent our nation's greatest "weapon" in defense of our way of life. This is our best hope for achievement of a decent world in which freedom and the concept of the dignity of the individual can survive and flourish.

The challenge of the coming decade to the children and youth of America in the field of vision care, as in all other vital areas of child welfare, CAN and WILL be met if, as a nation, we have the vision to work together and utilize our resources and skills with determination and intelligence.

APPENDIX A

Bibliography

1. APELL, R. J. and R. W. Lowry, Jr.: Preschool Vision. American Optometric Association, 1959.

2. AUSTIN, Caroline: Mass Preschool Vision Screening. Children, March-April, 1959.

3. BETTS, Emmett A.: An Evaluation of the Baltimore Myopia Control Project. Journal of the American Optometric Association. Vol. 18, No. 9, April 1947.

4. BETTS, Emmett A.: Visual Readiness for Reading. Foundations of Reading Instructions. American Book Co., 1946.

5. BETTS, Emmett A. and Agnes Sutton Austin: Visual Problems of School Children. The Professional Press, 1941.

6. BING, Lois B.: The AOA Policy on School Vision Screening. The Journal of the American Optometric Association. Vol. XXVIII, No. 8, March, 1957.

7. BING, Lois B.: Visual Problems in Reading and Optometric Limits. Monograph No. 239. American Academy of Optometry, 1958.

8. _____: Blueprint for Visual Screening. Euclid Public Schools, Euclid, Ohio. Rev. 1959.

9. BLUM, Henrik L., Henry B. Peters and Jerome W. Bettman: Vision Screening for Elementary Schools. The Orinda Study, University of California Press, 1959.

10. BORISH, Irvin: Clinical Refraction. The Professional Press. 1954.

11. BROCK, Frederick W.: Two Eyes Can Be Worse Than One. Education, Vol. 77, No. 8, April 1957.

12. _____: Check Your Child's Vision. American Optometric Association. 1958.

13. CIOCCO, Antonio: Changes in the Types of Visual Refractive Errors in Children. Public Health Reports, Vol. 53, No. 35. U. S. Gov't Printing Office. 1938.

14. _____: Conducting Interprofessional Forums on Children's Vision. American Optometric Association. 1957.

15. CRANE, M. D., Franklin M. Foote, Richard G. Scobee, and Earl L. Green: Screening School Children for Visual Defects. Children's Bureau, U. S. Dept. Health, Education and Welfare, No. 345, 1954.

16. DEBOER, John J. (Edited by): Unsolved Problems in Reading. El. Engl., Reprinted from Oct. and Nov., (Champaign, Ill., Nat'l Council of Teachers of Eng., 1954.)

17. _____: Do You Know These Facts About Vision and School Achievement. American Optometric Association.

18. EBERL, Marguerite T.: Manual on Visual Care of the Non-Achieving Child. American Optometric Association, St. Louis, Mo. 1959.

19. EBERL, Marguerite T.: Report to the Midcentury White House Conference on Children and Youth. American Optometric Association, 1950.

20. EWALT, H. Ward, Jr.: The Baltimore Myopia Control Project. Journal of the American Optometric Association, Vol. 17, No. 6, Jan. 1946.

21. GESELL, Arnold, Francis L. Ilg and Glenna Bullis: Vision —Its Development in Infant and Child. Harper and Brothers, 1949.

22. GETMAN, G. N.: What About Your Child's Vision? American Optometric Association.

22A GETMAN, G. N.: Streff, J. W.: Mommy and Daddy. American Optometric Association.

23. GORDON, Dan M.: Squint in Children, Jnl. of Pediatrics (St. Louis) 29: 640-646, Nov., 1946.

24. GRAY, William S. and Nancy Larrick (Edited by): Better Readers for Our Times. International Reading Association Conference Proceedings, Vol. 1, Scholastic Magazines, 1956.

25. GREGG, James R.: Variable Acuity. Journal of the American Optometric Association, Vol. 18, No. 8, March 1947.

26. HACKMAN, Roy B.: An Evaluation of the Baltimore Myopia Project. Journal of the American Optometric Association, March 1947.

27. HARMON, Darell Boyd: Notes on A Dynamic Theory of Vision, Optometric Extension Program, Revision, 1958.

28. HIRSCH, Monroe J.: Effect of School Experience on Refraction of Children. Vol. 28, No. 9, American Academy of Optometry, 1951.

29. HIRSCH, Monroe J.: The Relationship of School Achievement and Visual Anomalies. American Journal of Optometry, Monograph 183. American Academy of Optometry.

30. ILG, Francis L. and Louise Bates Ames: Child Behavior. Dell Publishing Company, Ed. Rev., 1959.

31. KELLEY, Charles R.: Visual Screening and Child Development. The North Carolina Study, Department of Psychology, North Carolina State College, 1957.

32. KEPHART, Newell C.: Help for Brain-Injured. Wisconsin Optometrist, 1957.

33. KEPHART, Newell C.: Visual Changes in Children. American Journal of Optometry, Monograph 93. American Academy of Optometry, 1950.

34. LUCKEISH, Matthew: Increase in Eye-Defectiveness in School Children from Grade to Grade, Journal of the Florida Optometric Association, Florida Optometric Association. 1953.

35. MILES, Paul: Children with Increasing Myopia. Missouri Medical Journal. Vol. 54, Dec. 1957.

36. _____: Monograph on Optometry. American Optometric Association.

37. MURROUGHS, Thaddeus, R.: A Clinical Guide to Amblyopia Therapy. American Optometric Association. 1958.

38. POTTER, J. A.: Bent, Leo G.; Zebell, Chester R.: A Vision Testing Program for University Students. Journal of the American Optometric Association, June, 1954.

39. _____: Reading Takes Seeing. American Optometric Association. 1958.

40. ROBINSON, Helen M. (Edited by): Clinical Studies in Reading II. University of Chicago Press, No. 77, 1953.

41. ROBINSON, Helen M. The Findings of Research on Visual Difficulties and Reading. Reading for Effective Living. International Reading Association Conference Proceedings, Vol. 3, 1958.

42. ROMAN, Melvin: Reaching Delinquents Through Reading. Charles C. Thomas, 1957.

43. RYAN, Vernon: Referrals from Visual Screening of School Children. American Journal of Optometry. Vol. 36, No. 8.

44. SATO, T.: The Causes and Prevention of Acquired Myopia. Kanehara Suppan Co, Ltd., Tokyo, Japan. 1957.

45. SCOBEE, R. G.: Esotropia. American Journal of Ophthalmology. Vol. 34, No. 6, 1951.

46. _____: Services for Children With Vision and Eye Problems. American Public Health Association, 1956.

47. SPACHE, George: Optometrists and Reading Specialists. Journal of the American Optometric Association, Vol. 28, No. 5, 1956.

48. SPACHE, George: Vision and Its Relationship to School Achievement. Journal of the American Optometric Association. December, 1957.

49. STEWART, Charles R.: TV and Prevalence of Ocular Discomfort in School Children. Optometric Weekly, Vol. 42, 1951.

50. SWEETING, Orville J.: An Improved Vision Screening Program for the New Haven Schools. Journal of the American Optometric Association, Vol. 30, 1959.

51. TAIT, Edwin F.: Textbook of Refraction. W. S. Saunders.

52. TAYLOR, Earl A.: Eyes, Visual Anomalies and the Fundamental Reading Skill. Reading and Study Skills Center, N. Y., N. Y., 1959.

53. _____: Teacher's Guide to Vision Problems with Check List. American Optometric Association.

54. WICK, Ralph E.: Tragedy of the Commonplace in School Visual Problems. The Journal of the American Optometric Association. Vol. XXIII, No. 2, 1956.

55. WILSON, Charles C.: School Health Services. National Education Association, 1953.

56. WINEBRENNER, Mary Ruth: Finding the Visually Inadequate Child. Visual Digest, 1952.

57. _____: Your Baby's Eyes. American Optometric Association. 1958.

58. _____: Your Eyes and Optometry. American Optometric Association. 1958.

59. _____: What Everyone Asks About Contact Lenses. American Optometric Association, 1959.

APPENDIX B

OPTOMETRIC VISUAL CARE FOR THE BRAIN-INJURED CHILD

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The visual and perceptual problems of the brain-injured child have come to the professional attention of optometrists through a very normal course of events. A large segment of the optometric profession has been deeply interested in the functional aspects of the ocular and visual mechanism for the past thirty years. [1] This interest has increased in the past twelve years when clinical practice demonstrated that a child's total motor organization was primary and essential to adequate visual performance in the classroom. [2] [3] [4] [5] [6] [7] [8] [9] [10] [11] [12] Hundreds of cases were being reported where the proper teaming of the two eyes and more efficient motility of ocular movements brought an enhancement of visual perceptual skills in spite of extreme ametropias. The age old physiological adage that function affects structure more than structure affects function apparently could also be applied to vision. Optometrists providing visual training for their patients found that visual skills could be enhanced to such a degree that visual perceptions were not entirely determined by the anatomy of the eye ball.

There were cases, however, which did not respond to the usual optometric clinical methods of training. Further study of visual processes, visual behavior, the neurology and psychology of vision suggested that attention to the total gross motor patterns was necessary. This led to interest in the pre-school child, his visual development, and his unique visual problems. [13] These problems were especially unique because methods and philosophies suited to the visual behavior of every person above the age of 7, 8 or 9 did not apply, nor were they clinically successful in caring for the very young child. Therefore, research and clinical investigation into the development of visual abilities by the child from infancy through childhood has become an important part of the profession's activity since 1945. This research provided a catalog of the experiential sequences and developmental processes that a child should achieve in the first six or seven years of his life. It is now evident that these processes and sequences are of primary significance if the visual mechanism is to make its proper contribution to the total gestalten essential for adequate perceptual performance within the cultural demands of 1960. [14] [15] [16] [17] These will be summarized later in this paper, and their application to the brain-injured child will be discussed.

It became significantly apparent out of these studies that a normal, non-pathologic pair of eyes were not enough for the visual performances demanded by culture. [18] [19] [20] [21] [22] Many children with no refractive error, who could achieve 20/20 sight (or its equivalent) on standard Snellen test conditions could not demonstrate normal visual behaviors and visual judgments of size, form, depth, direction, or distance.

Complete and thorough neurological examinations made by qualified neurological specialists upon many of these children showed them to be normal in every respect. At least all neurological test results were negative. Developmental procedures of optometric visual training were provided for these children. [23] [24] These procedures were based upon the studies of visual development from infancy mentioned above. These procedures were administered to provide children with the opportunity to re-experience each level of visual development. This program of clinical guidance was carefully designed to insure that each child made every possible integration of visual, tactual, skeletal, proprioceptive, verbal, and auditory stimuli as mechanisms facilitating a total perceptual organization.

Out of all of this research and clinical activity optometry has evolved a philosophy which can be applied to every child and more especially applied to the child diagnosed as brain-injured.

1. The visual mechanism is anatomically, physiologically, neurologically and psychologically designed to operate as the most adequate sensory receptor for information regarding the external world. [25] [26] [27] [28] [29] [30]

2. The visual mechanism is not solely dependent upon the structural or functional adequacy of the receptor end organs (the ocular globes) for its perceptual ability although these adequacies are most desirable. When inadequacies do exist, the optometric application of proper lenses to enhance function and consistency of ocular performance may significantly contribute to the perceptual results. Nevertheless, these oculi, in and of themselves, are not capable of obtaining all the visual information essential to the fullest interpretation of the external world. [31] [32] [33] [34]

3. Children do not achieve the ultimate visual development through visual experience alone. They must have every opportunity to integrate tactual, auditory, verbal and all proprioceptive experiences with the visual experiences to assure ultimate visual development. [35] [36] [37]

4. Visual development can only be achieved through active movement within actual visual space so the relationship between the physical self and physical space can be learned. Thus, an accurate grasp of the body scheme and an extensive knowledge of body movements are necessary before the visual mechanism can be expected to comprehend space and its contents. [38] [39] [40] [41] [42]

5. Therefore: the visual mechanism reaches its ultimate levels of contribution to the perception of size, form, depth, direction, and distance, as a result of total organismic motor patterns related to these visual experiences. The verification and abstraction of motor patterns by the visual mechanism through the feedback and integrative systems of the central nervous system provide a total organization wherein vision can substitute for overt, trial and error exploration of the external world. [43] [44]

6. As a result, visual training based upon a total organismic development concept will contribute to a greater self-sufficiency in every child. This concept of visual training is of even greater importance to the brain-injured child because the very nature of his hanicap has its greatest impact upon his visual perceptions of his external world, and prevents his acquisition of many visual perceptual skills when left to his own devices. As a result, his general and cultural intelligence may remain at a level below his potential and his lack of visual development can prevent the fullest possible utilization of his biologic endowment. [45] [46] [47] [48]

In the usual course of events children who had been diagnosed as brain-injured by qualified neurologists become available for optometric examination and care in many offices scattered across the nation. These children showed the same absence of refractive errors, the same nonpathologic oculi, and the same visual problems as seen in the so called normal children. Carefully designed and controlled optometric procedures were used with these children. These children also demonstrated significant gains in visual behavior and visual judgments following the training. Their social and academic achievements clearly indicated gains that were greater than time or other guidance methods had produced. Finally, their scores on standard intelligences tests, administered by qualified psychologists showed significant gains in I. Q.'s. The fact that these I. Q. gains are possible has been further substantiated by independent and unrelated studies of I. Q. changes as reported by Dr. Robert Felix, director of the National Institute for Mental Health, and by Professor Arthur W. Combs of the University of Florida. These latter reports do not specifically state that these investigators have been such gains in known brain-injured children, but their data which shows that I. Q.'s can change substantiates the psychological tests on damaged children.

An extensive search of recent literature in several allied fields dealing with the functional behavior of the human being has proven very interesting. There are many verifications of the 15 year old optometric philosophy that considers the visual-motor processes as primarily essential to the development of perceptual abilities. In many instances this literature repeats and restates the concepts which have been clinically applied by optometry in dealing with children diagnosed as brain-injured and with those who operated "as if" they were brain-injured in spite of negative neurological findings.

Many data have been published reporting that most children with brain injury are below normal in many areas of visual-motor behavior. The most characteristic lack demonstrated by these children is in figure-ground interpretations. [48] [49] [50] Optometry holds that this lack of skill does not mean this type of child can never acquire some visual perceptual skill. It merely means that left to his own devices he did not achieve some of the visual-motor abilities expected in all children. Neither does optometry hold that if these children are given proper visual training and guidance, they will become normal children. It does hold, just as reported by other clinicians dealing with

the brain-injured child, that these children can become more self-sufficient and culturally adequate than they were previous to the assistance. [42] [46] [48]

One outstanding fact seems to dominate the research of many investigators in many disciplinary approaches to the problem of the brain-injured child. Vision and visual skills should be considered as the dominant sensory-motor process in any clinical approach to these children. Optometry primarily concerned with the function and clinical care of the non-pathologic visual mechanism, conceives of vision as the total perceptual process which allows an individual to respond to, interpret, and manipulate his external world as the result of past or present light pattern stimuli from the retinae. This concept of vision was utilized in a clinical project to assist handicapped children.

A staff of clinicians representing optometry, ophthalmology, education and psychology set up two training periods of one month duration in Colorado in July of 1957 and 1958. Children were brought to this project by one or both parents, and an intensive program of training was instituted for the parents and for the children. The parents were required to attend lectures and demonstration sessions concerned with the problems of their children. The children were under constant supervision during daylight hours by one or more of the staff. This supervision provided constant learning situations which assisted each child to develop visual-motor performance skills. The program for each child was designed so he would re-experience or recapitulate each level of the visual development sequences which were originally reported in the book, VISION—ITS DEVELOPMENT IN INFANT AND CHILD, by Gesell, Ilg, Bullis, Getman and Ilg.* These studies have been clinically extended in the past ten years by a group of research optometrists, working especially in the area of visual guidance for retarded children.

A. Gross-motor activities which would integrate proprioceptive experience with related visual experience.
B. Pre-academic activities which would integrate tactual experience with related visual experience.
C. Speech development activities which would integrate verbal experience with related visual experience.
D. Oculo-motor activities which would integrate the mechanics of sight with visual interpretations.

In every area of activity visual motor function and behavior was given dominance and emphasis. The never ending variety of experiences given these children cannot be fully described here. A movie of the entire project has been made which illustrates these many procedures. Since this is a summary report, we must be content to report the concept and the results and leave the details of technique for a later discussion.

Every child attending these training periods made significant gains. One youngster, age 17, dismissed from previous special school as psychotic beyond help, is now a dependable, self-sufficient job holder in a large midwestern city. Another, age 13, who came to this project speechless, completely helpless and dependent upon her parents for everything except toilet care, is now doing acceptable academic work in a special classroom. Another, age 13, who received several social promotions in special classrooms in now achieving in the lower third of her group of a standard academic system two grades below her chronologial age grade. Social and interpersonal abilities were improved in every child. All made progress in self-sufficiency. Twenty children in all received the benefits of this special project. At least four have been returned to society as contributors.

The optometric profession in presenting this interim report urges your consideration of a functional concept of visual performance and visual-motor processes in every consideration of every child. Visual performance is not determined by the Snellen Chart nor by the refractive status of the eyes. Visual performance and achievement determine a child's ability to cope with his world, be he brain-injured or not. If we can learn to see the child's world as he sees it, we can guide and assist him to visually interpret more of the world—and a more complete and productive child will result, regardless of his diagnostic label.

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*Published in 1949 by Hoeber, New York, N.Y.

Selected Bibliography

This bibliography is by no means complete. It has been selected merely to provide a minimum number of references containing sufficient material to justify consideration of the points raised or developed in this paper.

1. Skeffington, A. M., and Associates. Postgraduate papers issued monthly by The Optometric Extension Program, Inc., Duncan, Oklahoma, 1926-1959, Inc.
2. Getman, G. N. "The Developmental Concept Applied to Visual Training." Optometric Extension Program, Inc., Duncan, Oklahoma, November, 1952.
3. _____ "Studies in Visual Development" privately published, 1954.
4. _____ "Studies in Perceptual Development" privately published, 1954.
5. _____ "The Child as a Total Organism." Author's mimeograph, 1949.
6. _____, Emery, L.; Poche, W.; Robbins, N.; Treganza, A.; "A Means of Observing the Processes of Form Discrimination in Young Children." Author's mimeograph reporting Postgraduate Research at Ohio State University, Dept. of Psychology, 1952.
7. _____, Kephart, N. D., "Perceptual Development for the Retarded Child." Purdue University Monograph, 1956. "Developmental Vision," Vol. 2, New Series, Optometric Extension Program, Inc., Duncan, Oklahoma, October 1957 to September 1958, Inc.
8. _____, Bullis, G. E., "Developmental Vision" Optometric Extension Program, Inc., Duncan, Oklahoma, December 1950 to September 1951, Inc.
9. _____, "How to Develop Your Child's Intelligence" 6th Edition, Announcer Press, Luverne, Minnesota, 1959.
10. Harmon, D. B., "The Coordinated Classroom, "AIA File No. 35-B, 1951.
11. _____, "Some Preliminary Observations on the Developmental Problems of 160,000 Elementary School Children." Medical Women's Journal, March, 1942.
12. _____, "A Dynamic Theory of Vision," Third Revision, Privately published, 1958.
13. Getman, G. N., "Developmental Vision, Vol. 3," Optometric Extension Program, Inc., Duncan, Oklahoma, October 1958 to September 1959, Inc.
14. Montessori _____, "The Montessori Manual," The W. E. Richardson Co., 1913. (Translated by Dorothy Canfield Fisher)
15. Piaget, Jean, "The Child's Conception of the World." Humanities Press, 1951.
16. Shinn, M. W., "The Biography of a Baby." Houghton-Mifflin, 1899.
17. Wheeler, R. H. and Perkins, F. T., "Principles of Mental Development." Thomas Y. Crowell and Co., 1932.
18. Bode, B. H., "How We Learn." Heath and Company, 1940.
19. Frank, Lawrence K., "Individual Development." Doubleday Papers in Psychology, Random House, 1951.
20. Gibson, J. W., "The Perception of the Visual World." Houghton-Mifflin, 1950.
21. Ittleson, W. H. and Contril, H., "Perception." Doubleday Papers in Psychology, Random House, 1954.
22. Kepes, Gyorgy, "Language of Vision." Theobold and Cuneo Press, 1947.
23. Lyons, C. V. and Lyons, E. B., "The Power of Visual Training." Journal of the American Optometric Association, 255-262. Part I., 1954.
24. _____, "The Power of Visual Training." Journal of the American Optometric Association, Part 2, November 1956.

25. Renshaw, Samuel, "Psychological Optics Papers." Optometric Extension Program, Inc., Duncan, Oklahoma, 1940-1959, Inc.

26 _____, "Postgraduate Research Lectures," Ohio State University, Educational Congress Lectures, 1940-1959, Inc.

27. Duke-Elder, Sir W. Stewart, "Text Book of Ophthalmology." Volume 1, C. V. Mosby Company, 1942.

28. Adler, Francis Head, "Physiology Of The Eye." C. V. Mosby and Co., 1950, 1953.

29. Linksz, Arthur, "Physiology of the Eye." Volume 2, Vision, Grune and Stratton, 1952.

30. Polyak, S. L., "The Retina." University of Chicago Press, 1941.

31. Vernon, M. D., "Visual Perception." Cambridge University Press, 1937.

32. _____, "A Further Study of Visual Perception." Cambridge University Press, 1952.

33. Gibson, James J., "The Perception of the Visual World." Houghton-Mifflin, 1950.

34. Pratt, Carroll C., "The Role of Past Experience in Visual Perception." Journal of Psychology 30, 1950.

35. Katz, David, "Gestalt Psychology." Ronald Press Co., 1950.

36. Hebb, D. O., "The Organization of Behavior." Wiley, 1949.

37. Gesell, A.; Ilg, F.; Bullis, G. E.; Getman, G. N.; Ilg, V.; "Vision, Its Development in Infant and Child." Paul Hoeber, Inc., 1949.

38. Cannon, Walter B., "The Wisdom of the Body." W. W. Norton and Co., 1932.

39. Sherrington, C., "Man On His Nature." Cambridge University Press, 1951.

40. Grossfield, H. D., "Visual Space and Physical Space." Journal of Psychology, 32, 1951.

41. Nielsen, J. M., "Ideational Motor Plan." Journal of Nervous and Mental Disorders, 108, November, 1948.

42. Ayres, A. Jean, "The Visual-Motor Function." American Journal of Occupational Therapy, Volume XXI. No. 3. May-June, 1958.

43. Wiener, Norbert, "Cybernetics." John Wiley and Sons, 1948.

44. Kluver, Wolfgang, "Cerebral Mechanisms in Behavior." Hixson Symposium. John Wiley and Sons, 1951.

45. Bender, Lauretta, "Psychopathology of Children with Organic Brain Disorders." Charles C. Thomas, Springfield, Illinois, 1956.

46. Brower, L. M., "Factors Inhibiting Progress of Cerebral Palsied Children." American Journal of Occupational Therapy, Nov.-Dec. 1956.

47. Strauss, A. A., and Lehtinen, L. E., "Psychopathology and Education of the Brain Injured Child, Vol. I, Grune and Stratton, 1947.

48. _____ and Kephart, N. C., "Psychopathology and Education of the Brain Injured Child, Vol. II, Grune and Stratton, 1955.

49. Bender, Lauretta, "A Visual Motor Gestalt Test and Its Clinical Use." Research Monograph #3, The American Orthopsychiatric Association, 1938.

50. Dolphin, J. E. and Cruickshanck, W. M., "Pathology of Concept Formation in Children with Cerebral Palsy." American Journal of Mental Deficiency, October 1951.

APPENDIX C

LICENSED OPTOMETRISTS AND CERTIFIED OPHTHALMOLOGISTS RELATED TO THE POPULATION OF THE UNITED STATES OF AMERICA

State	Population	Certified Ophthalmologists	Population Per Certified Ophthalmologists	Licensed Optometrists	Population Per Licensed Optometrists
Alabama	3,151,000	28	112,536	207	15,222
Alaska	206,000	3	68,667	16	12,875
Arizona	1,136,000	21	54,095	86	13,209
Arkansas	1,768,000	14	126,286	151	11,709
California	13,922,000	452	30,801	2269	6,136
Colorado	1,673,000	53	31,566	227	7,370
Connecticut	2,252,000	81	27,824	295	7,634
Delaware	438,000	9	48,666	35	12,514
Dist. of Columbia	831,000	51	16,294	114	7,289
Florida	4,098,000	84	48,786	382	10,704
Georgia	3,779,000	44	85,886	290	13,031
Hawaii	584,000	19	30,737	60	9,733
Idaho	640,000	10	64,000	85	7,529
Illinois	9,637,000	228	42,268	2402	4,012
Indiana	4,533,000	67	67,658	510	8,888
Iowa	2,799,000	35	79,971	396	7,068
Kansas	2,136,000	31	68,903	289	7,391
Kentucky	3,040,000	32	95,000	284	10,704
Louisiana	3,068,000	41	74,829	257	11,938
Maine	943,000	20	47,150	152	6,204
Maryland	2,895,000	49	59,082	194	14,923
Massachusetts	4,866,000	157	30,994	998	4,876
Michigan	7,803,000	119	65,571	879	8,877
Minnesota	3,321,000	83	40,012	469	7,081
Mississippi	2,185,000	15	145,667	138	15,833
Missouri	4,255,000	90	42,278	630	6,754
Montana	666,000	9	74,000	94	7,085
Nebraska	1,452,000	24	60,500	219	6,630
Nevada	267,000	9	29,667	26	10,269
New Hampshire	572,000	9	63,556	87	6,575

LICENSED OPTOMETRISTS AND CERTIFIED OPHTHALMOLOGISTS RELATED TO THE POPULATION OF THE UNITED STATES OF AMERICA

State	Population	Certified Ophthalmologists	Population Per Certified Ophthalmologists	Licensed Optometrists	Population Per Licensed Optometrists
New Jersey	5,627,000	141	40,227	838	6,715
New Mexico	830,000	13	63,846	65	12,769
New York	15,888,000	694	22,893	2003	7,932
North Carolina	4,498,000	45	99,956	317	14,189
North Dakota	644,000	10	64,400	73	8,822
Ohio	9,200,000	140	65,714	1172	7,850
Oklahoma	2,277,000	24	94,875	274	8,310
Oregon	1,769,000	50	35,380	317	5,580
Pennsylvania	11,043,000	290	38,079	1640	6,733
Rhode Island	862,000	13	66,308	160	5,386
South Carolina	2,370,000	22	107,727	161	14,720
South Dakota	702,000	8	87,750	110	6,382
Tennessee	3,463,000	56	61,839	337	10,276
Texas	9,138,000	157	58,204	850	10,751
Utah	851,000	22	38,682	89	9,562
Vermont	376,000	9	41,778	41	9,171
Virginia	3,797,000	41	92,610	268	14,168
Washington	2,722,000	63	43,206	387	7,034
West Virginia	1,976,000	26	76,000	172	11,488
Wisconsin	3,862,000	78	49,513	508	7,602
Wyoming	316,000	7	45,193	39	8,103
TOTAL	171,147,000	3,787	45,193	22,062	7,758

Sources, Blue Book of Optometrists, 1958
Red Book of Eye, Ear, Nose and Throat Specialists, 1959
Directory of Medical Specialists, 1957
Bureau of the Census, Statistical Abstracts, 1958

Dr. TRAMONTI. This will indicate why we are in complete agreement with the statement found in the report of the President's Panel on Mental Retardation as follows:

> All professional personnel should be oriented to the special needs of the retarded. Physical and emotional handicaps are common among the retarded and require early detection and competent treatment. The retarded child is subject to all of the diseases and health hazards to which the intellectually normal child is heir. In addition, his problems of retardation are frequently complicated by such serious conditions as cerebral palsy or epilepsy, speech, hearing, visual disorders, and dental defects.

Based on my own experience there is no question but that mental and visual or perceptual development are directly related.

It is therefore essential that at an early age a child who has a visual problem should be given attention in order to improve that child's visual capabilities even before school age.

We all realize the importance of vision but may overlook its importance to the preschool child. At birth the infant's eyes and visual mechanism are far ahead of any other pattern of growth and development.

His eyes are 75 percent of adult size at the time of birth. Seven years later the visual apparatus is its adult size while the remainder of the body continues in growth for almost 15 more years.

Vision leads the child's growth pattern. As he mouths an object, bangs it to hear the sounds, pokes at it, feels it in the palm of his hands and tips of his fingers, as he throws it into space and feels it with his whole body, he is exploring the world and the space about him.

Soon he learns to discriminate primarily with his vision.

A child is born with the mechanism for vision but he must learn to use it.

Dr. Arnold Geselle, formerly of the Geselle Institute of Child Development, New Haven, Conn., with which our association has worked closely, said "—to understand the total child you must understand vision, to understand vision, you must understand the total child."

I like to put it this way: The child unable to experience a normal visual perceptual growth pattern will not experience normal growth patterns; a child unable to experience normal growth pattern is not able to experience a normal visual perceptual pattern.

In other words, the two go hand in hand. In other words, vision and growth are simultaneous.

For the last 7 years, I have been closely associated with medical and medically allied professional disciplines related to child development, primarily in the field of cerebral dysfunction, with manifestations of impaired neurological function such as neuromotor, intellectual, sensory, behavioral and perceptual disorders.

These may be found singly or in combination, and in varying degrees.

There can be a combination of physical and intellectual impairment.

There are many children with slight subtle signs of neurological impairment and normal IQ but functioning at such a low level of performance and school achievement as to be regarded as retarded.

I think that sentence is so important, I would like to repeat it.

There are many children with slight subtle signs of neurological impairment and normal IQ but functioning at such a low level of performance and school achievement as to be regarded as retarded.

My interest and work in these fields has been in the investigation of the visual perceptual problems of retarded children.

It is said that vision is the result of a very simple eye and a very complex brain.

A visual sensation is that which the eye sees but the mental modification of this sensation is visual perception.

Formal and informal experimentation in this area has been carried out.

At the Meeting Street School, Children's Rehabilitation Center, and also with private patients from the pediatric practice of a prominent physician in Providence, R.I., we worked with children who were greatly retarded in school performance and were showing achievement considerably below their intellectual potential.

Both with cerebral palsied children and with children who showed no signs of gross organic pathology, in a high proportion of cases we found significant improvement in school performance following a period of visual perceptual training.

In considering preliminary findings, it appeared essential that at least one phase of our problem be conducted in the Bradley Hospital setting where all the patients are seen in individual psychotherapy.

A pilot study has been carried out in the attempt to discover if the visual-perceptual diagnostic procedure could predict which of the patients were school problems.

On the basis of this procedure the children were classified into groups labeled "perceptual problem" and "no perceptual problem."

The testing and diagnosis were done completely independently of knowledge of such factors as IQ, psychiatric and neurological diagnoses, personality testing, or school record.

When the visual perceptual findings were related to school performances, it was found that in the "perceptual problem" group 55 percent were at least 2 years retarded in reading, according to formal school tests, and only 26 percent of the "no perceptual problem" group were retarded in reading to such an extent.

A more striking finding was that 50 percent of the children in the "perceptual problem" group were at least 2 years retarded in arithmetic, while no cases in the "no perceptual problem" group were so retarded in arithmetic.

Another interesting finding was that between the results of psychological testing and the perceptual capabilities of the patient.

On the basis of the overall psychological test, the psychologists made the diagnosis of "signs of organic impairment."

Of the former group, 50 percent were independently diagnosed on the basis of visual perceptual tests, as being in the "perceptual problem" group, while only 11 percent were found to be in the "no perceptual problem" group.

This work has brought me into a team of dedicated workers—pediatricians, neurologists, orthopedists, psychologists, psychiatrists, otologists, social workers occupational, speech and hearing, physical therapists, teachers, and other professional personnel.

I cannot overemphasize the importance of this total team approach for dynamic goals in the diagnoses and treatment of these children.

Diagnostic and treatment centers, outpatient or resident, are a physical necessity which you can help to supply.

It is in the public interest that all professions should work together.

The important contribution which our profession has made to improving the mental development of a child through visual training and the use of lenses is frequently overlooked and sometimes even denied.

We are pleased to note that the National Institute of Child Health and Human Development, which was authorized by the 87th Congress, is beginning to function and that its program will provide "an additional resource for attacks on the causes and prevention of mental retardation in the context of the basic processes of human development" (mental retardation program of the U.S. Department of Health, Education, and Welfare, fiscal year 1964).

This very excellent overall program of the Department also includes a demonstration training center for medical and allied professional personnel, as well as the development of a demonstration service center for a comprehensive community approach to mental retardation, through the Bureau of State Services.

As far as we are aware, the optometric profession has not been brought into these programs, but we believe that eventually they will, and the sooner it is accomplished the better.

This statement has dealt primarily with vision problems of children because that is the area in which I have specialized.

However, our profession is also working extensively in providing vision care for the aged and the partially sighted.

Even among adults and particularly among the aged, visual performance frequently has a direct bearing on mental health.

By means of subnormal vision aids, such as telescopic and microscopic lenses, as well as by means of contact lenses, our profession has rendered an important service to adults and particularly to the aged and infirm, as well as to children.

The bills as introduced, while they do not specifically provide for the utilization of the services of optometrists, are broad enough in their language to provide such services.

We believe it would be helpful if the committee, in making its report, would deem it appropriate to mention the importance of vision in combating mental retardation and improving mental health and at the same time indicating the congressional intent that optometrists should be part of the team which will be organized to carry out the provisions of these two bills.

While sitting here this morning and this afternoon I was aware of the fact that most of the speakers mentioned institutionalization.

Dr. Pratt made a statement saying that by 1970 more than one-half of the mentally retarded persons in this country will be children.

Now, when the time comes, are we going to appropriate more money to institutionalize these children, or are we going to do something to habilitate as well as rehabilitate them and prevent them from going into institutions, and to make them capable of going to normal schools and earning a normal livelihood?

It has been my privilege to appear before this committee, for which I am grateful.

If there are any questions you would like to ask, I will endeavor to answer them at this time.

Mr. O'Brien (now presiding). Thank you very much, Doctor.

I take it it is your considered belief that faulty vision uncorrected can either cause a child to be retarded or to give the appearance of being retarded?

Dr. TRAMONTI. No, that is not exactly right, Mr. Chairman. You notice that in my report I say visual perceptual difficulties and not vision difficulties.

Visual perceptual difficulty as referred to is what the child or what the patient understands or the meaning he gets from what he sees.

Many of the children we see and work with have perfect vision, if 20/20 vision is understood to be perfect vision.

A child may have 20/20 vision and still have a visual perceptual problem.

Correcting a vision problem is a very simple matter compared to correcting a visual perceptual problem in the mentally retarded.

But the visual perceptual disorders—and I am sure that anyone here dealing with children who has seen or who knows perceptual visual problems will agree that we do not know very much about it, and there is a great deal to learn.

And there is tremendous room for research in this area.

Mr. O'BRIEN. We are very grateful to you, Doctor. And I am sure the committee will give full consideration to the recommendations you give.

And I would just like to say one more thing before adjourning this hearing—and I apologize for Mr. Roberts, who had an emergency call—that in my time here in Washington I don't think I have ever seen legislation supported by such a distinguished and unselfish group of our citizens, and I know that the full committee is most grateful to all who have testified.

Thank you, Doctor.

And the hearing is adjourned.

(Whereupon, at 4:15 p.m., the subcommittee adjourned, to reconvene at 10 a.m., Thursday, March 28, 1963.)

MENTAL HEALTH

THURSDAY, MARCH 28, 1963

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

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

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

Our first witness today will be the Honorable Mr. Farbstein, our colleague from New York, who has introduced H.R. 3939 and H.R. 3940, which are identical to H.R. 3688 and H.R. 3689.

Mr. Farbstein we are indeed happy to have you with us.

STATEMENT OF HON. LEONARD FARBSTEIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. FARBSTEIN. Thank you Mr. Chairman. I appear before your committee today to offer my unqualified support for H.R. 3688 and H.R. 3689, identical with my bills H.R. 3939 and H.R. 3940—in my estimation two top priority bills that deserve immediate consideration and passage to help the mentally ill and retarded of our Nation.

In the last decade a great deal has been done to dredge up from oblivion the fact about the horribly debilitating conditions that these people are forced to subsist in through sheer neglect. Moreover, these facts, unlike the persons they describe, have not been relegated to oblivion or remained the secret of an inarticulate few, they have been the subject of articles in some of the country's major magazines, the basis of a fervent appeal by hopeful parents and relatives and finally, the last few years, the testimony of the President of the United States for the absolute need for change and a new approach toward treating the mentally ill and retarded.

For example, on February 5, he said:

> This situation has been tolerated far too long. It has troubled our national conscience, but only as a problem unpleasant to mention, easy to postpone, and despairing of solution. The Federal Government, despite the nationwide impact of the problem, has largely left the solutions up to the States. The States have depended on custodial hospitals and homes. Many such hospitals and homes have been shamefully understaffed, overcrowded, unpleasant institutions from which death too often provided the only firm hope of release.

But the President not only offered testimony, he also outlined a solution. And, as we all know, the two bills before your committee are an important part—the actual backbone—of that solution.

H.R. 3688, and my bill H.R. 3939, would provide for assistance in both the construction and initial operation and staffing of community

mental health centers. The authorization of appropriation for the 5 years of the bill's duration is not specified. This matter is left to the good judgment of Congress in hopes that with a need so unmet they will be as liberal as possible.

The innovation and radical departure contained in the bill, of course, is not solely the fact of construction, but also the fact of construction at the community level. The near barbarian practice of exorcising the mentally sick person to a State institution, miles from home and usually even farther from recovery, would be abandoned. And, in case if any advocates did remain for this form of public institution and treatment up until 1962, certainly the report of the Joint Commission on Mental Illness and Health filed with Congress in that year must have proved to them that here was an unmodified black mark on our national conscience. As I recall some of the counts of indictment were these: more than one-half of mentally ill patients in public hospitals receive no active treatment of any kind to improve their condition: only 20 percent of these hospitals have instituted therapeutic reforms in line with modern trends; in contrast to a general hospital where $31.16 is spent on a patient, $4.44 is spent in a mental hospital per day; little, and usually no, research is done in these hospitals; and, finally, only 29 percent of the Nation's 277 such institutions have ever received approval from the Joint Commission on Accreditation of Hospitals.

Maybe to further bolster my case, I should use the experience of my home State of New York as an example of how quickly progress can be effected with funds and interest. New York was the first State to pass a Community Mental Health Act in 1954. Although I do not have the figures to describe the initial situation when the act was instituted, I do have some figures for the 1959–62 years to show the momentum the program is gaining. The following are from the Interstate Clearinghouse on Mental Health of the Council of State Governments.

> The number of clinics rose from 142 in 1959 to an estimated 167 in 1962 * * *. The first emergency clinic opened in 1959–60: there were three in 1960–61, and establishment of another two was anticipated for 1961–62. Inpatient units of general hospitals during the same period grew from 16 to an estimated 25 (from 1,992 to 2,300 beds).

Now, this growth is just a beginning: many are still not being reached by present facilities, personnel shortages still exist, and chiefly the New York act does not provide for construction. The best it has been able to do is to create small units for mental health purposes in general hospitals or existing institutions.

Needless to say, New York is in the vanguard with her mental health and community activities. Yet, if she ever is to achieve a program of the desired preventive, diagnostic and rehabilitative scope she must have the spur of Federal money in expanding facilities and staffing them. Moreover, her need with all she has done is ample evidence of the need that must exist in some areas of the country where States simply could not budget such a program.

My own bill, H.R. 3940, is identical to H.R. 3689. I especially urge the passage of this separate bill for mental retardation because a separate bill for research and facilities for this 3 percent of our population is by now imperative.

Always before, this group has received from the Federal Government only a small share of someone else's allotment—either earmarked or channeled through the allocation of research grants. The only exception to this is the public law of the 87th Congress financing scholarships for leadership personnel in this area.

As in H.R. 3688, and my bill H.R. 3939, the authorization in title II for the construction of treatment facilities is not specific, although $5 million in fiscal year 1965 and $10 million in the following years must go to facilities associated with colleges or universities or their hospitals.

The authorization for the construction of research centers is specific, $6 million for 1964, $8 million for 1965, $6 million for 1966 and 1967, and $4 million for 1968.

Under these two titles the ultimate goal of prevention and the immediate goal of maximum care and training would be furthered simultaneously.

I guess there are many, although it is hard for me to believe, who still do not see the justification for spending so much on a small segment of the population like the mentally retarded. It seems to me there are two urgent reasons and it is faulty or incomplete logic that prevents people from recognizing them. One is purely mathematical: mental retardation disables 10 times as many people as diabetes; 25 times as many as muscular dystrophy, 20 times as many as tuberculosis; and 600 times as many as infantile paralysis. Yet, these programs receive many times the attention and money directed toward the mentally retarded. People have permitted themselves until now to be lulled into a false sense of hopelessness. Or, maybe the absence of either the prospect of actual death (in contrast to a living vegetable-like death) or the prospect of recovery to a somewhat normal life befuddled thinking so that no one for a long time could see his way clear from complete neglect to the intermediate solution of demanding maximum performance from a very real but limited capacity for living.

My second broad reason is (Mr. Kennedy has emphasized this) the possibilities for discovery about the entire learning process in examining the particular malfunctionings of the mental processes that lead to retardation.

As to the actual construction of research and treatment facilities authorized by the bill, I can see no difficulties arising from the two titles. Under title I, the Surgeon General would oversee that the research facility grants go to public or nonprofit institutions who will have proven fiscally sound and could be responsible for keeping the facility dedicated to mental retardation research for at least 10 years. The chief criterion for approval will be the potential of the planned research for "advancing scientific knowledge pertaining to mental retardation and related aspects of human development."

As for title II, construction estimates at the Public Health Service project that my home State of New York could receive anywhere from $648,143 to $2,930,244 (the first figure being computed on a possible $10 million appropriation and the second on a possible $40 million). As I mentioned before a piece of legislation devoted exclusively to the mentally retarded could accelerate considerably the present development which is now only one small facet of the Mental Health Act of

1954 in New York State. At present, there are estimated to be only 10 public clinics in the State, which clinics are probably far less ambitious ventures that the more comprehensive facilities anticipated by this act.

H.R. 3688 and H.R. 3689 deserve and demand passage this year. The need is too acute for further delay to be tolerated. Through the standard grants-in-aid formula every State in the Nation, and, thus, the Nation stand to profit by their enactment. I urge the passage of both.

Mr. ROBERTS. Thank you for a very fine statement, Mr. Farbstein, we hope you will come back soon.

Our next witness will be Dr. Robert E. Cooke, professor of pediatrics, the Johns Hopkins University School of Medicine, Baltimore, Md.

STATEMENT OF DR. ROBERT E. COOKE, PROFESSOR OF PEDIATRICS, THE JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE, BALTIMORE, MD.

Dr. COOKE. Thank you, sir, very much.

Chairman Roberts, it is a great pleasure and privilege to testify again before your committee. The technical as well as legislative knowledge demonstrated by the previous committee was most impressive. I appear today in support of H.R. 3689—the Mental Retardation Facilities Construction Act—as chairman of the Joint Committee on Pediatric Research, Education, and Practice, whose constituents are the American Academy of Pediatrics, the American Pediatric Society, the Society for Pediatric Research, the American Board of Pediatrics, and the Pediatric Section of the American Medical Association.

This legislation is the result of the deliberations of the outstanding people in the United States—scientists, educators, lawyers, businessmen, clergymen—who have pooled their best thoughts on how to meet the increasing problem of mental retardation. I have had the privilege of serving on the President's Panel on Mental Retardation, as well as on various National Institutes of Health special committees and study sections. As chairman of the medical advisory board of the Joseph P. Kennedy, Jr., Foundation, which is concerned with the support of research, service, and training in mental retardation, I have been concerned with the development of research, service, and training programs to meet the major handicapping condition of our children—mental retardation.

As a physician, research worker, and educator in a great medical institution, I see daily the hardships and heartaches which families endure without complaint that result from this most disabling symptom of all handicapping conditions. Although progress is being made and the efforts of the National Institutes of Health have been rewarding, there are now perhaps a dozen treatable cases of mental retardation—such as phenylketonuria, galactosemia, maple sirup urine disease, tyrosine disease, fructose intolerance, leucine intolerance, hyperglycinemia, cretinism, and hydrocephalus—which account for less than 1 percent of the retarded. Even though we have at least 70 labels to put on causes of mental retardation, the term "idiopathic" or unknown cause applies to the majority.

Why, then, are there so many causes?

If one visualizes the development of the nervous system as a gigantic wiring operation, far more complex than any computer that will ever be built, which begins as a single unit that reproduces itself repeatedly, specializes and differentiates, it is little wonder that there may be missing or abnormal circuits. Thus, slight deviations in this developmental process may produce a myriad of disturbances, all with the major symptom—mental retardation.

Although we know almost nothing of the detailed reasons for mental retardation, cases can be put into one or another pigeon holes. Some are the result of genetic abnormalities caused by mutant genes transmitted by normal-appearing, intelligent parents. Others are the result of environmental influences, some operating shortly after conception, others during pregnancy or during the birth process. Many factors operating in the newborn period, particularly in the premature infant, arrest or slow development of the brain. Environmental influences such as intellectual stimulation, experience, maternal contact, emotional stress, play a major role in intellectual development in the early years of life.

If we consider some of these areas in detail, for example, the genetic causes which have been studied more intensively in the last few years with modern basic science techniques than any other field in mental retardation, we see widespread application in one condition—phenylketonuria (PKU). Knox has reviewed all cases of phenylketonuria treated with diets low in phenylalanine up to 2 years ago. Of 466 untreated cases, only 2½ percent had intelligence quotients over 60. The use of a low phenylalanine diet in the treatment of 44 patients over the age of 3 did not produce any improvement in mental ability, although seizures at times may have been lessened. A low phenylalanine diet was used in the treatment of 43 patients under the age of 3. The mean age at the start of treatment was 16.2 months, the mean duration of treatment of 16.8 months. This group had 18 times as many children with IQ's over 60, and twice as many children with normal EEG as the untreated group. Of the whole treated group, the final IQ was inversely correlated with age at the start of treatment in a highly significant manner. In fact, a minimal loss of nearly five points in the IQ occurred each 10 weeks that treatment was delayed. These results indicate how important full understanding of cause is. But it is worth remembering that this condition, PKU, accounts for less than 0.1 percent of all the mentally retarded.

What about mongolism.

This disorder occurs as the largest single entity causing severe retardation which requires—at least in some people's minds—institutionalization. Here a major breakthrough has occurred. A duplication of a chromosome was found—either trisomy 21 or translocation of a segment of 21—which results from a disturbance in the separation of chromatin material in the formation of egg or sperm. Such advances represent enormous progress. Yet what do we really know of mongolism? How does this extra chromosome bring about the physical and mental stigmata of mongolism? At the moment, trisomy 21 represents little more in our understanding of the problem than the curved little finger which is so characteristic of these children.

These are not idle academic questions. Unless detailed understanding of each of these conditions is known, specific treatment is impossible. Infection during pregnancy is known to produce mental retardation. The German measles virus accounts for only a small number of the babies damaged by viruses during pregnancy. How do these viruses get into the fetus? What alters the placenta—the guardian of the fetus so that these can pass? How can the infant be protected against such infection? These are unknown quantities at the present time.

Likewise, totally unknown are the factors which interfere with the nutrition of the fetus by the placenta. What are the factors that bring on prematurity which so frequently leads to mental retardation? Such factors as virus infection, ionizing radiation, mutant genes, maternal medication, dietary deficiency, require far more investigation during fetal life than through other periods since minor events in the mother at these times may produce catastrophic defects in the fetus crippling him for his lifetime. Nevertheless only a handful of investigators is presently exploring exclusively some of these avenues largely because no focus of interest and concern in fetal and neonatal development exists within the present structures of medical schools.

Cultural retardation is thought to be a major cause of mental retardation. Literally millions of children in the low socioeconomic groups do not rise above the intelligence of a normal 12-year-old child. What impairs their development? Factors during pregnancy? Nutritional disturbances? Inadequate stimulation? Emotional disruption? These questions remain unanswered despite the obvious therapeutic implications. At Johns Hopkins over half of the children born on the ward service seem severely deficient in language ability by 36 months of age, yet ability to communicate is the most important skill in our society. Do these children suffer from early brain damage during pregnancy or during delivery? We have little evidence for this. Could this be genetic? Or is their environment in some way stifling their development?

Why is there so much scientific ignorance of this problem? All these processes are the result of arrest or slowing of development. Human development has received less attention in many respects than the growth of cattle. Medical schools have had neither physical facilities, funds, nor personnel to carry out research in these areas or to conduct even elementary teaching programs.

Traditionally, medical research and education have been concerned with the death-dealing disorders. It is only within the last few years that even meager attention has been given to problems of early life which lead to handicapping, lifelong disabling defects.

Because of the broad spectrum of causation of mental retardation, research in the development of the nervous system and its functions ranges through most of the existing departments of medical schools and universities. At the present time, these interests are diffuse and scattered, bearing little relationship to each other, and there is little likelihood that numbers of investigators will emerge in this generation with our present system of medical education which concentrates interest on the later stages of life. The creation of the centers for research on mental retardation and related aspects of human development through title I of the Mental Retardation Facilities Construc-

tion Act of 1963 will provide in part the physical facilities needed to develop a nationwide research undertaking. The wisdom of the proponents of this bill is manifested by the broad approach recommended for these facilities including "biological, medical, social, and behavioral approaches." The expansion of one discipline or another is not adequate in meeting such a multifaceted problem as mental retardation.

Unfortunately, no funds are provided automatically for the core staff of such centers. If these physical facilities are to be filled with scientists dedicated to the study of the development of intelligence and behavior and its major deviation, mental retardation, additional operational funds are or must be provided for at least 5 years. If no operational funds are provided, such centers will simply represent a kind of apartment house sheltering old programs within a paper institute rather than leading to aggressive new research.

Mr. ROBERTS. Doctor, are you speaking of the 10 comprehensive research centers?

Dr. COOKE. That is right, Mr. Roberts.

Investigators brought into a new environment cannot be expected to immediately develop their own support and it is well recognized that with such a program as mental retardation research, universities at the moment do not possess the resources to support such a major investigation. Funds should be appropriated to provide support for a core staff for a 5-year period. At the end of this time, the centers should become self-sufficient through existing granting mechanisms. Such construction funds and additional continuing support would lead to the development of research centers in which disciplines such as genetics and neurochemistry, electrophysiology, fetal physiology and metabolism, early behavior and language development and learning ability would be brought to bear on problems of the development of intellect. The feedback of information at each level—basic and applied—will be great, and information of immediate application as well as of fundamental concern should be forthcoming. Solutions to such problems would make possible not only improved learning for the retarded but also great strides in the teaching of the normal or gifted.

Unfortunately, despite all of the major breakthroughs which will result from such centers, all of the problems of the retarded cannot be solved in one generation. It is in this regard that title II of this bill is of particular importance. Special consideration has been given in section 201 in the specific location of some facilities for the retarded in conjunction with university medical centers by the assignment of specific funds for grants for construction of facilities for the mentally retarded which are associated with a college university hospital including affiliated hospitals. Such action recognizes that only through the vigorous and effective recruitment and training of future investigators and physicians, nurses, social workers, physical therapists, speech therapists, psychologists, that adequate numbers of individuals will be available to carry out not only research but adequate treatment of the retarded in years to come. Interest in problems of mental illness outranks those in mental retardation as far as recruitment of psychiatrists and nurses by approximately 10 to 1. In my survey of facilities for the retarded in England for the President's Panel

on Mental Retardation, the answer to this difference was clearly presented. From an institutional standpoint, the mentally retarded are looked at largely as incurable in contrast to the mentally ill. At the present time, the training of medical students in mental retardation largely rests on occasional visits to the large institutions for the mentally retarded which represent in large measure a kind of one-way street and present only the irreversible, hopeless nature of the condition. Almost no opportunity exists for frequent contact with the optimistic aspects such as educational and vocational progress.

In the past, training programs for physicians, nurses, social workers, vocational therapists and recreational therapists have been conducted in settings which maximize the therapeutic hopelessness of mental retardation. These settings, to a large extent, have been the large, multipurpose (so-called comprehensive) residential institutions with very low discharge rates and a concentration of patients who represent the therapeutic failures of the community. Furthermore, these large residential institutions have been notoriously short of staff so that the quality and quantity of the training experiences have been severely limited.

The experience of students visiting wards for the retarded in a large institution is given by the following quotations from a recent paper by Dr. Oscar C. Stein, instructor in public health, at Johns Hopkins, entitled "Field Trips for Medical Students—Problems of Mentally Retarded Children." I quote:

> Part of the shock of students who visit this facility may be related to the experience of being confronted with so many problems at once. The physician is confident that he has certain specific measures to offer an individual patient in discomfort: when the student is faced with the large number in severe distress, he is extremely uncomfortable merely because of the numbers. When students are interested in such a facility they go largely as spectators rather than as physicians.

Training and educational programs, in order to encourage recruitment, must be placed in settings in which reasonable optimism and enthusiasm for success are likely. It is not sufficient to reiterate that "the mentally retarded can be helped." It is necessary then for each student to discover himself that the retarded and their families are being significantly improved by his or her efforts. This opportunity for student contact with the treatment aspects is absolutely essential.

Likewise, there is no clinical focus within university hospitals for mental retardation comparable to existing psychiatric services for the mentally ill. The creation of an inpatient and outpatient service for the mentally retarded in each university or university affiliated hospital would go far toward creating interest among medical students, nurses, social workers, psychologists and educators in mental retardation. Not only will these facilities improve training, but will present opportunities for demonstration of advances in diagnosis and treatment of a medical, social, psychological, educational, and vocational nature as they are developed through university research. These clinical facilities can thereby guide nonuniversity programs in their work with the retarded throughout the Nation.

Unfortunately, the wording of the present legislation will not make it possible for a fruitful use of the "$5 million of the sums to be appropriated for the fiscal year ending June 30, 1965, and $10 million of the sums to be appropriated for any of the next 4 years" toward

construction of clinical facilities at university hospitals. Unless such funds are exempted from the State formula mechanism described in section 202 each university hospital will receive funds in such meager dribbles that no effective facility can be built. Likewise, States having university hospitals which are not prepared to move ahead with such a program will have funds accumulate which are required to establish an effective facility elsewhere. Section 202 should be amended so that funds for university clinical centers can be awarded on a grant basis to provide adequate construction funds at one time for an effective building program consistent with the proposal of the President in his message to the Congress on mental retardation. Facilities should be built for, and I quote from the President's message:

(1) Clinical inpatient units as an integral part of university-associated hospitals in which specialists on mental retardation would serve; (2) outpatient diagnostic, evaluation, and treatment clinics associated with such hospitals, including facilities for special training; and (3) satellite clinics in outlying cities and counties for provision of services to the retarded through existing State and local community programs, including those financed by the Children's Bureau, in which universities will participate.

Just as with the research centers, it is hoped that specific funds will be appropriated to provide a core clinical staff. Hospitals and universities have no source of support of such personnel at the present time and neither the Public Health Service nor the Children's Bureau are authorized to support such service functions except on a demonstration basis.

In conclusion, I should like to echo my support for the other provisions within this bill, making possible the development of State plans for the care of the retarded, planning for the retarded as well as construction of community facilities. I have not commented in detail because of any lack of enthusiasm but simply because others are here to emphasize the virtue of these aspects. In case of the probability that one State agency might be responsible for programs under the Community Mental Health Centers Act and the Mental Retardation Facilities Act in some States, section 202c should be amended. It is possible that because of greater interest of this one agency in one problem or the other, all funds might be utilized for one purpose—mental illness or mental retardation—with the other field suffering.

To avoid this possibility, it would seem reasonable that H.R. 3689, 202c, page 7, line 10, should be amended with the substitution of wording such as the following:

(1) A showing satisfactory to the Secretary by the State agency designated in the State plan approved under this title that this agency has afforded a reasonable opportunity to make application for the portion so specified and that there have been no approvable applications for such portion.

The wording after (2) should remain as it is written in the bill.

This minor alteration in wording would make it possible for the Secretary to review what is actually being done in each of these areas and to avoid a State agency putting its emphasis only in one direction or the other. It is unlikely that the Secreatry would go behind a certification as would be required in the present wording to prevent inequitable use of funds.

The proposed plan to permit adjustments of allotments seems wise because of the enormous need for Federal support in each of these areas of mental illness and mental retardation.

In conclusion I should like to thank very much the Chair for allowing me to present this statement.

Mr. ROBERTS. Thank you, Doctor Cooke. It is certainly a pleasure to have you before our subcommittee. I remember quite well the fine presentation you made in our hearings on the Child Health Institute and we are very grateful to you for your continued interest.

I would like you to supply for the record a list of the President's panel—a list of these outstanding scientists and businessmen and doctors.

I would also like to commend you on the changes which you recommend with reference to the mental retardation. I agree with you that I see no money at all for staffing either in the comprehensive centers nor in the community centers which would be built. Yet I think that the mental retardation part of the bill may be the more important part as far as rehabilitation possibilities and recovery possibilities have been of working with the children. I don't mean to discount the importance of the mental health part of the bill but I would not like to see us have the mental retardation part of the bill where we have so few answers to start out with a weak approach. I agree with you unless we do consider this matter of staffing, we are simply going to end up with a lot of buildings and facilities.

Not long ago I visited a section of a hospital in Montgomery that is devoted to the mentally retarded. They had wonderful facilities, very well set up, but one of the nurses remarked to me, "We do not have the trained personnel that we need to handle these cases."

I certainly agree with you that personnel is the part that needs the strengthening. It may be that we can go in for a limited period of time and then let the States and local jurisdictions take over but I certainly feel we ought not to start out with an automobile with no engine in it. That is apparently what we were about to do.

The gentleman from Minnesota.

Mr. NELSEN. No questions.

Mr. ROBERTS. The gentleman from New York.

Mr. O'BRIEN. No questions.

Mr. ROBERTS. Thank you very much, Doctor.

Dr. COOKE. Thank you, Mr. Chairman.

(The following material was supplied for the record by Dr. Cooke):

THE JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE,
Baltimore, Md., March 28, 1963.

Hon. KENNETH A. ROBERTS,
Chairman, Subcommittee on Health and Safety, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

DEAR CONGRESSMAN ROBERTS: I am enclosing a list of the members of the President's Panel on Mental Retardation which I should appreciate having inserted in the record of the hearings.

Sincerely,

ROBERT E. COOKE, M.D.,
Professor of Pediatrics.

PRESIDENT'S PANEL ON MENTAL RETARDATION

Mr. Leonard W. Mayo (chairman), executive director, Association for the Aid of Crippled Children, 345 East 46th Street, New York, N.Y.

Dr. George Tarjan (vice chairman), superintendent and medical director, Pacific State Hospital, Pomona, Calif.

Judge David L. Bazelon, U.S. Court of Appeals for the District of Columbia, Washington, D.C.
Msgr. Elmer H. Behrmann, associate secretary for special education in the National Catholic Education Association, 4472 Lindell Boulevard, St. Louis, Mo.
Dr. Elizabeth Boggs, research chairman, National Association for Retarded Children, Inc., 75 Edgewood Road, Upper Montclair, N.J.
Dr. Robert E. Cooke, professor of pediatrics, the Johns Hopkins Hospital, Baltimore, Md.
Dr. Leonard S. Cottrell, Jr., staff social psychologist, Russell Sage Foundation, New York, N.Y.
Dr. Edward Davens, deputy commissioner, Maryland State Department of Public Health, Baltimore, Md.
Dr. Lloyd M. Dunn, coordinator, education for exceptional children, George Peabody College for Teachers, Nashville, Tenn.
Dr. Louis M. Hellman, Department of Obstetrics and Gynecology, State University of New York, New York City College of Medicine, Brooklyn, N.Y.
Dr. Herman E. Hilleboe, commissioner of health, New York State Department of Health, 84 Holland Avenue, Albany, N.Y.
Dr. Nicholas Hobbs, chairman, division of human development, George Peabody College for Teachers, Nashville, Tenn.
Dr. William Hurder, associate director for mental health, Southern Regional Education Board, Atlanta, Ga.
Dr. Seymour Kety, National Institutes of Health, Bethesda, Md.
Dr. Joshua Lederberg, department of genetics, Stanford University School of Medicine, Palo Alto, Calif.
Dr. Reginald Spencer Lourie, director, department of psychiatry, Children's Hospital, Washington, D.C.
Dr. Oliver H. Lowry, professor, biochemistry and pharmacology, Washington University School of Medicine, St. Louis, Mo.
Dr. Horace W. Magoun, department of anatomy, University of California, School of Medicine, Los Angeles, Calif.
Dr. Darrel J. Mase, dean, College of Health Related Services, University of Florida, Gainesville, Fla.
Mr. F. Ray Power, director of Division of Vocational Rehabilitation, State Department of Education, Charleston, W. Va.
Dr. Anne M. Ritter, director of psychological services, Kennedy Child Study Center, New York, N.Y.
Dr. Wendell Stanley, professor of virology, University of California, Berkeley, Calif.
Dr. Harold Stevenson, director, child development research, University of Minnesota, Minneapolis, Minn.
Mr. W. Wallace Tudor, vice president, Sears, Roebuck & Co., Chicago, Ill.
Mr. Henry Viscardi, Jr., president, Abilities, Inc., Albertson, Long Island, N.Y.
Mrs. Irene Asbury Wright, speech pathologist, 515 Lincoln Avenue, Albany, Ga.
Dr. Ernest P. Willenberg, director of special education, Los Angeles City Board of Education, Los Angeles, Calif.

Mr. O'BRIEN (presiding). The next witness will be presented to the committee by the distinguished colleague of ours, Congressman Udall, of Arizona, with whom it is my pleasure to serve on another committee of the Congress.

You are very welcome, Mr. Udall.

Mr. UDALL. Thank you, Mr. Chairman, and I shall just take a moment. I wanted to thank the committee for making it possible for me having a reunion with an old friend, Dr. Lindsay E. Beaton, of Tucson, Ariz. Dr. Beaton is not only one of the leading psychiatrists and neurologists in the Southwest but he has been a distinguished civic leader, he is a man with a real concern about civic problems, he is widely recognized throughout Arizona and the Southwest for his various accomplishments.

Dr. Beaton, in the field of medicine, has been the past president of the Arizona State Medical Society, he is currently vice chairman of

the AMA staff, mental health; and member of the House of Delegates of AMA. I have no information as to the statement he is here to present. The only argument I have with him is that he is a member of the wrong political party but I know that his testimony will be frank and forthright.

He is articulate and a very well informed physician and well informed citizen. So it gives me a great deal of pleasure to present to the committee Dr. Lindsay Beaton, of Tucson, Ariz.

Mr. O'BRIEN. Thank you. I say we have a distinguished witness presented by a distinguished colleague.

Mr. UDALL. I thank the chairman for those remarks.

Mr. O'BRIEN. We have with us at this time with Dr. Beaton, who has just been introduced, Dr. Charles Hudson, member of the board of trustees of the American Medical Association, and accompanied by Dr. Walter Wolman, secretary of the Association Council on Mental Health.

Gentlemen you may proceed in any order you desire. We hear first, I assume, from Dr. Hudson.

STATEMENT OF DR. CHARLES L. HUDSON, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY DR. LINDSAY E. BEATON AND DR. WALTER WOLMAN

Dr. HUDSON. Mr. Chairman, Mr. Nelsen, I am Dr. Charles L. Hudson, of Cleveland, Ohio, where I have been in the practice of internal medicine for the past 25 years, most recently as a member of the staff of the Cleveland Clinic. In connection with the clinical interest of today's subject, it may be pertinent to mention that I am an associate clinical professor of the Departments of Medicine and of Preventive Medicine at Western Reserve University. I am also a member of the board of trustees of the American Medical Association.

With me are Dr. Lindsay E. Beaton, a practicing psychiatrist of Tucson, Ariz., who is vice chairman of the American Medical Association's Council on Mental Health, and Dr. Walter Wolman, director of the AMA's Department of Mental Health.

Let me express the American Medical Association's appreciation for the opportunity to comment on H.R. 3688 and H.R. 3689, dealing with the subjects of mental health and mental retardation.

The American Medical Association heartily approves of the concern shown by the President of the United States and by his committee over what we consider to be one of America's most pressing and complex health problems. The magnitude of this problem need not be argued. It is shown in such familiar statistics as the fact that one out of every two hospital beds in the United States is occupied by a mental patient. The action of this committee can have a profound effect on the health of the people of our country.

Every physician, regardless of type of practice, has an important stake in working toward the improvement of our mental health knowledge and resources. Therefore, the American Medical Association has been concerned with combating mental illness and promoting mental health. Let me briefly highlight our more recent activities in this area.

In 1955, the AMA's Council on Mental Health, in cooperation with the American Psychiatric Association, engaged in a study which led to the formation of the Joint Commission on Mental Illness and Health. The resulting report was recognized by the AMA's board of trustees as the basis for a program aimed at the treatment and prevention of mental illness. Subsequently, the American Medical Association, through its Council on Mental Health, formulated a program outlining general and specific areas in which the AMA and its constituent societies could participate in the problems existing in mental health and illness.

In October 1962 the AMA sponsored the first National Congress on Mental Illness and Health. The purpose of this meeting was to discuss and organize effective regional and State mental health activities to implement the AMA's mental health program. Almost 2,000 individuals—representing the medical profession, allied health groups, lawyers, educators, State and Government agencies, and citizens' groups—attended the congress.

Mr. Chairman, I ask that two documents—the "AMA Statement of Principles on Mental Health" and the "Program of the Council on Mental Health"—be inserted at this point in the record of these proceedings.

Mr. O'BRIEN. Without objection, so ordered.

(The material referred to follows:)

AMA STATEMENT OF PRINCIPLES ON MENTAL HEALTH

Mental illness is America's most pressing and complex health problem. Tremendous strides have already been made in improving the care and treatment of the emotionally disturbed but much remains to be done. The mental health field is vast and includes a network of factors involving the life of the individual, the community, and the Nation. Any programs designed to combat mental illness and promote mental health must, by the nature of the problems to be solved, be both ambitious and comprehensive.

The American Medical Association recognizes the important stake every physician, regardless of type of practice, has in improving our mental health knowledge and resources. The physician participates in the mental health field on two levels—as a man of science and as a citizen. The physician has much to gain from a knowledge of modern psychiatric principles and techniques and much to contribute to the prevention, handling, and management of emotional disturbances. Furthermore, as a natural community leader, he is in an excellent position to work for and guide effective mental health programs.

For these reasons, the Council on Mental Health of the American Medical Association was charged with developing a realistic, positive program which would more fully integrate the physician into the Nation's mental health efforts. The council has drawn up such a program, placing special emphasis on how the AMA, through its constituent societies and departmental councils and committees, can make significant contributions in the field of mental health.

Many of the existing shortages and problems in mental health must be met at the community level. Adequate facilities must be readily available for treating individuals on both an inpatient and outpatient basis. These facilities extend beyond psychiatric units in local and State hospitals and include child guidance centers, vocational and family counseling services, low or variable cost adult psychiatric services, home care treatment, followup clinics and rehabilitation centers. Continuing, long-term programs must also be planned at the community level to meet the mental health needs of the child, the family, the aged, as well as the mentally retarded, the delinquent, the alcoholic, the narcotic addict, and the sociopath.

This is a broad order which obviously cannot be filled for some time. Its scope increases with the realization that facilities and programs must be staffed by persons trained in both medical and nonmedical disciplines. The AMA will

work to alleviate current personnel shortages and also to encourage careers in mental health.

The AMA will also be more active in encouraging physicians to become leaders in community planning for mental health. The AMA's First National Congress on Mental Illness and Health, October 4–6, 1962, was organized so that physicians and other interested parties could meet together to discuss and organize effective regional programs. This Congress is part of a continuing effort to effectively channel physician participation into mental health activities.

Shortages in mental health personnel and facilities are related to a shortage of funds available for mental health needs. Few communities have the resources necessary for adequately developing and expanding their mental health services. For this reason, the AMA supports multiple source financing for community mental health services and recognizes the need for additional expenditures, at all levels, in this area.

The AMA has always stressed the importance of the physician-patient relationship in the practice of medicine. Modern psychiatry has made significant contributions in bringing about a deeper understanding of this concept and its importance in treating illness. Knowledge of interpersonal relationships and psychiatric techniques should be integrated into all phases of the physician's educational development.

The American Medical Association has a deep interest in fostering a general attitude, within the profession and among the lay public, more conducive to solving the many problems existing in the mental health field. The Council on Mental Health is encouraged to implement the programs necessary to fully utilize the resources of the medical profession in the fight against mental illness.

Program of the Council on Mental Health

The major health problem facing the nation today is mental illness. This is confirmed in many ways—by, for example, the familiar statistic that one out of every two hospital beds in the United States is occupied by a mental patient. Certainly the magnitude of the problem cannot be argued; nor the need to find solutions through prompt and effective actions.

The medical profession has a clear responsibility to assume leadership in the mental health field and to work with professional and lay groups in a sustained, coordinated effort to effect sound, workable mental health programs.

Recognizing this duty, in 1955 the American Medical Association and the American Psychiatric Association conduced a series of meetings to study needs in the field of mental illness and health. These led, in turn, to the formation of the Joint Commission on Mental Illness and Health.

The Joint Commission's report, published in March, 1961, culminated a 5-year study in which 36 national organizations participated. "Action for Mental Health," as the report is called, was recognized as "an historical contribution to the promotion of mental health and the prevention and care of mental illness," by the Board of Trustees of the AMA at its New York meeting, June 24–29, 1961. The board of trustees also stated that the joint commission report was to "be considered as the basis for a program which the American Medical Association can endorse and support after the recommendations of the National Conference on Mental Health are available."

"Action for Mental Health" is, therefore, considered as a supporting document for this report.

The AMA's Preliminary Program Conference on Mental Illness and Health was held September 29–October 1, 1961, with 175 distinguished professional leaders in attendance. It had four primary objectives:

1. To assess current activities in mental health.
2. To focus on definite problem areas.
3. To seek solutions for specific problems.
4. To study means for the prevention and management of mental disorders.

This document has been extracted primarily from the deliberation and recommendations of the preliminary conference. Supplementary proposals and plans were submitted to the Council on Mental Health by the chairman of State society committees on mental health who participated in a 2-day conference held February 2–3, 1962.

This document outlines the broad scope of problems existing in mental health and illness and suggests both general and specific areas in which the AMA and

its constituent societies can participate. It has been accepted by the board of trustees as the base for positive AMA programs in the field of mental health and illness.

THE PHYSICAN AND COMMUNITY NEEDS

There is a demonstrable shortage of adequate mental health services at the community level coupled with a growing public awareness of the need for such facilities. As the Joint Commission report points out, communities now want more than just private psychiatric care and State hospitals. They recognize the need for child guidance clinics, low or variable cost adult psychiatric service, inpatient phychiatric facilities, home care treatment, day and night hospitals, followup clinics, vocational counseling, sheltered workshops and family counseling.

In every community where these needs are to be met, either partially or in full, close cooperation between physicians and laymen is imperative. Local lay organizations can supply vital services in certain areas involving mental health. The medical profession must provide guidance for these groups to assure programs embodying sound professional principles and practices.

Mechanisms should be established to enable the profession to furnish medical guidance and support on the National, State and local levels. Such arrangements will enable the individual physician, and State and county medical societies to participate more effectively in assessing community mental health needs and in planning and establishing the required services. When necessary, the profession must also be prepared to support enabling legislation. The council encourages the Woman's Auxiliary of the AMA to help in the augmentation of national and community mental health programs.

Medical societies should be a source of up-to-date information on mental health facilities in their area and should cooperate with other agencies in establishing 24-hour psychiatric information centers dispensing pertinent mental health information.

To facilitate such activities, the AMA will expand its liaison with national mental health organizations and encourage its constituent societies to do the same at their respective levels. The AMA will also gather and disseminate informational material relating the physician to community health needs (both urban and rural).

THE MEDICAL PROFESSION MENTAL HEALTH SERVICES IN THE COMMUNITY

Comprehensive mental health programs will vary from community to community but, generally, facilities and staff should be available to service the needs of the following groups and problem areas.

Children

Many diverse factors influence the child's development from the prenatal period through early adulthood. Preventive measures such as psychological counseling during periods of environmental stress and "well-child" conferences focusing on normal growth and development patterns can make substantial contributions to improving the mental health of the children of a community.

The AMA urges physician participation in and support of such services as prenatal and neonatal care centers, children's psychiatric clinics and units in general hospitals, day care centers, and school counseling and guidance services. The profession also recognizes the need for an expansion of existing facilities in this area.

The physician plays a key role in safeguarding the mental health of the children who are his patients. He must be aware, for example, that hospitalization is a serious experience for a child and that hospitalization, for mental or physical illnesses, should be avoided unless absolutely necessary. If hospitalization is indicated, the physician must minimize its traumatic effect by preparing both the child and the parents for the experience. Whenever possible, it is advisable that very young children should not be separated from their mothers.

In the hospital, the child (and particularly the mentally ill child) should have treatment programs and facilities separate from those afforded adults. A professional staff oriented to this age group and including the child psychiatrist, psychologist and social worker should be available when and as needed. The physician should also urge that extensive hospital visiting privileges be allowed for the child's parents.

In the case of physically or mentally handicapped children, there must be adequate rehabilitative care facilities. This care must extend beyond physical therapy for often psychological assistance and special educational aids are necessary to help both parents and child adjust to the handicapped condition.

As a service to interested physicians, the AMA will supply pertinent information on child development, family dynamics and related mental health principles.

The mentally retarded

There are more than 5 million Americans who are mentally retarded and their existence constitutes a medical, educational, and social problem of vast dimensions. Care facilities for these individuals must be integrated into every community's mental health program.

The extent to which this problem can be ameliorated in future years depends largely upon continued research. Some breakthroughs have been effected as, for example, the prevention of some types of mental retardation as a result of our increased knowledge about body metabolism. However, there is still a lack in research planning, personnel, and financing which must be overcome.

The AMA supports efforts to provide better standards of care for the institutionalized retarded, special educational programs, day care centers within the community, counseling services for the parents of retarded children and efforts to create job opportunities for retarded adults. For these programs to be effective, the Nation also needs additional facilities and an increase in properly qualified personnel.

Juvenile delinquency

Despite the efforts of public and private agencies, juvenile delinquency remains a serious national problem. The physician can play an important role in curbing delinqueney in his community. In the course of his practice, he can often detect early maladjustment and development problems during childhood and adolescence. Furthermore, his medical knowledge is needed in planning effective programs for agencies dealing with delinquents.

State and local medical societies are urged to prepare directories of local resources for the care of juvenile delinquents and make these directories available to physicians; to work more closely with other professionals concerned with the problem; to support psychiatric clinics associated with juvenile and criminal courts; to encourage physicians to become health advisers and leaders in community programs; and to acquaint their members with screening programs aimed at the early detection of the potential delinquent.

The family in mental illness and health

Physicians, regardless of specialty, have always recognized that a patient's family is a relevant factor in the management of illness. This principle is of great importance in dealing with mental diseases. It is essential, therefore, that the physician know the social environment of the family and its effect on a patient's personality. In particular, the psychiatrist should reestablish his medical role as adviser to the patient's family.

Often problems of mental illness and health involving family relationships will require teamwork by various professionals. Thus, the physician will be called upon to work closely with members of allied health groups such as psychologists, social workers and family and marriage counselors.

The aged

Our rapidly increasing aged population has special mental health problems involving, among other factors, improved care facilities and greater integration into community life. The AMA discourages the use of public mental hospitals as custodial facilities for the nonpsychiatric aged and supports the development of new and adequate community facilities staffed by well-trained personnel.

On the community level, available psychiatric facilities should be assessed and steps taken to correct existing shortages. Special housing facilities for the nonsenile aged should be encouraged as well as an expansion of units available for psychiatric care of the aged in general hospitals. State and local medical societies are urged to provide community leadership in establishing facilities to meet the medical and social needs of the aged.

Rehabilitation

The object of all treatment programs is to enable the individual to function as independently and effectively as possible—rehabilitation is essential to this end. All treatment facilities, including psychiatric hospitals and clinics, should, there-

fore, have rehabilitative services available during hospitalization and provide outpatient services for posthospital care and for persons whose illness does not require hospitalization.

A referring physician should be informed of a patient's hospital progress and followup treatment after discharge. Such explanations of therapeutic plans facilitate the continuity of treatment. As a corollary, the referring physician also has an obligation to request this information.

Alcoholism

Alcoholism is a medical, social and economic problem. Although many disciplines and professional personnel are needed to work with the alcoholic, supervision of treatment should be under the direction of a physician.

Physicians should be encouraged to support better facilities for dealing with the medical aspects of alcoholism, particularly in the general hospital. Hospital programs for the alcoholic should include: supervision during withdrawal by qualified physicians; psychiatric evaluation of the patient and his family followed by psychiatric care for the patient; and adequate followup treatment and rehabilitation services.

The profession must help in convincing the general public that alcoholism is a disease requiring medical diagnosis and treatment, rather than a criminal act demanding punishment. The profession should also consider the desirability of enabling laws facilitating treatment of alcoholics.

Narcotic addiction

Narcotic addiction, a complex problem involving pharmacological, psychiatric and socioeconomic factors, requires special treatment often supplemented by psychiatric, rehabilitative and social care. Unfortunately, society tends to view the narcotic addict as a moral transgressor who must be punished. As long as this attitude persists, the problem of dealing with the Nation's active addicts is unnecessarily compounded.

Physicians should urge the repeal of laws providing minimum mandatory sentences for addicts and urge that they be given the same parole opportunities as other offenders. Physicians should also support legislation requiring Federal institutions to accept commitments ordered by State courts for drug addiction.

Since most addicts are to be found in large cities, States with lesser addiction problems are encouraged to establish special treatment institutions in cooperation with neighboring States, or to provide special facilities within existing institutions or carefully controlled clinics for the withdrawal and rehabilitation of nonhospitalized patients.

The AMA supports the development of treatment program with special facilities for withdrawal therapy, rehabilitative services and intensive long-term supervision after withdrawal. The profession also urges more research into the nature of narcotic addiction and the care of the addict.

Sociopaths, sex psychopaths and psychiatrically deviated offenders

The problem of the sociopath is an exceedingly thorny one and a wide difference of opinion exists as to its proper management. Physicians, and others, should recognize that, even though committed to jail, the sociopath needs psychiatric evaluation and treatment. Facilities should be made available for effective treatment of these patients (prisoners). These facilities should provide for external control, automatic and frequent review of cases, intensive vocational and other training programs, and a full range of psychiatric services.

LEGAL ASPECTS OF PSYCHIATRY

The legal problems associated with mental illness are exceedingly complex and include such subjects as hospital admissions, the rights of the mentally ill patient, privileged communication and confidentiality, criminal responsibility and expert testimony. Many of these areas require further study and clarification by both the medical and legal professions. The AMA will continue to foster interprofessional communications and cooperation on National, State and local levels, between the medical and legal professions—particularly when mental health legislation or medicolegal education are involved.

Hospitalization for the treatment of a mental condition should not be the equivalent of an adjudication of incompetency. States should be urged to permit medical referrals to mental hospitals without court action or legal forms in cases where the patient or the family do not object.

The profession believes that the legal rights of the mentally ill must be safeguarded and both patients and hospital staff familiarized with these rights. Hospitalized mental patients should be allowed to communicate, by sealed mail, with their attorneys, families, and the courts; and communications with their psychiatrists as well as their hospital records should be privileged, consistent with public policy.

When necessary, physicians are urged to support legislation to implement positive medico-legal principles.

HOSPITAL AND OTHER MEDICAL CARE PROGRAMS

Community medical care is provided in many ways and through many facilities. Private practice, tax-supported agencies, and voluntary programs play essential parts in caring for all forms of illness.

Mental health resources are a vital part of this complex. Physicians should eye them critically in terms of their defects and assume the initiative in correcting any deficiencies. The medical profession has always insisted on high standards of care for mental and physical illnesses whether provided in State, private, or general hospitals or through outpatient clinics.

General and private hospitals are usually the primary and central resources of the community's network of medical services. They should provide care for the psychiatric patient. Where adequate facilities are not available within a community, psychiatric units should be established within the general hospital to assure early and effective treatment. However, the hospital should be used for the treatment of the mentally ill only when there is a definite indication of need and not as a substitute for other resources. Physicians should also encourage the establishment of psychiatric clinics as part of the general hospital's outpatient services or make other arrangements that will guarantee adequate medical direction and responsibility.

It is important that the psychiatric patient have easy access to all the community's treatment centers including, of course, the hosptial. Whenever possible, admission to a hospital for mental illness should be on the same basis as admission for a physical illness.

Physicians are urged to participate in clinical and community medical services which involve the treatment, aftercare, and rehabilitation of the mentally ill. Similarly, hospital staffs should establish and develop training and research programs in mental illness and health and engage in interchanges on medically related matters with skilled colleagues throughout the community.

EDUCATION OF THE PUBLIC

The public's lack of understanding and frequent misinformation about psychiatric illnesses are basic causes for the rejection of the mentally ill and of programs intended to aid them. It is of paramount importance that this unfortunate climate of opinion be changed. Reporters and writers for communication media such as newspapers, magazines, radio, and television must receive thorough and accurate information regarding mental illness to enable them to correctly interpret current trends in psychiatric thought.

By communicating a positive, understanding attitude toward emotional disorders and mental illness, the practicing physician can be a powerful influence in eradicating the present stigma associated with mental illness by patients' families and the general public.

A concerted campaign to interest and inform the public on mental health matters will be undertaken by the AMA and State and county medical societies in cooperation with hospital, speciality, and education groups. The mental health committees of the local medical societies are also encouraged to cooperate with the woman's auxiliary in establishing and developing public information programs.

The profession should also provide medical direction to mental health associations planning informational programs about referral services; training programs for volunteers; distribution of education materials; direct services to former patients and their families; promotion of pschiatric services in general hospitals; mental health career projects; and research.

EDUCATION OF THE PHYSICIAN IN MENTAL HEALTH

The understanding of the physician-patient relationship and its proper use in the treatment of illness is modern psychiatry's major contribution to the

education of the general practioner and the specialist in fields other than psychiatry.

Since so many diseases, even those of known organic origin, have functional components the knowledge and therapeutic use of the physician-patient interplay are essentials in the armamentarium of every practicing physician. Since time immemorial physicians have sought to treat the total patient—an impossible goal without some knowledge of psychiatric principles.

Utilization of the dynamics of the physician-patient relationship occurs at varying levels of psychological insight. A doctor may, for example, deliberately minimize emotional involvement, as in some surgical situations. The treatment of mental illness, however, may demand the fullest awareness by the patient and his therapist of their feelings about themselves and each other.

From the physician's standpoint, the important element is self-knowledge and recognition of his emotional bent toward the patient and his illness. With such insight, the doctor can make use of one of his most valuable tools—the skillful employment of his personality as an instrument of therapy. The patient must also be helped to recognize his feelings toward himself, his illness, the doctor, and the part these feelings play in his treatment.

Premedical and undergraduate education.—The council on mental health through the AMA's Council on Medical Education and Hospitals well seek the means whereby undergraduate medical students can have more training in social and behavioral sciences—such as courses in economics, psychology, sociology, and cultural anthropology.

Medical schools should adopt a flexible attitude toward admission requirements and this attitude should be made known to high school and college advisers, as well as potential candidates. This principle has been spelled out by the American Medical Association and the American Association of Medical Colleges in "Functions and Structure of a Modern Medical School" (October 1957):

"Because basic knowledge of biology, physics, inorganic and organic chemistry and human behavior are the foundation stones of medicine, adequate college courses in these subjects, as well as demonstrated competence in English, should be required. It is important that a medical college restrict its admission requirements to this minimum so that a college student preparing for the study of medicine will have the opportunity to acquire a broad liberal education or to study a specific field in depth according to individual interest and ability. The complexity of modern medicine can be best served by physicians who in a composite represent a variety of backgrounds in education and experience."

The council feels that while medical teaching has certainly enriched students' understanding of diseases it has not placed sufficient emphasis on the interpersonal implications of diagnostic and therapeutic procedures. Both psychiatrists and behavioral scientists can make significant contributions to medical education by concerning themselves more with the processes by which the individual doctor and patient communicate with each other. Techniques should be fashioned for constructive teaching oriented toward the following goals:

1. Development of awareness in the individual student of his own characteristic way of meeting implicit or explicit demands of sick patients; and how to modify patterns of behavior which may be self-defeating in the student's goal of diagnosing and treating illness.

2. Development of a conceptual framework and supporting data so that elements in the doctor-patient relationship can be taught more effectively.

It is important that the dynamics of personality interaction receive greater stress in medical schools if physicians without specialized training in psychiatry are to play a major role in effectively treating the emotional problems of their patients. Wherever applicable, curriculum development for the medical student should also focus attention on such problems as alcoholism and drug addiction, juvenile delinquency, mental retardation, family dynamics, and the special problems of children and the aged.

House officers' education.—In general, graduate training programs are deficient in teaching interns and residents the social and emotional aspects of medical practice. The majority of hospital staffs are unaware of the importance of these factors and tend to emphasize their special interests. Unfortunately, specialty board requirements abet this narrow view of medicine.

The Council on Mental Health endorses the following statement in the "Essentials of an Approved Internship" of the AMA's Council on Medical Education and Hospitals:

"*Psychiatry.*—There is a distinction between psychiatry as a basic science and psychiatry as a special medical skill. The former is an indispensable part of all

medicine; the latter is the province of graduate training and beyond the internship. Certain basic science aspects of psychiatry, namely those relating to the psychology of acute and chronic illness, of disability, of surgical intervention, of convalescence, and of the doctor-patient relationship are of common concern to all those who care for the sick. Knowledge of these matters should be shared by all members of the teaching staff, as such knowledge should be applied to the study and care of all patients.

"If inpatient psychiatric services are not available in the hospital, the education of the intern in this field should be provided by psychiatrists assigned to the various clinical services. These physicians should not only assist in the management of acute psychiatric cases but should provide a continuous consultative educational service relating to all types of patients' problems, thus furnishing an additional contribution to the total care of the patient.

"The primary goal of such instruction should be a familiarization with methods which may lead to better understanding on the part of the intern of the emotional status of all his patients."

A study of both the formal and informal methods of teaching the psychological, social, and emotional factors in illness in the house officer programs should be a significant part of the projected study by the Advisory Committee on Graduate Medical Education and Training of the AMA.

Provision should be made for interns and residents to become familiar with community mental health agencies and resources. The AMA encourages programs which give the house officer the responsibility for continuing care of patients with protracted illness as they pass through the hospital, its outpatient services, and into the community.

The continuing education of the practicing physician.—The physician is responsible, within his competence, for the care and treatment of mental patients as he is for other forms of illness. Knowledge is, of course, the key to the physician's understanding, communicating, accepting, and participating in the mental health field. It is essential, therefore, that all means of continuing professional education be utilized to help the practicing physician improve his skill in dealing with the psychiatric aspects of his practice.

The council recommends that postgraduate educational opportunities be expanded on the following three levels:

1. Relatively short courses designed for those physicians without specialized psychiatric training. These courses should include material leading to improved understanding of the physician-patient relationship and the psychological aspects of disease. They should also provide sufficient knowledge of common psychiatric phenomena to enable the practicing physician to recognize them with reasonable promptness and to take appropriate action.

2. More intensive training in the management of well-defined emotional problems, either primary or accompanying an organic illness. This skill can only be acquired in situations in which the physician is personally involved and aware of his role in the management of the patient's illness. These programs are most profitably carried out in general hospitals with adequate psychiatric staffs to train and supervise in conjunction with other appropriate personnel.

With such training, the physician retains his primary identification and recognizes that he does not thereby become a psychiatrist. Physicians who have completed such courses should be better able to carry on the treatment of patients after discharge from psychiatric inpatient services.

3. Advanced courses for the psychiatric specialist, which stress improving him as a teacher in the foregoing programs and strengthen his capacities as a consultant to other physicians.

The most useful means of exchanging medical information between physicians occurs in the clinical face-to-face relationship and steps should be taken to provide such situations for the psychiatrist and his fellow physicians.

The council on mental health will work with other agencies, both private and public, to spur the development of more postgraduate educational programs in the field of mental health. It is hoped that the council can be of service to the American Academy of General Practice, the American Psychiatric Association, other specialty groups, and State and county societies participating in such programs.

Persons in psychiatric education are encouraged to cooperate with educational centers for medical and nonmedical counseling in order to develop standards and review curricula in psychology, psychiatry, family dynamics, social sciences, and other approaches to counseling. They should also be prepared to teach courses to candidates in nonmedical health professions.

PERSONNEL PROBLEMS IN MENTAL HEALTH

An acute shortage of adequately trained personnel exists throughout the mental health field. This shortage necessitates the efficient use of those persons available. Supplementary training in psychiatric principles should be given general practitioners, public health nurses, and others to enable them to function effectively in this area. Although tens of thousands of volunteer workers do a yeoman's job in the overall fight against mental illness, they cannot be considered as permanent substitutes for paid employees.

Across-the-board recruitment drives are urgently needed in the field of mental health and must be carried out on a sustained, high-priority basis. The AMA will continue to act as a coordinator of efforts to meet the manpower shortage in medicine and allied health fields.

Unfortunately, economic barriers often deter able men and women from choosing careers in medicine. Other economic barriers prevent medical schools and teaching hospitals from providing the best in medical education. All potential resources, including those of local, State and Federal Governments, should be mobilized to eradicate these barriers. Some Federal assistance is currently available for predoctoral training in most medical science and allied health fields and some universities may use Federal funds for this purpose. Medical students can now obtain substantial loans and scholarships from the AMA and loans are also available from many State and county medical societies, from local citizens' groups and other private organizations.

The AMA, in cooperation with other agencies, will relay information on the health sciences to vocational guidance counselors. Special attention will be paid to interest high school and college students in mental health careers. State and county medical societies and branches of the woman's auxiliary are encouraged to develop special programs aimed at attracting more students to work in the field of mental health. Educational institutions are also encouraged to institute cooperative programs with medical, research and service organizations to provide practical experience for personnel training in the health field.

In seeking the services of allied professional groups and volunteer workers, the physician should rely upon them to the maximum extent consistent with sound professional practice in treating the mentally ill. The physician should provide them with required medical information in keeping with their professional identity and status.

FINANCING MENTAL HEALTH PROGRAMS

An increase of funds is essential if the Nation hopes to fill the many shortages existing in available mental health facilities and personnel. For example, additional expenditures are urgently needed to enable mental hospitals to provide treatment comparable to that of well-managed general hospitals; introduce and/or improve psychiatric services in general hospitals; provide clinics for children and adults and special training schools for the mentally retarded.

Few communities have the resources necessary to meet their mental health needs. The AMA therefore supports multiple source financing for community mental health services and accepts the need to expand this financing. It also supports increased expenditures for State and Federal mental hospitals.

Shared financing tends not only to preserve local responsibility but also to develop more effective and stable programs. For example, if a clinic depends entirely on voluntary contributions, it may be forced to curtail its services in lean years; if it depends entirely on local tax funds then it must refuse to accept patients from adjacent areas. Community mental health funds must come from both public and private sources, including philanthropy and patients' fees.

In terms of tax dollars, responsibility for the support and development of community health programs must be shared by local, State, and Federal agencies. In such programs, the apportionment of funds will vary depending on the wealth and industrial tax base of the communities and States involved.

It is essential that both present and future financial resources be used with maximum efficiency and efficacy. To this end, physicians must be assured of serving in a professional advisory status to guarantee the most judicious medical programing of the funds to be spent. Close working relationships must be maintained and strengthened between the medical profession and the appropriate State and Federal departments engaged in distributing and utilizing funds for mental health services. To aid in fund distribution, the AMA should study current

financing mechanisms, current and expected needs, and recommend future actions and programs.

In the years to come, increased coverage of the cost of mental illness by private insurance companies should substantially augment private funds available for mental health needs. The AMA supports the principle that voluntary health insurance programs should be expanded, on a basis analogous to ordinary medical and surgical care, to include the costs of mental illness.

RESEARCH IN MENTAL HEALTH

Advances in caring for the mentally ill and promoting mental health will depend on increased understanding arrived at through research. Insight into mental health and illness has progressed rapidly in the last 10 years but is still at an early developmental stage and must be fostered and expanded. There can be no call for quick answers. Orderly progress will depend on advances in sciences basic to psychiatry and all of medicine, ranging from cellular biology to the social, behavioral and clinical sciences.

Important opportunities exist for States to provide research institutes in university centers and research facilities in State hospitals. It is preferable that these activities be undertaken as a joint venture with a medical school that has an active nucleus of research workers. The problems of patients in State hospitals provide inspiration for important fundamental research and also a testing ground for research products. The stability of such research projects depends on continuous and adequate support.

Financial support of research in sciences basic to mental health is particularly necessary as well as funds for clinical investigations. Such support must be assumed by all levels of society, government (State, local, and Federal), voluntary citizens' organizations, private foundations and industry. Funds for custodial care, treatment and community services should be supplemented by more realistic expenditures for research projects, research facilities and training. The widely used formula allocating 2½ percent of mental health budgets for research and training is felt to be inadequate.

The profession should work to increase the prestige and economic status of research scientists. The salaries of established investigators should be substantial and the responsibility of the institution and not depend on periodic grant funds. Grant programs should be reserved for supplementary support of individual research activities.

Increased financial support must be supplemented by efforts to recruit creative and productive people for mental health research. Students can be encouraged to enter and remain in research activities by:

1. Having more stress placed on scientific attitudes and methods during undergraduate and graduate training and by providing more opportunities for research experience while students are still in their creative and formative period.
2. Providing more opportunities to explore new rather than conventional mental health areas and by encouraging independent research and responsibility.
3. Providing productive investigators with a higher degree of job permanence.

Investigators from allied health professions (biochemistry, pharmacology, physiology, social sciences, etc.) should be encouraged to participate in research activities in psychiatric settings.

The council believes that serious consideration should be given to expanding research efforts in the following areas which hold the promise of significantly advancing our knowledge of mental illness:

(*a*) In basic (molecular and cellular) biology including genetics. Genetics offers particular opportunities for new knowledge in the field of mental health ranging from the use of demographic technics to the study of the interaction of heredity environment.

(*b*) In neurophysiology, neurochemistry, and psychopharmacology. Recent advances in relating electrical activity of the brain to states of consciousness, to innate and emotional behavior and to learning emphasize the value of increasing research in fields interrelating electrophysiology and the behavioral sciences. The evident behavioral changes induced by many psychopharmacological agents are important not only as an aid to therapy, but also in providing leads for research in the biochemical processes underlying behavior, normal and deviant. The need for more knowledge of the biochemistry of neutral metabolism and

synaptic transmission and of the understanding of the psychopharmacological activities in these terms calls for increased research in these fields.

(c) In the social and behavioral sciences. Although important advances have already been made in methodologic and substantive areas in the study of behavior, personality development and the social and community aspects of mental health, these areas need further study.

(d) Nosologic descriptive and dynamic clinical psychiatry and systematic research in psychodynamics including psychoanalytic theory and practice. In recent years for the most part these areas have been relatively static. Further progress is essential specifically to develop short-term dynamically oriented techniques of psychotherapy for practicing physicians.

(e) In communication and information theory, data processing, and mathematical model building, and their implications. Information theory, computer sciences and the mathematics of relationships in general seem to have advanced now so as to permit a comparable forward step in the interpretation of psychobiological phenomena such as patterns of neural interaction.

(f) Evaluative studies of programs of care, treatment, prevention, and rehabilitation in the hospital, clinic, and community. Communication to the public on the present status of this field of study should be based on objective findings and should not promise more than can be delivered.

Dr. HUDSON. They contain more detailed information about the AMA's activity. It is our belief that in the field of mental illness and health the American Medical Association is essentially in accord with the intent of the President's message on mental illness and mental retardation.

Mr. Chairman, at this time and with your permission, I would like to ask Dr. Beaton to present the comments of the American Medical Association on H.R. 3688 and H.R. 3689. At the conclusion of his remarks, we shall be pleased to attempt to answer any questions that the committee may have.

Mr. O'BRIEN. Thank you very much Dr. Hudson. I think your suggestion that we hold the questions until we hear the comments on the entire problem is very wise. At this time we hear from Dr. Beaton.

Dr. BEATON. Mr. Chairman, Mr. Nelson, the American Medical Association has given great consideration to the medical problem to which H.R. 3689, the Mental Retardation Facilities Construction Act of 1963, is addressed. The program of the council on mental health contains a statement on this subject which may appropriately be quoted here:

> There are more than 5 million Americans who are mentally retarded and their existence constitutes a medical, educational, and social problem of vast dimensions. Care facilities for these individuals must be integrated into every community's mental health program.
>
> The extent to which this problem can be ameliorated in future years depends largely upon continued research. Some breakthroughs have been effected as, for example, the prevention of some types of mental retardation as a result of our increased knowledge about body metabolism. However, there is still a lack in research planning, personnel, and financing which must be overcome.
>
> The AMA supports efforts to provide better standards of care for the institutionalized retarded, special educational programs, day care centers within the community, counseling services for the parents of retarded children, and efforts to create job opportunities for retarded adults. For these programs to be effective, the Nation also needs additional facilities and an increase in properly qualified personnel.

We are particularly pleased with the emphasis this bill places on research facilities for we believe that the ultimate answer to this problem is one of prevention. We recognize, of course, that in the meantime mentally retarded individuals must be cared for and must also be educated and trained to the very limit of their personal

capacities. The problems of the mentally retarded have implications of greater concern to psychiatry than to any other single discipline. It is our staunch belief that care facilities for these individuals should be integrated into every community's mental health program.

We think, therefore, that a State health agency is the proper instrumentality through which a program for the mentally retarded should be administered. Accordingly, the single State agency referred to in section 204(a)(1) of H.R. 3689 should be a health agency. Furthermore, we believe that the single State agency administering this program, as well as the State advisory council, should be the same as those designated in H.R. 3688, should both bills be enacted into law. This seems advisable since rapid advances in medicine indicate that the two will be more closely interrelated in the future.

COMMENTS ON H.R. 3688

It is our interpretation that H.R. 3688 will spur the development of comprehensive mental health programs at the community level. Since the AMA's program is also predicated on the concept of community care, we are pleased to endorse the intent of this bill. Psychiatric knowledge, techniques, and tools have now progressed to the point where it is feasible as well as desirable to treat the centally ill patient in the context of his home environment. Community care will also mean that all practicing physicians will be able to participate in the treatment of their mentally ill patients.

PROVISIONS ON CONSTRUCTION

Title I of H.R. 3688 pertains to the construction of community mental health centers. Many communities do not have the resources necessary for adequately developing and expanding their mental health services. The use of matching grants for the construction of community mental health centers will place within the reach of the community the opportunity to provide these needed services to its residents.

We are in essential agreement with the provisions for local planning and superintendence. These provisions recognize that medical programs, planned and administered at the local level, are most responsive to the needs of the citizenry.

Single State agency and State advisory council: We would like to call the attention of the committee to paragraph (1) of section 104, which designates a single State agency as the sole agency for the administration of the plan. We believe that this designation should be made more specific and that the agency named should be the State health agency which has medical leadership and is most familiar with the mental health problems of the State.

In addition, paragraph (3) of section 104 makes no provision for medical representation on the State advisory council. We believe that this oversight should be corrected and that provision should be made to include representatives from the medical profession as well as representatives of other nongovernmental organizations or groups. As I have stated, mental illness is basically a medical problem and sound planning and administration demands sound medical advice and guidance.

COMMENTS ON REGULATIONS

The President, in his admirable message, stated:

> We need a new type of mental health facility, one which will return mental health care to the main stream of American medicine.

He added that—

> Ideally, the center could be located in an appropriate community general hospital, many of which already have psychiatric units.

Later in his message, the President commented that—

> For the first time, a large proportion of our private practitioners will have the opportunity to treat their patients in a mental health facility served by an auxiliary professional staff that is directly and quickly available for outpatient and inpatient care.

We entirely agree with these statements made by the President, and would hope that his expressions would be carried out in the administration of the law, should this bill be enacted. In this regard then, the already established general hospital should be given priority consideration in planning for the establishment of the community mental health center. In most instances, the general hospital provides the best opportunity for continuity of treatment and integration of service in caring for the mentally ill. This does not establish the general hospital as the sole facility to sponsor such centers for, as outlined in the President's message, other already exiting outpatient facilities could also be used. Whenever possible, the community mental health center should be integrated into the existing medical complex of the community.

SERVICES AND PAYMENT

Paragraph (d) of section 103 is concerned with services to be rendered by the community mental health center and the payment for such services. There is no question but that as the bill states, these centers must provide services, for people unable to pay for them. However, as the President noted in his message, these centers should have a fee-for-service basis. As he pointed out—

> Individual fee for services, individual and group insurance, other third-party payments, voluntary and private contributions, and State and local aid can now better bear the continuing burden of * * * costs to the individual patient.

The President added, and we feel rightly so, that—

> The success of this pattern of local and private financing will depend in large part upon the development of appropriate arrangements for health insurance.

INITIAL STAFFING

We have thus far commented on title I of H.R. 3688 which pertains to the construction of community mental health centers. Title II of the bill concerns the initial staffing of the centers.

The AMA "Statement of Principles on Mental Health" recognizes the national shortage of mental health facilities and services and urges that those needs be met at the community level. To encourage this community responsibility, H.R. 3688 not only proposes to provide matching funds for the construction of the facility, but also funds to subsidize a substantial part of the cost of staffing the activity during its initial years.

Whether the Federal Government should provide a part of the funds for staffing is a question that we cannot resolve within the limited time we have had to consider this measure. One viewpoint holds that such Federal financial assistance during the early years will enable the community mental health center to undertake a properly staffed program from the start. Further, that within a short period of time, the influx of patients and the probable transfer of State funds from other institutional facilities, will make continued Federal financial support unnecessary. And, finally, that many communities do not have the resources to pay the initial staffing costs needed to insure a successful program. This opinion is conditioned upon the 4-year limitation placed on Federal participation.

A second point of view maintains that the Federal participation under the bill should be limited to the construction costs of the community mental health center. It is urged that once a center has been constructed, the community should assume the remaining responsibility. This viewpoint reflects the feeling that once reliance is placed on a Federal subsidy for staffing, the role of the Federal Government as a provider of funds will not easily be terminated.

COMMUNITY MENTAL HEALTH CENTER DEFINED

Title III, section 301, paragraph (b) defines the term "community mental health center" as "a facility providing services for the prevention *or* diagnosis of mental illness, *or* care and treatment of mentally ill patients, *or* rehabilitation of such persons * * *" (emphasis added). As written, this definition implies that the centers could be built to provide for only one category of services. We doubt that this is the intent of the bill, although we recognize that in some instances a center providing only one of these services might be desirable. As a rule, a complex of services is essential to comprehensive mental health programs.

CONCLUSION

Dr. Hudson has stated that the American Medical Association has a deep and abiding interest in the problems of mental illness. We believe that mental health programs must be both ambitious and comprehensive. Accordingly, the AMA has pledged itself and its resources to ameliorating these problems in a manner consistent with the highest standards of medical practice.

We feel that the community is the vital center for forward-looking comprehensive programs. We must meet and solve the many problems at the doorstep instead of turning our backs on and isolating the mentally ill. These persons can no longer be treated on an "out-of-sight, out-of-mind" basis.

For these reasons and for reasons more fully elaborated in our program and in our statement of principle, we support, with the reservations noted, H.R. 3688 and H.R. 3689. We believe that these measures should be implemented in such a way so as to guarantee every American the very best in medical care and treatment, and we stand ready to help achieve this standard.

There can be little doubt that these bills are of the utmost importance in our common goal of improving the Nation's mental health profile.

In conclusion, let me thank you for the opportunity granted to the American Medical Association to comment on these important measures.

Dr. Hudson and Dr. Wolman and I would be pleased to answer any questions that you may have.

Mr. O'BRIEN. Thank both of you gentlemen for your fine statements. I have two questions. One is a rather large, philosophical question.

We are constantly confronted here with talk of centralization in Washington, Federal intervention in local affairs. Would you think it proper if I were to state that this bill could be interpreted in a very broad way as a move toward decentralization? In other words, isn't it true that we now have a centralization in our several States of these mental patients and that this bill without bringing Washington too much into the picture financially also would turn back much of this responsibility to the locality?

Dr. BEATON. Is that addressed to me, Mr. O'Brien?

Mr. O'BRIEN. Yes.

Dr. BEATON. Yes, I think that is historically right. The care of the mental health in the United States has been a socialized form of medical care. This bill is designed to return the care of the mentally ill back to the communities in which those persons reside. It is exactly as you have stated, a move away from centralization and back to local community care.

Mr. O'BRIEN. My second question is again addressed to Dr. Beaton. I notice on page 5 and page 6 when you discussed title 2 you referred to two points of view with regard to staffing. Now I would like to ask what is your personal opinion and that of the AMA Council on Mental Health with regard to title II of H.R. 3688?

Dr. BEATON. Well, I am here, Mr. O'Brien, as a representative of the AMA and I doubt that my personal opinion has any particular value. If you do wish me to give the position of the council on mental health, I can. Is that correct sir?

Mr. O'BRIEN. I think it would be helpful, doctor, because we do have at this point in the hearings two points of view, and unfortunately perhaps with us we have to make the decision between the two. I think that when we get people of your standing before us it helps us a great deal if we do have your personal views on the matter.

Dr. BEATON. The Council on Mental Health of the American Medical Association voted to recommend to the board of trustees of the American Medical Association its favorable consideration the staffing provision with the understanding that such staffing would be rigorously limited to a period of 4 years and 3 months and, of course, with the further recognition that there might be other considerations which would guide the board of trustees in perhaps altering that recommendation.

Mr. O'BRIEN. There is not any question that this matter of staffing is a very serious one. What will be required in terms of different categories is help staff these facilities adequately; 420 health centers, 150 retardation centers, 10 research centers?

It seems to me that at the outset it is going to be very difficult to staff them depending entirely on local resources. That is only a personal opinion. I get the impression that it coincides with what you

have just said. I hope that at some point in these hearings that we might have a projection of those figures so we could get a general idea.

This could be one of the stumbling points along the legislative highway in this matter of staffing.

I think that if we go along with the staffing for 4 years that we ought to be able to outline to the members of the full committee and to the House, the extent of the staffing problem. I don't suppose that you do have any such projection in mind at this point?

Dr. BEATON. We have no actual figures, Mr. O'Brien, on the numbers of staff which would be required or where they are to be obtained. However, it would be our feeling that as community mental health centers were developed State hospitals would decrease in size and patient population and that a number of physicians now serving those State hospitals would be available for community mental health centers.

Furthermore, it is a well-recognized fact in medical education that more and more young men who wish to become physicians want to go into psychiatry. I think this attitude would be encouraged by the passage of these bills. I think that their passage would be a great stimulus to the development of psychiatric interests in our senior medical students.

Finally, may I point out that one of the main points of this bill, and one of the main points of the AMA, is that the family physician will be allowed to care for his own mentally ill patients in his own hospital. Perhaps, then, the large increase in staff, which seems inevitable under the bills, will not be quite as great as it appears.

Mr. O'BRIEN. The family physician then could, I assume, be most helpful if the patient was near him because he would have an understanding of some of the family problems and so forth, which are factors in this matter.

Dr. BEATON. Yes, sir. That is exactly right. I think that any family physician or general practitioner would probably tell you that 60 to 70 percent of his practice consists of persons of functional or emotional illness rather than organic physical illness.

Mr. O'BRIEN. Mr. Nelsen.

Mr. NELSEN. In the staffing of these hospital centers it seems to me in the earlier testimony that figures were developed indicating Federal money was being allocated to the various medical schools for training purposes.

These then are two questions which come to mind: Are the facilities available for the training of the staff, and is there money available to assist in the training program? To your knowledge, Doctor, has there been considerable activity in that field? Has the training of personnel that would be qualified to go into these particular types of institutions or centers been stimulated?

Dr. BEATON. I think, Mr. Nelson, that that is probably a question that Dr. Hudson, who after all is associated with the medical school, could answer better than I could.

Dr. HUDSON. I was going to say that one usually speaks from his own point of view. At Western Research University, we have a very fine hospital associated with the university. A large part of its charge is to train not only medical students, but nurses and other personnel who might take care of the mentally ill in the future.

The care of the mentally ill must be decentralized. There must be many people who may not have the special training that others do, who will do this kind of work. Of course, this is well within our experience; the family physician has been doing this type of work for years.

Mr. NELSEN. One of the things that those of us who have been in the processes of government for a number of years have noted is that the disposition to lean on the Federal Government or the State is quite easily cultivated.

The greater area here must be in the assuming of responsibilities at the State level and when you get to dealing with Federal moneys for personnel and when you talk about a terminating date, they say there is nothing so permanent as a temporary program.

I endorse the idea that we must depend on the States and I also would like to be sure that we are proceeding in a manner that stimulates the States to do the job because it will never be done unless they do it.

It is my hope that if we do pass a measure of this kind that it will stimulate the impetus at State level, decentralized in the States. I think you are probably aware of our own Minnesota situation where years ago, quite a long time ago, we started our mental health program and it has been very successful in many ways and we have spent millions of dollars.

We thank you for appearing before this committee and we value your suggestions and recommendations. No more questions.

Mr. O'BRIEN. I would just like to spell this out before we conclude.

Dr. Beaton, is it correct to say that the AMA takes no definite position on initial staffing?

Dr. BEATON. The AMA has not yet been able to reconcile the differences of opinion, expressed in our statement.

Mr. O'BRIEN. Has the council on mental health taken a definite position?

Dr. BEATON. Yes, sir. As I formerly stated.

Mr. O'BRIEN. Thank you very much gentlemen. You have been most helpful. I have an idea that your testimony will loom very largely when we get down to it.

Dr. BEATON. Thank you, Mr. Chairman.

Mr. O'BRIEN. The next witness is the Honorable Andrew J. Biemiller, director, Department of Legislation, American Federation of Labor & Congress of Industrial Organizations.

Andy, you are most welcome, as always.

STATEMENT OF ANDREW J. BIEMILLER, DIRECTOR, DEPARTMENT OF LEGISLATION, AMERICAN FEDERATION OF LABOR & CONGRESS OF INDUSTRIAL ORGANIZATIONS, WASHINGTON, D.C., ACCOMPANIED BY MISS LISBETH BAMBERGER, ASSISTANT DIRECTOR, SOCIAL SECURITY DEPARTMENT, AFL–CIO

Mr. BIEMILLER. Thank you.

Mr. Chairman, my name is Andrew J. Biemiller. I am director of legislation for the AFL–CIO which represents 13½ million working men and women, who with their families total about 50 million American citizens. I am accompanied by Miss Lisbeth Bamberger, who is

assistant director of the AFL–CIO Social Security Department and is also a consumer representative on the Federal Hospital Council.

The challenge of combating mental illness and mental retardation has been with us for a long time. The number of the afflicted and the burdens they and their families must bear have been called to the attention of the public again and again over the years. But not until the President presented his program incorporating a "wholly new national approach" to mental illness and mental retardation to the Congress in February of this year has this country had a call to action of a magnitude adequate to the scope of the problem.

The people of the Nation owe a great debt of gratitude to the President for his leadership, and to the Joint Commission on Mental Illness and Health and the President's Panel on Mental Retardation for their painstaking efforts and imaginative recommendations that underlie the legislation that this subcommittee is now considering. We congratulate the distinguished chairman of this subcommittee for holding these hearings at this early date, and we look to the subcommittee and to the full committee with much hope for favorable action on the bills before you.

The AFL–CIO Executive Council fully endorsed the President's proposal on mental illness and mental retardation, and we come before you to support H.R. 3688 and H.R. 3689, which would provide the essential groundwork for this program.

As the executive council stated in a unanimous resolution passed on Feb. 26, 1963:

> The Nation's past failure to meet the problems of mental illness need not and must not be allowed to continue. There is new hope today. As President Kennedy has said, "The time has come for a bold new approach. New medical, scientific, and social tools and insights are now available." The President's highly imaginative and thoroughly practical proposal would for the first time make community-centered mental health services, including diagnosis, treatment, and rehabilitation, available to all. Based on the creation of comprehensive community health centers, built and staffed with Federal financial assistance, the administration's mental health program can be expected—within a generation—to reduce the number of patients under custodial service by at least half, to enable substantial numbers of the mentally ill to remain in their own homes without hardship to themselves or their families, to save public funds, and to reduce profoundly the misery which mental illness now entails for millions of American families.

The AFL–CIO is particularly concerned with the problem of mental retardation because of the disproportionate toll that mental retardation takes in low income families. The AFL–CIO Executive Council issued this statement on mental retardation:

> There are in the country today between 5 and 6 million mentally retarded children and adults. As the President told the Congress earlier this month, "Mental retardation strikes children without regard for class, creed, or economic level. * * * But it hits more often and harder at the underprivileged and the poor; and most often of all, and most severely, in city tenements and rural slums where there are heavy concentrations of families with poor education and low income—in some slum areas 10 to 30 percent of the school age children are mentally retarded, while in the very same cities more prosperous neighborhoods have only 1 or 2 percent retarded."
>
> Since mental retardation has been found to be so frequently associated with deprivation of the basic necessities of life and poor medical care, a broad program of prevention is fundamental. The President has called for such a program, including Federal assistance to States and localities to improve their maternity and child health care services. In addition, the President proposes Federal help in the establishment of community facilities and services for the

mentally retarded and an expansion of our resources for the pursuit and application of scientific knowledge related to mental retardation. We fully support these proposals.

Enactment and implementation of H.R. 3688 and H.R. 3689 will not do the entire job that needs doing. But their enactment will move us much farther along toward effectively dealing with mental illness and mental retardation than we have ever been in the past. Two factors combine to make this so:

First, Federal grants are needed to construct the facilities provided for in the bill—the community mental health centers, the centers for research in mental retardation, and the facilities for the diagnosis, treatment, and rehabilitation of the mentally retarded. Construction on the scale that is needed cannot be expected to be undertaken without Federal funds. The same is true of initial staffing of the community mental health centers. Local communities will not be able to take on the whole of this burden, unaided, at the outset. So, the Federal funds provided by H.R. 3688 and H.R. 3689 are essential.

But beyond the provision of the necessary Federal funds, enactment of this program will encourage people all over the Nation who are now working in the mental health and mental retardation field. It will encourage those who may wish to devote their energies to this field in the future. The importance of this encouragement cannot be overestimated.

We call for one specific change in H.R. 3688. Section 302 of that bill amends the Public Health Service Act to enlarge the Federal Hospital Council from 8 to 12 members. One of the four new members would be an authority in matters relating to mental health. We agree that this change is necessary and advisable, since the responsibilities of the Federal Hospital Council would be enlarged from those provided in the original Hill-Burton Act. In addition to advising on the administration of the hospital and medical facilities program, the Federal Hospital Council would be charged with advisory responsibilities in the administration of the Community Mental Health Centers Act and the Mental Retardation Facilities Construction Act. We therefore endorse the proposed enlargement of the Council.

We are opposed, however, to changing the composition of the Council from the present balance, as specified in the Hill-Burton Act, which provides that half the members shall be "persons who are outstanding in fields pertaining to hospital and health activities," and half the members shall "represent the consumers of hospital services and shall be persons familiar with the need for hospital services in urban or rural areas."

H.R. 3688 would change this balance, giving two-thirds of the membership on the Council to representatives of providers of service, and only one-third to representatives of the public. We believe that such a change would be a very serious mistake. One of the reasons for the great success of the Hill-Burton program since it started in 1946 has been the fact that the needs and views of the consumers of service have consistently received the same serious considerations as the needs and view of the providers of the service. This healthy balance must be maintained if the proposed new program in mental health and mental retardation is to get off to a good start, and if damage to the existing Hill-Burton program is to be avoided.

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Therefore, we ask that section 302 of H.R. 3688 be so amended as to restore the original balance of representatives of providers of services and representatives of the consumer public on the enlarged Federal Hospital Council. Mr. Chairman, the same would apply to section 212 of H.R. 3689.

With this one change, we wholeheartedly support the bills before you. We, in the labor movement, have—as one of the basic premises of our existence—the conviction that neglect and suffering cannot be tolerated where people can take action, individually and together, to reduce or eliminate them. We believe that the proposed legislation will stimulate lay citizens and professionals, voluntary agencies and public bodies on the local and State, as well as on the national level, to grapple with the vast unmet needs in the areas of mental illness and mental retardation with a new sense of hope and with a dramatically increased chance of success.

Mr. Chairman, we urge enactment of H.R. 3688 and H.R. 3689 so that the country can soon get started on action to help free millions of American families from some of the pain and anguish of mental illness and mental retardation—pain and anguish and family heartbreak which we can drastically reduce and perhaps eventually eliminate entirely.

Mr. O'Brien. Thank you for a very fine statement, Mr. Biemiller. I agree most heartily with one sentence you had where you said this program would encourage those who may wish to devote their energies in this field in the future.

I think that Mr. Nelsen would agree with me that more and more in our mail we find expressions of interest on the part of young people for getting into this rather difficult field. It is not an easy choice of a vocation but sometimes a bit frustrating to advise. This opportunity would be to develop at a community level. I think that there would be a rush of applicants by well-qualified young people to get into this field. I agree most thoroughly.

Mr. Biemiller. May I state, Mr. Chairman, that my own son has decided to go into this field, to my great pleasure. He is up at Cornell now in the graduate school working in this area of mental retardation—of children particularly.

Mr. O'Brien. And I have a great admiration for young people who have this desire because as I say it is not an easy choice. There are a lot of occupations we can think of that would be easier, which indicates to me that we have a great many young people in this country today who are still willing to meet that challenge if they can find a way to do it.

I have one other question. You mentioned the balance of the Council should be changed from one-half to one-third. Do you think that there might be a peculiar circumstance during the transitory period where temporarily it might be desirable to have more emphasis on the so-called providers of the service?

Mr. Biemiller. May I refer that question to Miss Bamberger who is, as I said, now serving on the Council and is quite familiar with its operations?

Miss Bamberger. Mr. O'Brien, the provisions that are in both the bills, to include a representative on the Council who is an expert in the field of mental health and one who is an expert in the field of

mental retardation, are quite essential, not only in the transitional period but in the long run since the Council will be asked to advise on the administration of both these new programs.

I can see no reason, however, why the present balance should be disturbed. If more technical experts are needed than could be put on the Council under the proposed provisions, perhaps the answer would be to increase further the number of people on the Council while maintaining the balance between the public representatives and the representatives of the providers of the service.

Mr. O'Brien. That is what I wanted to hear. I think it has been stated simply for balance to have future people on the Council who are particularly skilled in this field, but your suggestion about enlarging the Council would take care of the problems in my mind.

Mr. Nelsen.

Mr. Nelsen. I noticed on page 2 of your statement, just prior to the last paragraph:

> In some slum areas 10 to 30 percent of the school-age children are mentally retarded, while in the very same cities more prosperous neighbors have only 1 or 2 percent retarded.

I am most curious as to the source of information for that figure.

Mr. Biemiller. It is from the President's statement to the Congress, and I presume his statement is based on the studies made by his panel.

Mr. Nelsen. I see.

That is all, Mr. Chairman. Thank you, sir.

Mr. O'Brien. Thank you, sir; very much.

Mr. Biemiller. Thank you.

Mr. O'Brien. Our next witnesses are Mr. Charles H. Frazier and Mr. Wayne Withers, representing the National Association for Mental Health, New York City.

STATEMENT OF CHARLES H. FRAZIER, REPRESENTING THE NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC., NEW YORK CITY

Mr. Frazier. My name is Charles Frazier. With me is Mr. Withers who will make his own presentation. We are both here on behalf of the board of directors of the National Association for Mental Health.

I also happen to be chairman of the board of directors of Pennsylvania Mental Health, which is the State mental health association in my State. I am also chairman of the board of directors of the Philadelphia General Hospital, which is a municipal hospital in Philadelphia and provides a very active psychiatric service in that hospital.

I have filed with the clerk, Mr. Chairman, a statement which I ask be incorporated in the record as though read, but I don't want to take the time of the committee in reading it here. I would, however, like to make one or two points about the need for the bill, and then make one or two suggestions for what I think might be its improvements.

Mr. O'Brien. Very well.

Mr. Frazier. My name is Charles H. Frazier. I am director of development for the Philadelphia Gas Works, a division of the United Gas Improvement Co., and a resident of Philadelphia. I am here today to testify as a member of the board of directors of the National

Association for Mental Health in behalf of its 800 chapters and divisions and its enrolled membership and volunteer corps of more than a million. I am also chairman of the board and past president of Pennsylvania Mental Health, Inc., the State division of the National Association for Mental Health.

My organization—the National Association for Mental Health—has been in existence since 1909; first, as the National Committee for Mental Hygiene, and then, since, 1950, under its present title.

The representatives of the National Association for Mental Health have been here in the Capitol many times before to testify on various mental health measures. In 1946, we came to congressional hearings to urge enactment of the National Mental Health Act. And almost every year since then, we have come back again to testify on appropriations measures for the National Institute of Mental Health.

For many of the people who are here to testify today, and perhaps even for some of the Members of Congress, mental health may be a matter of relatively recent interest. But our organization has been in this work for many decades. I make note of this, not to establish any prior claim or prerogative or position of authority, but rather to impart to you, some of the great satisfaction that we feel in the knowledge that such a measure as H.R. 3688 is now before the House for consideration and, we hope, for enactment.

Fifty-four years ago when the National Committee for Mental Hygiene was organized by Clifford Beers, there were few who knew about mental illness and the mentally ill. Then there were known only the lunatic asylums—the horrible places where you sent away the brother or mother or father who went out of his mind—and you sent that relative away because no one knew that anything could be done with him except to shut him away so that he would not be any trouble to society, nor any harm to himself.

This was how you handled insanity or lunacy then. A few psychologists and psychiatrists identified the different forms of abnormal behavior, but they were practically the only ones who knew or even cared, except for the few hardy doctors and social workers and interested citizens who had visited the lunatic asylums, and there had seen the human wreckage, the miserable, starved, frozen, brutalized, terrorized things that were once human. And it was only these few people who saw, even in those broken things, the hand and the spirit of God, and the persistent image of a human being, twisted and misshapen, and distorted though that image was.

It was these few people and some others who were drawn to the cause, who saw in the misshapen beings—not subhumans possessed by demons; not witches; not the work of the Devil—but human beings who had something wrong with them, something wrong that made them behave so differently, so peculiarly. There was great wisdom in these men and women; wisdom which led them to see the bizarre behavior as symptoms, and which led them to understand that these were symptoms of disordered functioning, just as the symptoms of physical illness were the evidences of disordered functioning. And with this insight and wisdom, they were able to see then, some 50 years ago, that science would continue to probe insanity, and to attempt to identify the different forms, and seek to learn the causes, and how to prevent them, how to treat the victims, and how to cure them.

It was this wisdom and this vision that motivated first, this handful, and then hundreds of others, and then thousands of others to work for improvement and change. Many years have passed since the first organized efforts began, and many changes have taken place; none easily, none quickly, none spontaneously. Government agencies and Government officials worked on this. And with them the psychiatrists and social workers and psychologists and clergymen and other professional people. And along with them the service groups and fraternal organizations and their hundreds of thousands of members. And with them the business organizations and the trade unions. And in the center and in the lead, the mental health associations.

And as a result of all this work, some truly great advances have been made. Today, there is hardly a newspaper, hardly a radio program, hardly a magazine issue, hardly a television program that does not concern itself in a truly serious way and knowledgeable way with the mentally ill, and the branch of medicine which treats them, that is, psychiatry. Today, mental illness is no longer a dark and mysterious and secret subject. And today, we recognize the mentally ill as sick people, suffering from biological and psychological disorders—disorders which can be treated and corrected. Certainly, medical science does not have all the answers to mental illness; but it does have some of the answers. And more important than that, it knows that there are answers—that they can be found—and when found, they can be applied to the relief of the millions of sufferers from mental illness—a name which covers dozens of different individual disorders of the mind, each with its own causes, each requiring different and special treatment.

I have spoken of the many different forces which, working together, have achieved this change. And everyone deserves great credit. But, if I were asked to identify the one single force which did most to implement this change and stimulate and catalyze many of the other forces which were thrown into action, I would say it was the National Mental Health Act of 1946 and the agency which it brought into being—the National Institute of Mental Health—and the services and programs of that agency.

In an unobtrusive way, that act and that agency provided grants, technical assistance, guidance to the States and communities and foundations, and schools of training and centers of research, making it possible for them to develop sorely needed programs of training, programs of research, and community mental health services. I say "unobtrusively," because my organization, with contacts in literally every community of any size in the United States, has not encountered a single instance where this Federal aid brought with it Federal domination, Federal interference, or Federal control. Now, it may be that there have been such instances, but if there were, they certainly did not come to our attention.

The brunt of the work, and the great overriding burden of the expense, and the genius of inventiveness and creativity has, without a doubt, been borne by the States and the localities and the foundations, private organizations, schools, and other local agencies and institutions. And there it will continue, as it must, because that is where the major and primary responsibility and authority is and must remain. But we must also welcome the kind of aid which the

Federal Government have given to facilitate and stimulate the development of great human and material resources which there are in our States and communities toward the conquest of this problem of mental illness—a problem which the American Medical Association has called America's most pressing and complex health problem.

Our organization, therefore, endorses with enthusiasm the measure which is before us for consideration today: H.R. 3688.

This measure addresses itself entirely to the development of community mental health services, specifically the creation and staffing of community mental health centers.

Traditionally, the care and treatment of the mentally ill has been considered and handled as a custodial problem, and for that reason the very great majority of the mentally ill have been housed in and cared for in State institutions. And, were we living with the limited knowledge and narrow perspective of 50 years ago, we would still continue to think only in terms of making life more endurable for the insane wards of the State. But we are not living 50 years ago, and we know that we are confronted not with a custodial problem, but with a medical problem. We are not concerned alone with ways in which to relieve overcrowding and insanitary conditions, and of eliminating abandonment and neglect, of giving humane care to people in mental institutions; we are concerned with providing medical care for sick people under the very same conditions and with the very same medical consideration as obtains in the treatment of other sick people. Ten years ago, the idea of treating mentally sick people in the general hospital, or in other treatment centers in the community, or in the offices of private physicians—10 years ago, this was considered daring and radical. But not anymore, not today.

Today, when you see an ambulance moving swiftly toward the hospital, there is a good chance that that ambulance may be carrying a mentally sick person to the psychiatric emergency ward of a general hospital.

Last year as many patients were admitted to the psychiatric wards of general hospitals as were admitted to the regular State mental hospitals, and a large proportion of those who came to the general hospitals were suffering from the various types of serious mental illnesses which in the past would have automatically been directed to a State institution.

Psychiatry has come a long, long way in the past 10 years. It has learned that the majority of mentally sick people do not need long-term hospitalization. It has learned that many can achieve quick recovery through short stays in a hospital, or even through outpatient care at a hospital, or by coming to the hospital during the day and going back home at night. All this has been made possible because of the psychiatric drugs, and because of new methods in group psychotherapy and other psychological treatment.

Psychiatry has also learned that separation and isolation of the patient from his relatives and friends, from his place of worship, from his normal human contacts in the community actually serve to intensify his illness and to make chronic patients out of patients who might be treated and discharged in a matter of days in a community setting.

The tragic story of the State custodial institutions has been too often told to warrant repetition in detail here. But if all the abandonment

and neglect, all the indifference and apathy, all the understaffing and inadequacy of facilities—if all that were corrected by some miracle today, and it would truly take a miracle to do it—if all that were to happen, it would still not provide an ultimately satisfactory solution to the problem, nor an ultimately satisfactory answer to the needs of the mentally ill.

There is one thing that physical change can never do for these hospitals, and that is to remove from them the quality of separateness and difference. Their isolation and their distance, their very identification as custodial institutions of the past, their very separateness from the community and hence from the mainstream of medicine serve to intensify and to make chronic the conditions which they are supposed to relieve. This is not just physical alienation. This is spiritual and philosophical alienation; and, even more important, it is medical alienation. So long as we continue to treat mental illness away from the community and away from community medical facilities, we will see the gigantic problem of mental illness intensify and grow worse.

There is one certain—and I mean certain—way to cut down this tremendous problem quickly, to save large proportions of the billions of dollars it is now costing the Nation, to reduce large numbers of victims of mental illness, to bring the whole problem permanently into line, and that is to bring the treatment of mental illness back into the community, for that is where it belongs.

There must begin, and there must begin immediately, a definite and decisive shift from the traditional, isolated custodial institution to the development of well-planned systems of comprehensive mental health services in the community. And we are very happy to see that H.R. 3688, companion bill to S. 755, provides a most practical, a most expedient way to do this. In H.R. 3688, we find the essential ingredients for such a development. We find the motivation, the plan, and the wherewithal.

H.R. 3688 provides Federal assistance for the creation of community mental health centers which will either, by themselves or together with other mental health facilities in the community, provide comprehensive services for prevention, diagnosis, treatment, and rehabilitation.

This may, at first glance, seem like a truly radical concept. Certainly, it is new and different and radical when compared to our traditional practices in regard to mental illness. But in reality, it is nothing new at all, because this is what we have been doing for decades with regard to the physically ill.

In pratically every community of any size, there exists a comprehensive, coordinated, interlocking system of services providing a continuity of care for physical illnesses. In many instances, you can find in a general hospital all of these: diagnosis, prevention, treatment, rehabilitation; and if you do not find all these within the walls of the general hospital, then you will find that the general hospital has worked out a relationship with other agencies and facilities so that there need be no gaps, no unfilled medical or surgical needs.

Well, this is exactly what H.R. 3688 is seeking to create in the realm of the psychiatric disorders. And that is continuity of services for comprehensive psychiatric care.

Hence, the concept of a single facility which can, within its own structure, or in alliance with other facilities, provide every type of

inpatient and outpatient service, for patients of all ages and suffering from every different type of mental disorders, in addition providing services for prevention and rehabilitations is a new one only as it applies to psychiatry. In effect, H.R. 3688 is attempting to bring the treatment of the mentally ill up to date and in line with the established methods for treating the physically ill.

H.R. 3688 proposes that these community mental health centers might be set up around existing facilities in general hospitals. This is an eminently practical and wise proposal, because it eliminates duplication and overlapping, and permits maximum utilization of the medical staff and other services which already exist for the other patients for whom the hospital was originally constructed. There are already a number of places where centers of this kind have already been established. One is the Mayo Clinic in Rochester. Others are the Mount Sinai Hospital in New York, the Montefiore Hospital in New York, and the El Paso, Tex., County Hospital.

Relationship to a general hospital, while important, is not essential in the concept of a community mental health center which provides comprehensive services. There are already in existence a number of such centers which provide all these services, and without connection with any other institution. Among these are the new Fort Logan Community Mental Health Center, near Denver, the Butter Mental Health Center in Providence, R.I., and the San Mateo Mental Health Center in California.

Without exception, these centers—all of them report remarkable success—with all kinds of patients, and those who make the reports—continue to stress the fact that relatively small investments bring very good results with large numbers of patients.

No one can say whether there is one best answer to the treatment and rehabilitation of the mentally ill and the prevention of mental illness. But we do know that the mental health center, as it is now emerging, is a very good answer; and, even though the form may change through further trial and development, we believe that the essential principles will continue unchanged because these are time-tested principles—tested in other areas of medical practice and now firmly established.

There is implied recognition in H.R. 3688, both of the permanency of principle and the likely transience of the form. The bill does not establish a rigid formula. It does not insist that the entire range of services be enclosed within the walls of a single structure. It provides instead that these centers shall, either alone or in conjunction with other facilities owned or operated by the applicant or affiliated organizations associated with the applicant, provide comprehensive mental health services. And it does not specify that those other facilities or those other affiliated organizations must be of a certain specific kind.

This is good. It provides a flexibility which permits local option. Each community can assess its own needs and resources and arrive at its own formula; one which suits it best. This encourages local enterprise and local responsibility, and assures local direction and control.

The measure makes only two things mandatory, and that is that the services provided by the center, either alone or together with other facilities, shall be comprehensive; and second, that they be part of a long-range plan.

The idea of comprehensive service is, as I have said, new in the field of mental health. What we have right now is a scattering of services, services which have grown up without investigation and plan. This is not something for which anyone need be criticized. For the past few decades, any one agency or organization which could do anything about bringing any kind of mental health service into being, did so, and very often did it against great obstacles and resistances. During that period we were happy enough to see any kind of service emerging, even though it was only a token service, even though it was part of a patchwork, even though it was only part of a trial and error operation.

But the day for that is over. We now have the knowledge, the patterns, the models, and the resources to create comprehensive services and to plan them in a way which will meet most of the needs of most of the mentally sick people, and not just an iota of the needs of just a fraction of the mentally ill.

Before a State can apply for Federal funds—either to construct or to staff these mental health centers—it must show that the particular center is part of a long-range plan to provide adequate and comprehensive mental health services in a community.

I can say, without any fear of being challenged, that there is not a single community in the entire United States which today offers comprehensive and adequate mental health services to all or even most of the people in need of them. In those few instances where comprehensive services do exist, they are inadequate to care for more than a portion of people who need them. In 99.9 percent of the cases, they are neither comprehensive nor adequate.

If we do not go about the deliberate business of planning and projecting, then we will be condemning our communities, our neighbors, our families to a continuation of enforced sickness. The problem of mental illness can be cut down. Hundreds of thousands of mentally ill people can be treated and saved. Additional hundreds of thousands can be helped in the early stages of illness and so saved from more serious mental illness. But if this is to happen, then every State will need to work out—with all of its communities—a plan for comprehensive and adequate mental health services, and then it will need to go about putting this plan into action, through the community mental health center.

H.R. 3688 provides the motivation, the plan, and the wherewithal. It would then be up to the States to act. Very wisely, H.R. 3688 places initiative and control of the entire process in the hands of the States and their communities. The Federal Government provides grants up to 75 percent for construction and for staffing—the latter on a diminishing basis—and the State, through its designated agency, makes use of this grant to implement a plan of comprehensive and adequate community mental health services.

That this kind of formula works to the great benefit of the States and communities has already been amply demonstrated. We know that the Hill-Burton formula of Federal grants for hospital construction has resulted in speedy development of additional general hospital services in communities throughout the country. With the stimulation provided by Federal grants, States and communities have moved ahead to fill up gaps, overcome inadequacies and to provide needed hospital services for their citizens.

In connection with mental health, we have seen how Federal grants to the States have resulted during the past 10 years in the development of community mental health services far beyond the Federal investment.

Through this process it has been demonstrated that community health services are vital. It is now time for the next stop, and that is, to bring to a level of adequacy the services which have been shown to be necessary, but which exist now only in token form.

In other legislation, provision is made for grants to enable the States to plan these comprehensive mental health programs. It is urgent that H.R. 3688 be adopted to provide the wherewithal for the implementation of these plans.

From 1909 on, the National Committee for Mental Hygiene—and then the National Association for Mental Health—helped to initiate and to develop some of the most important programs in the fight against mental illness. Included in these developments are the psychiatric clinic movement; the mental hospital inspection program; first nationwide training program for psychiatrists, psychiatric social workers, and clinical psychologists—a program later taken over by the National Institute of Mental Health; the enactment of the first Federal mental health law—the Mental Health Act of 1946; the establishment of student counseling services in schools; sponsorship of the first comprehensive research program on schizophrenia; and many others.

Throughout the years, our organization has carried on an intensive program of public education: To make the Nation aware of the problem, to relieve fear and reduce prejudice, to keep hope alive, to stir sympathy and concern for the mentally ill, to stimulate interest in the State and communities, to mobilize community forces for necessary action to meet the needs of the mentally ill.

Each year, as I have said, we have appeared before committees of the Congress to testify on Federal mental health legislation. It has been most gratifying and most heartening to note the dedication and concern with which these committees have regarded the plight of the mentally ill. Many of the gains which have been made have come as a result of Federal legislative initiative and action. We urge now that this committee and that the entire House act favorably on H.R. 3688 so that we may truly move ahead into a new era in the fight against the Nation's most pressing and complex health problem: mental illness.

You have had explained to you during the past 2½ days a great deal of the background for the bill; but, basically, we see this measure—as I think you mentioned, Mr. Chairman—as a means of decentralizing the care of the mentally ill and returning this important function insofar as possible to the community.

Now this is not needed because of any philosophy of government; but rather, because of what we have learned in terms of how to treat mental illness. We have found out—and particularly since World War II—that the mere act of sending a patient away or putting him away very often contributes and contributes disastrously to the severity of his illness. Therefore, what we are trying to do now with this legislation and have been trying for the past 5 years with inadequate tools

is to avoid this traumatic experience in the early stages of mental illness.

That is the importance of the Community Facilities Act. It is to make it easy to receive care for mental illness quickly, promptly, and at the point where mental illness strikes.

Now this bill creates something known as "community mental health centers." I think it is important for the committee to realize, as I am sure you do, that this is not a static form. A community mental health center may be one thing in the city of Philadelphia, it will be something completely different in some of the smaller towns and cities throughout the land. The importance, as has been pointed out by Dr. Beaton, is that this center, wherever it may be located, be a combination of facilities of diagnosis, of what you might call psychiatric first aid, of clinical facilities perhaps to avoid hospitalization, then for a rapid short-term emergency treatment in hospitals, and finally, for aftercare.

The way those facilities are put together in any given community will depend on the other resources in that community, both physical and from the standpoint of personnel.

We believe this act is important here and now to follow through on the planning for the care of the mentally ill which is going on under the auspices of the National Institute for Mental Health and the various State mental health authorities. There is being tooled up in Pennsylvania, as in all of the other 50 States, a planning program which is going to give us, we hope, within a very short time, a comprehensive target, so that we can say by—let us say 1975, to mention a date well out into the future—we are going to achieve the kind of care of the mentally ill that we need in all of our States. We need that kind of a program, we need that kind of a blueprint, because getting there is going to be a long, slow process and we have to know which steps to take first and how best to proceed on this road to the ultimate goal. Unless we have a goal, we cannot tell intelligently, we cannot plan our year-to-year activities.

I assume that the bill is intended, when it speaks of plans to be provided, to tie in with this planning effort which is already underway with the assistance of matching funds from the Institute of Mental Health.

Finally, I wanted to say a word about manpower which the chairman touched on. The manpower is, of course, the key to the success of this program. There is not enough manpower. All of the efforts of the National Institute for Mental Health in training grants should go on, but the link between the deficiency in manpower and the community programing is very direct.

There is a wealth of psychiatric service available in many of our communities which is not in any way tapped by the official State program. Doctors are somewhat reluctant usually to join the State service; whether it is because of low salary, whether it is because of location, whether it is because they don't like working for an official body, I can't say. The fact of the matter is that our State hospitals are understaffed. Even where we have enough money to pay for additional psychiatrists, psychologists, social workers, and nurses, we cannot attract them to the State system.

If we put our principal emphasis on community facilities, I am sure it is going to be possible to recruit much additional personnel into

this field. The location will be one thing, the auspices will be another thing which will attract people, and also it is going to be possible to use a great many part-time people in this field. By part time I mean part time, let us say, for institutional practice and part-time private practice. I don't know how many psychiatrists there are in Philadelphia, for instance, but I venture to say that only a very small fraction of them are connected with the public practice of psychiatry as against private practice.

Since these facilities and institutions that will be created under the Community Mental Health Service Act will in most cases be mixed facilities with both public and private money, we think that the device of bringing this care back to the community is going to make a lot of manpower available which is not now available.

I do share your concern, Mr. Chairman, that we don't know how many people we are talking about but I submit that until the plans are completed and submitted to the Secretary or to the National Institute of Mental Health for what kinds of community mental health centers and where they are to be, it is pretty hard to give you the table of organization that you need.

I understand that there was submitted for the committee's information and benefit a kind of a tentative table of what it might look like but certainly for Pennsylvania I could not begin to tell you, because we have not focused on what we are going to do in this community, that community, and the other community. We have 10 to 20 mental health facilities of one kind or another in Philadelphia itself. These have to be welded into a community mental health program and this act is going to make it possible to do so.

I want to make two or three points with respect to the legislation itself. Section 103C and throughout the act the words "construction" are used. I am wondering whether it would be necessary or desirable to amend the act to say "construction or reconstruction" because I visualize in many communities that we are not going to put up new buildings. I would hope that we would spend just as little money as possible on new buildings, and that we could utilize existing facilities. Just take the whole field of TB; we don't care for the TB patients any more in city hospitals. We have contagious diseases hospitals which are not used any more. It seems to me that the first effort should be in any community not to build something new but to utilize what you have, and this may mean construction, remodeling, or what have you.

Second, $103, line 13, refers to the care of those who are unable to pay for service. I am wondering whether it would not be desirable to get in the concept to pay in whole or in part because we have a great dichotomy in the financing and care of mental illness. You have people going free to the State hospital or public facility and then you have people spending anywhere from $25 to $50 a day in private facilities. Now, for most people who need care for mental illness, there is someplace in between which is probably closer to fitting their own pocketbooks. Mental illness does not strike any particular class in society but it is only the very wealthy who can pay $50 a day for an extended visit in a hospital. So, I am suggesting that we do not try and visualize in this bill one group of people who can pay nothing and another group of people who are private patients. This does not relate to what the situation actually is in the community.

Third, on section 104(a), subchapter 2, the bill speaks of the Secretary assuring himself that the State agency has the authority to carry out the plan. I am wondering whether it would not be desirable to say "authority and ability" because the Secretary should concern himself with the efficient expenditure of Federal funds, that they not be allotted where there was not adequate competence both within the State organization and within the other complex of State services.

Mr. O'BRIEN. Would that not get you into the field of Federal domination and control? Would that not set up an area of judgment on the competency of State officials that could lead to some mighty big rows?

Mr. FRAZIER. I think you might want to be careful, Mr. O'Brien, exactly how you phrased this, but certainly the thought ought to be in there. After all these are taxpayers funds that are being spent and the Federal Government has to concern itself that they are going to be well spent.

Mr. O'BRIEN. Perhaps we could have certain requirements that would not involve the use of the word "ability" because the Secretary might have one view of mental hygiene in any State, and the commissioner of mental hygiene in Minnesota or Pennsylvania, for example, might have another.

Mr. FRAZIER. Yes, I think subjective judgment should be ruled out but he does have to assure himself that the moneys are going to be competently expended.

Section 104(A)(6) refers to a plan for the administration of these facilities. I am wondering whether it would not be desirable to state "administration and future financing?" This would tie in again with section 203 of the act which refers to the 4-year tapering off period. It seems to me important that the Secretary have before him some idea of how the State and the community is going to be weaned from the 75-percent initial support which I think is important because we do have to get a start here. We are long overdue in this start but Federal support does have to stop at some point. It seems to me that as a part of the initial submission of the plan it would be desirable for the State submitting the plan to explain just how it was going to carry this on the after Federal support stopped.

I would like to associate myself with the remarks of Mr. Beaton. There is a great deal in his testimony that I should think should commend itself to your attention. I was very much impressed by listening to it. We welcome the interest of the AMA now in joining together these two streams in the practice of medicine and hope it continues.

There was one reference in his remarks to the fact that the statement—the State mental health authority should be—I forget the exact words, I think the State health department. I would be somewhat concerned in the case of Pennsylvania where our commissioner of mental health, whose office is the place where the plans should be made, would be the one engaged in planning there rather than the State health department which has virtually no responsibility in this area.

I think that a proper reading of the statement would indicate that Dr. Beaton was aware of this but I wanted to make these remarks just so that it should be clear. We believe that it is important that the

State authority referred to be the State authority which is peculiarly competent in the mental health field.

Thank you, very much, Mr. Chairman. If you have any questions that I can answer, I would be glad to try. If not, I would ask Mr. Withers to take over.

Mr. O'BRIEN. I might say at the outset, that while Dr. Beaton, did use "the State health agency," he did qualify it by saying "which has medical leadership and is most familiar with the mental health problems of the State." I think that probably would spread over the State mental health department without too great difficulty.

I have just one question again since it is a broad question. Our chief problem in this matter again is one of Federal intervention, Federal control. Would it be correct to say that the States have done a great deal in the field of mental health but that they started in an era of hopelessness where custodial care was 90 percent of the problem?

We had that concept and now they have gone very far in the wrong direction in the light of recent developments in this field of mental health, so that the argument for Federal help would be a temporary help to get them on the right track and then let them go from there under their own power, is that correct?

Mr. FRAZIER. Mr. O'Brien, I wish I had put that in my statement because that is exactly the position in which we now find ourselves.

Pennsylvania is spending in the order of $100 million a year on what essentially is an outmoded system. It is stuck with that system because it has the facilities, there is nothing else that we can do with the 40,000 patients who are in Pennsylvania's hospitals. Nevertheless, we have to make this change of direction as effectively and rapidly as possible so that the State can devote the $100 million, and we hope less than $100 million actually, to the kind of care in the community when it is needed, where it is needed.

Mr. O'BRIEN. That would enable them, from their own resources, to spend properly what is now being spent—we will not say on a lost cause, but in the wrong direction, and they themselves in testimony of people from several Stetes conceded that. Don't you believe that if the Federal Government can get the States faced in the right direction, then through these same appropriations, same amount that they are now appropriating, they can accomplish the job in the future without continuing Federal assistance?

Mr. FRAZIER. I certainly believe that, Mr. Chairman, and I think even that the financial burden might be less, when this system is finally geared around to rapid emergency treatment and not limited to care.

If the average cost is around $2,000 a year to keep a patient in a State hospital with inadequate care, a stay anywhere from 2 to 30 years, you can see what the total cost of that mental illness is.

If you can treat a patient in 3 weeks' time by spending $30 a day, you may have spent $500 or $600 in a very short period, up to a thousand dollars perhaps but you have not committed yourself to the $2,000 to $60,000 expenditure on one case of mental illness that you have with custodial care in the State institution. This is not only a humane measure, it is a financially desirable measure from the standpoint of the taxpayer.

Mr. O'BRIEN. I am also looking at it from the standpoint of the politician, if you will. I get just a little tired of being listed as a spender for everything I vote that involves dollars.

Now once in a while, I think this is a striking example, you, by voting to spend dollars, deserve to be listed among the economizers rather than the spenders.

Mr. FRAZIER. Mr. O'Brien, among my business friends I will be glad to put you in that category if this measure is enacted.

Mr. O'BRIEN. Of course, I don't suppose that will extend to all my votes, but on this one I would hope that it would be considered as an economy move. I know we spend in New York State a tremendous amount and I know what we are getting for it.

What we are getting for it does not link with what the medical profession is able to do today to get consideration for these people. I would like to have some help to enable my State to spend that $300 million, or whatever it is, in the correct way.

Mr. FRAZIER. More effectively?

Mr. O'BRIEN. Yes.

Mr. FRAZIER. Yes, sir.

Mr. O'BRIEN. Mr. Nelsen.

Mr. NELSEN. Doctor, do you do some work that is voluntary in contribution to the services in your community; that is, donated services to any of the institutions?

Mr. FRAZIER. I should explain, sir, I am a simple engineer and not a doctor. I am a layman who has been interested in the field of mental health for over 25 years, I guess, associated with one organization or another, but I am not a doctor.

Mr. NELSEN. To your knowledge do the psychiatrists in the communities donate some time where there is a clinic of some kind, is there some donated services now by the local practitioners?

Mr. FRAZIER. I am sure there are some donated services now. For instance, at the Philadelphia General Hospital I am sure that some of the people on our staff, if you will, donate services but this thing can go very, very much further.

Mr. NELSEN. In the event this program is enacted and these local centers are established, the manpower problem would probably be, to some degree, met by voluntary available services by local practitioners. Would that not be a possibility?

Mr. FRAZIER. By both voluntary services and, if you will, by paid part-time service. I thing that it is only reasonable particularly for young psychiatrists, when you ask them to work in a State facility for wards of the taxpayer, if you will, that you give them some compensation.

It never will be as much as they could get in the private practice of psychiatry.

Mr. NELSEN. I think that in almost every small town I know of there are nurses who perhaps have married and their children are off to college and they have a little time available. I know that is true in our local hospital and there is a tremendous amount of personnel throughout the country who might, as you say, go to a local institution but they would not go to a centralized hospital at some distant point. Would that be a true statement?

Mr. FRAZIER. It is particularly critical in the field of nurses. We have one-third of the nurses that are required in our State hospital system and I would say about half of the nurses that we have on our manning tables.

The answer basically is that you just can't get the kind of personnel that you speak of to go away from their homes. Now if you center these facilities in the community, you will be able to attract married nurses with or without small children.

We are starting at the Philadelphia General Hospital a retraining program for nurses who have gone out of the field, have raised their children and now they are 45 or so and they have 20 years of useful service and we want to get them back into the profession. There is a tremendous field there that is being wasted now.

Mr. NELSEN. My daughter, Miriam, who is now 20 years old, is in nurses training at Fairview Hospital and has just completed her training at Anoka Hospital which is a hospital for mentally disturbed people. Her observation there was that one of the great problems is the fact that there are not enough nurses to give the personal attention that is so necessary.

These inmates become so isolated and neglected that they go backward instead of forward. A little incident that she related to me concerned one of the patients she cared for. She got this young lady to finally make some valentines to send to her family and write a letter to her father.

She then was able to do her hair for her and take her to the auditorium where she had never gone for months and months, simply because of a lack of this personal attention which is so characteristic of our hospitals.

I think the point you bring out is very well taken. I thank you for it.

Mr. FRAZIER. I appreciate your commenting on that point because you reminded me of something I didn't cover and I really should have been, connected with the Citizens Voluntary Mental Health Movement. One of the big things that we laymen can do is render this kind of voluntary service in mental hospitals.

Now it becomes quite a problem of logistics if the hospital is 20 miles out in the country and you have to organize transportation, buses and so on. We believe that bringing mental health facilities to the community will tremendously heighten the interest of the citizens.

Maybe even the mental health associations can go out of business, which would delight me greatly, although our staff might not like to hear me say so, because the presence of these facilities in the community will do a great deal to bring the problems of the mentally ill to the attention of people, but it will also make possible this kind of bedside service by volunteers as well as by the professional personnel in short supply which will speed up recovery in many instances.

Mr. O'BRIEN. Thank you very much.

Mr. Rhodes.

Mr. RHODES. Mr. Frazier, I would like you to enlarge a little more on the program in Pennsylvania. In my opinion, Pennsylvania in recent years has made tremendous progress with mental health. You mentioned that much of the money has been spent without good reason. I know in my own particular district there is a mental hospital.

I noticed that they developed quite a number of new facilities and have greatly improved the service. Even today the institution is crowded. I suppose it reflects the kind of situations we have all over the country where there are insufficient hospital beds, psychiatrists and not enough of the professional help that is needed.

I was wondering if you would enlarge on the statement that the money was not properly spent.

Mr. FRAZIER. Mr. Rhodes, I didn't mean to put any implication there that it isn't being spent as well as we can spend it in the light of the facilities we have and the program we have. You are quite correct that we have made tremendous strides in Pennsylvania.

In 1955 a Mental Health Act was passed. We set up a new department. There have been great advances, there have been many facilities built. We have built a community mental health center in Delaware County which is just outside of Philadelphia which is a prototype of the kind of program that we are here talking about.

We are doing things in Pennsylvania but we are not doing them fast enough. The size of the problem creeps up on you and all you do is run like the devil and try to catch up.

I certainly didn't mean by what I said to imply any criticism of the administration of the program in Pennsylvania. We are proud of what we have accomplished with limited resources. We just need this little shot in the arm to be able to move ahead.

Mr. RHODES. I am sure you didn't mean it that way, Mr. Frazier. What I wanted to know is, what do you think should be done that is not being done so far as the program in Pennsylvania is concerned? I can agree on the need for community facilities and services. There is a great need for them, but it seems to me there is a great need also for more hospital beds.

I think of the people that come to me for help in getting into one of the veterans' hospitals. I know at the Lebanon, Pa., hospital they have a waiting list of about 500 applications for people with mental illness. That is true, I believe, of veterans' hospitals all over the country. There is a tremendous need for more hospitals and more beds.

There should be both large institutions and more local facilities to meet the problem of the mentally ill.

Mr. FRAZIER. That is exactly what we are trying to do here. These community mental health facilities, whether we have them in Allentown or Reading, or in how many communities I am not prepared to say, but the point is there will be many more inpatient beds.

In many cases they will be connected with general hospitals as the plan provides. We are now moving in that direction to try to create a willingness on the part of the board of directors of these general hospitals to have psychiatric units in their hospitals but that willingness on the part of these hard-pressed administrators is going to be tremendously heightened if we say, now you can get, say, $2,500 a bed to refurbish your wards as a part of this overall community service plan.

It is a way of enabling us to do more rapidly and more comprehensively and on a planned basis the kind of thing that we know how to do now but just don't have the resources to accomplish.

Mr. RHODES. Mr. Frazier, the other day I mentioned what I thought was one of the difficult problems in this field and that is to recruit enough people who are willing to go into the study of psychiatry. It is not a popular field with many students although the need for good phychiatrists is very great.

I think there is great difficulty in getting psychiatrists to do volunteer work in a mental hospital. It seems to be there should be some

added inducement to enlist people in this kind of service. Perhaps one of the answers is much better pay than goes to psychiatrists who serve on staffs in our mental institutions.

Many of them who do serve come just right after they are out of college and leave this hospital service after a short stay. Do you think the service can be made attractive enough to get the kind of personnel that is needed?

Mr. FRAZIER. I did mention, sir, if you have a service based largely in the community I thought it might be possible, not to get a private psychiatrist necessary to donate his time, but to be willing to spend on the public service two afternoons a week, whatever fraction of his time would be an effective fraction, for adequate compensation, again not as much as he might make in his office but at least for the young doctors enough to keep the wolf away from the door.

It is going to be much easier to staff these community mental health centers with many of the personnel devoting part of their time to this than if you make it entirely a full-time staff basis.

I think it is better for the community and better for psychiatry and better for medicine if there is an interchange between the public and private practice.

Mr. RHODES. I want to commend you, Mr. Frazier. I feel indeed that committees such as you are serving on all over the State of Pennsylvania, and I presume all over the Nation, are making a tremendous contribution in helping the mentally ill and their families.

Mr. FRAZIER. Thank you, Mr. Rhodes.

Mr. O'BRIEN. I think we will hear from Mr. Withers now and then after his testimony we will recess until 2 o'clock.

Mr. Withers.

STATEMENT OF WAYNE E. WITHERS, DIRECTOR OF THE BOARD, NATIONAL ASSOCIATION OF MENTAL HEALTH; PAST PRESIDENT, MENTAL HEALTH SOCIETY OF GREATER MIAMI, FLA.; AND DIRECTOR, DADE COUNTY CHILD GUIDANCE CLINIC

Mr. WITHERS. My name is Wayne E. Withers. I am a businessman and both my residence and business are in Miami, Fla. I am here today to testify as a director on the board of the National Association for Mental Health. I have been active in the mental health program for about 8 years, having served as president of the Mental Health Society of Greater Miami, having also served as president of the Florida Association for Mental Health and presently serving as a member of its board. I am also presently serving as a director of the Dade County Child Guidance Clinic.

Speaking for the Mental Health Association as well as myself, I cannot begin to impress upon you the great need for the legislation contained in H.R. 3688. It provides a plan which will do much to combat one of our Nation's major health problems. A plan which embodies part of the President's mental health program and recommendations of the joint commission's report on mental health.

The Nation has made great strides in the past few years in the mental health field but there is so much yet that must be done—more so in some States than in others. H.R. 3688 provides the tool by

which States may increase these strides and in turn, strengthen this Nation's mental health program.

My State of Florida has recently had a survey completed by the American Psychiatric Association in which the needs of our State are set forth and recommendations are made for better treatment, care and rehabilitation for the mentally ill. These needs are not peculiar to the State of Florida, but can be applied to the whole Nation. I am happy to see how much H.R. 3688 parallels the recommendations set forth in this survey.

One of the major recommendations made by the American Psychiatric Association survey is the organizing of a Department of Mental Health for all State mental health services. The responsibility for the total State program will rest with this department.

After having studied the survey, we, in the State of Florida, realize the great need for rehabilitation and outpatient care, which has been recommended. A recent pilot study was conducted in Alachua County. An outpatient clinic was operated, which offered services to recovered patients that had been released from hospitals and had been returned to their homes or to nursing homes. This study proved that the number of these released patients having to return to hospitals was cut by some 50 percent. The need for community based facilities such as this has been proved. Many of our people will not have to return to hospitals, more beds can be made available and added expense for additional treatment can be avoided.

The survey also emphasizes the urgent need for a program for psychotic children. Florida, like many other States, now has no State operated facilities for the treatment of the emotionally disturbed child. Many children are diagnosed as needing treatment but there is nothing available for a mentally ill child under the age of 12 in our State. These children are usually left in the community with no treatment.

I would like to digress. During my term as president of the State association I had an opportunity to visit all of our State hospitals. At the time that we visited Chattahoochee, which is our largest State institution, we had the opportunity to visit the maximum security ward for the criminally insane—the men's ward. There were some hundred patients in this ward and we noticed that a very large percentage of these patients were men between the ages, I would say, of 18 and 22. The question was asked of the director of the hospital, who was conducting us around, Where are the older patients? and he replied that, believe it or not, they got very few older men as patients in this maximum security ward due to the fact that the person that is going to commit a criminally insane act will probably do so at an early age. I thought at the time how many of these men would not have had to be in this institution in this predicament if a program for emotionally disturbed children had existed in our State.

As recommended in the survey, our State hopes soon to be able to develop inpatient units of 25 beds in Gainesville in connection with the University of Florida Medical School Department, and in Miami in connection with the University of Miami Medical School Department, where a nucleus of professionally qualified specialists already exist. These would be teaching and treatment units and would place a major emphasis on training personnel so that the manpower pool in this field will grow and eventually come closer to meeting the need.

Though these units will emphasize training of personnel the size of the unit will no where near meet the need for bed spaces necessary for the children of our State.

The shortage of trained personnel for emotionally disturbed children, as well as adults, is felt throughout the country and the training of personnel in inpatient and outpatient facilities can do much to eliminate this shortage and to educate professional staff for new units as they are formed.

A third unit eventually placed in the Tampa area would be a part of a recommended State mental health center, or a medical school if one is established in Tampa. These inpatient centers for children should also provide outpatient services and possibly part-time hospitalization and should develop a close liaison with other agencies working with children's problems. Child guidance clinics, schools and institutions for the mentally retarded, are all in need of greatly expanded psychiatric service.

We realize that also the pressing need for mental health centers for adult treatment located in major urban areas where the majority of the people reside and where professional staff are more easily obtained.

This, incidentally, was also a recommendation of the APA survey, as was the maintaining and staffing of psychiatric beds in general hospitals and improving or renovating of existing physical facilities now used for temporary care of patients awaiting admission to the State hospitals. A program of therapy should be provided at these facilities, without which they represent little improvement over holding the patient in jail.

I could recite much more to this committee as to needs and lack of service throughout our land, much of which I am sure you are already familiar with. I can now only urge that this committee and the House act favorably on H.R. 3688 so that we may do our part toward fighting the Nation's No. 1 "stepchild" and most pressing health problem—mental illness.

Thank you.

Mr. O'Brien. Thank you, Mr. Withers.

I would like to ask you this one question. I was impressed by the questions asked of Mr. Frazier.

I think all of us have had experience of trying to find a bed for somebody in a mental hospital or in a veterans hospital. Isn't it a fact that the overriding purpose of this legislation is to effect more cures so that actually there will be more beds for those who need custodial treatment?

Mr. Withers. Yes, I definitely think so. In our mental health centers where there may be outpatient facilities, day care, even possibly short-term bed care, I am sure that in these centers it would free beds in your larger State institutions.

Mr. O'Brien. Another experience I have had, and I think Mr. Rhodes has had it, too, is that very often you have a patient that they want to send to the State hospital at some distance away, but the family would like to have that person in the local veterans hospital because it is local. Now if you had other facilities in the community where that patient could possibly be treated without leaving home, don't you think that would have the effect of lessening the demand for a bed in veterans hospitals?

Mr. WITHERS. Yes; and I thoroughly believe that treatment close to a patient's home is good therapy. I think that the idea is good, it helps him to recover much faster if he can be near his friends and his family.

Mr. O'BRIEN. Very very human viewpoint. If I had someone in my family who was mentally disturbed, I would do everything in my power to try to get that person in a local veterans hospital so we could visit and so forth. I don't think I would exert as much pressure if there were other facilities locally where the patient could be treated, with some hope for cure, and would be near family and friends.

Mr. WITHERS. That is entirely true; yes, sir.

Mr. O'BRIEN. Mr. Rhodes.

Mr. RHODES. Mr. Withers, I would like to ask you how Florida handles problems of families moving into your State with a member of the family confined in a mental hospital in another State.

Mr. WITHERS. Well, in most instances we have to try and take care of them.

Mr. RHODES. Do you have agreements with other States for a transfer of such patients?

Mr. WITHERS. Not that I know of.

Dou you know, Mr. Frazier?

Mr. FRAZIER. There was a bill before Congress, there has been a bill within fairly recent years on an interstate compact but I didn't know whether it had been enacted or not. There was a certain amount of opposition on the part of some people who believed that this was a way of railroading political opponents, to Alaska, and I kind of lost track of the bill at that point. Half the States do have a reciprocal arrangement though.

Mr. O'BRIEN. Would the gentleman yield?

Mr. RHODES. Yes.

Mr. O'BRIEN. Your mention of Alaska; I was almost stabbed to the heart, that happened to be my bill and I can't tell you how refreshing it is to consider a mental health bill in the atmosphere we have here compared to what we went through on the Alaska mental health bill. One letter I received stated in the first paragraph that I was a Communist, in the second paragraph that I was guilty of treason, and in the third paragraph that I should be the first inmate of the new mental institution in Alaska.

The final paragraph stated:

> Please send me a copy of the bill. I will reserve further comment until after I read it.

We were accused of this gigantic plan to establish a 1-million-acre concentration camp in Alaska and that people here, health officers, presumably Communists, would come into peoples' homes in the dead of night and whisk them off to that concentration camp. I think our difficulty there was we tried to write into the bill commital provisions, and when you try to do that at a national level you are in trouble because I suspect there is a certain percentage of our population figures we are after them.

Mr. FRAZIER. Nobody knows who is mentally healthy Mr. Chairman. We only know who is mentally ill.

Mr. O'BRIEN. Thank you very much, Mr. Withers.

We will recess now until 2 o'clock at which time our first witness will be Mrs. Eileen Jacobi, dean of the Nursing School, Adelphi College.

(Whereupon, at 12:07 a recess was taken until 2 p.m. of the same day.)

AFTERNOON SESSION

Mr. ROBERTS. Mrs. Eileen Jacobi, dean of the School of Nursing, Adelphi College, New York, appearing for the American Nurses Association.

STATEMENT OF MRS. EILEEN M. JACOBI, DEAN, SCHOOL OF NURSING, ADELPHI COLLEGE, GARDEN CITY, N.Y.; ACCOMPANIED BY MISS JUDY THOMPSON, WASHINGTON REPRESENTATIVE OF THE AMERICAN NURSES' ASSOCIATION, INC.

Mr. ROBERTS. We are glad to have you, Mrs. Jacobi.

You may proceed with your statement.

Mrs. JACOBI. Thank you.

Mr. Chairman, I am Eileen Jacobi, dean of the School of Nursing, Adelphi College.

I would like to introduce Miss Judy Thompson, Washington representative of the American Nurses' Association.

I appear here today to speak on behalf of the American Nurses' Association in support of bills to assist the States in the construction and initial operation of community health centers, and for grants for construction of research centers and facilities for the mentally retarded.

Psychiatric nursing is my area of specialization and I am currently vice chairman of the ANA Conference Group on Psychiatric Nursing. The conference group plans educational programs for the membership and at present is engaged in developing standards for practice in psychiatric and mental health nursing.

The treatment of the mentally ill in State hospitals has been handicapped because of the size, location, and staffing patterns of these large institutions. Too frequently care has been custodial rather than therapeutic because of the lack of professional personnel.

This results in long or permanent hospitalization for individuals with mental illness and, additionally, the isolated location of most State hospitals has deprived patients of close, supportive contacts with family and friends. Recruitment of qualified personnel has also been difficult because of this.

The establishment of community mental health centers is a relatively new approach to the prevention and treatment of mental illness. Many communities already have available diagnostic and treatment facilities, inpatient and outpatient psychiatric services, provisions for emergency care and for rehabilitation.

In most instances, however, these are not coordinated to the extent that continuing supervision of patients is provided from the acute phase of the illness through to complete rehabilitation.

The community mental health center can focus on coordinating these various efforts to improve services to patients and families. Mental illness is a family center problem.

The availability of services in localities where people live can result in early recognition of illness and intervention at a time when treatment is more likely to be successful. For patients who may still require hospitalization away from their homes, the community mental health center is a resource for providing followup care and rehabilitative services after discharge.

It can be anticipated that the hospital stay would, therefore, be shorter enabling the individual to resume his proper role in society.

In addition to providing a direct service to patients and families, the mental health center would also have an educational function in the community. The report "Action for Mental Health" notes the rejection of the mentally ill, because of lack of knowledge and understanding of the pathological process, by members of the family and community.

Important to eventual recovery is the support and understanding of relatives, friends, and employers. Because hospitals for the mentally ill are generally in isolated areas, an effective sustained plan for interpretating mental illness and interpretation of the patient's needs to his family is frequently impossible.

Closer collaboration is necessary between mental health personnel and other health workers in public and private community agencies, and with practicing physicians, nurses, and social workers. Although their major function may not be directly related to mental health and mental illness, they also have a responsibility in prevention, in followup care and in rehabilitation.

The staff of the community mental health center would become a resource for helping these allied professional groups broaden their understanding and knowledge of mental health and, therefore, provide more effective service. The centers would provide clinical facilities where doctors, nurses, psychologists and social workers in their basic professional training could gain firsthand experience in working with psychiatric patients and their families.

In addition, consultant service would be available for the child and adolescent. It is the schools and courts that must often deal with problems arising out of unrecognized mental illness. We have studies to show that where guidance and counseling has been given to families, delinquency rates decrease within these communities.

The problems of mental retardation have frequently been ignored, and the condition accepted as hopeless. Little has been done in prevention, treatment, and rehabilitation of individuals affected with varying degrees of retardation. In the President's message to Congress on mental illness and mental retardation, he called attention to the fact that, "Until a decade ago, not a single State health department offered any special community services to the mentally retarded."

Some efforts in this area have been made by voluntary agencies and professional groups but generally the care provided has been primarily custodial.

Scattered, concentrated, programs have demonstrated that proper medical care and training can help some of the individuals become socially oriented and self-supporting members of our society. Research and studies into the causes and the possible prevention of the condition is an essentially unexplored area.

There is great need for a change in the care and treatment of the retarded. Institutions for their care, like those of the mentally ill,

have been isolated from the home community and are woefully understaffed. Like our State mental institutions much of the care has been given by untrained aids or attendants. The same reasons for bringing the care and treatment of the mentally ill back to the community apply equally well to the care and treatment of the mentally retarded.

The need for training nurses to work with the mentally retarded has been recognized as a professional responsibility. In most of the schools preparing nurses and other health personnel the educational program has been too often geared to the care of the acutely ill individual with insufficient emphasis on conditions that are of a chronic nature.

The shortage of professional nurses is acute in all services but it is especially severe in the field of psychiatric nursing. Graduate education is the desirable minimum for practice in this field if we are to move from custodial to therapeutic nursing care.

While there are some Federal funds available for graduate education, only 8 percent of nurses hold a baccalaureate degree, the prerequisite for advanced study.

Support of baccalaureate education in nursing is urgently needed. This has been indicated in the recent report to the Surgeon General by the consultant group on nursing. The success of programs to combat mental illness and mental retardation will be dependent in large measure on the availability of well qualified professional manpower.

In conclusion, I wish to thank you, Mr. Chairman, for providing an opportunity for the American Nurses' Association to speak to your committee in support of this legislation.

Thank you.

Mr. ROBERTS. Thank you, Mrs. Jacobi.

We are certainly happy to have your statement and your comments on the measure before us.

I am wondering, you speak of the problem of shortage of nurses which you say is acute, especially in the field of psychiatric nursing. I wanted to ask you what you think about the manpower situation, maybe I should say womanpower situation, in connection with mentally retarded comprehensive research centers and also in community type of facilities? Now where are we going to get that help when we know we start out with a shortage and when there is no provision in nursing, say at these levels; that is, as far as the Federal Government is concerned?

Mrs. JACOBI. I think one of the gentlemen that spoke this morning brought attention to the fact that there is an untapped resource in the nurse within the community who is currently tending to her family responsibilities.

She cannot travel to remote areas or isolated areas to the institutions currently provided for the mentally ill and retarded. I think as the facilities for the care of the mentally ill and mentally retarded are moved into the home community these nurses will be available on a part-time basis or on a voluntary basis.

We will also, as I mentioned in the report, have facilities available where the nurse within the educational program can have firsthand experience in learning about the problem and how to cope with it. I think this will be our best recruitment device rather than being faced

as a practitioner with his overwhelming responsibility with which he is unable to cope because of the vast numbers of patients.

I think we need also to attract or to recruit the young students early in high school, to careers geared toward the care of the mentally ill, these students must arrive at this preparation through the basic nursing educational program.

We have not had sufficient emphasis on recruitment for careers for the care of the psychiatric patient or the mentally retarded.

Mr. ROBERTS. You think, in other words, as we decentralize the facilities that you have, as you say, an untapped source of professionally trained people who would like to work in their own communities but who could not leave their communities to go to an isolated hospital.

Thank you again very much for your statement. We appreciate your appearance. It is always good to see you, Miss Thompson, before our committee.

Thank you very much.

Our next witness appearing here is Mr. Charles Emmerich, chairman of the Health and Education Committee on behalf of the National Association of Counties, located here in Washington.

Mr. Emmerich comes from De Kalb County, Ga., and is chairman of the board of commissioners.

Mr. Emmerich, we are certainly glad to have you appear here today and receive your statement.

Mr. Emmerich will be introduced by the distinguished gentleman from Georgia, Mr. Weltner.

Mr. WELTNER. It is a pleasure for me to bring to this committee, Mr. Charles Emmerich, who appears here in a dual capacity. Mr. Emmerich is the chairman of the board of county commissioners for the county of De Kalb. This county has grown 88 percent in the past 10 years and you can see that Mr. Emmerich would have his hands full with that job.

Not content with this, he has established a name for himself in the National Association of County Officers and appears here primarily in his capacity as chairman of that association's committee on health and education.

It is my pleasure to present my constituent, Mr. Emmerich.

Mr. ROBERTS. Thank you Congressman. We are happy to have you.

Commissioner, we are happy to have you and we certainly appreciate your support of this wonderful association on behalf of this legislation.

STATEMENT OF CHARLES EMMERICH, CHAIRMAN OF HEALTH AND EDUCATION COMMITTEE, NATIONAL ASSOCIATION OF COUNTIES, WASHINGTON, D.C.

Mr. EMMERICH. Thank you, Mr. Roberts.

I am pleased to be here. In fact, I want to express my appreciation for a Government and the political leadership that makes it possible for hearings of this type. I think it strengthens our democracy and I think it gives a chance for the local boards to be heard.

We appreciate it very much, we are indebted to you and your committee.

As Congressman Weltner stated, I represent NACO, which is the National Association of Counties. This is an organization which is very active in at least 44 States and represents most of the 3,043 counties of this great country of ours.

I speak as their chairman of the health and educational committee. Also I speak as a commissioner who lives in a metropolitan complex in Atlanta, Ga. Atlanta is like the 211 other areas of its kind in this country and we are aware very much of the problems which we are faced with in the area which we are going to discuss today.

I would like to point out that I am a layman as far as mental health is concerned. I am a local politician and this is the area in which I speak.

I would also like to present, and which I have already done so, a written statement for the record and then for a few moments, I would like to make some observations without reading the statements, if this is all right.

Mr. ROBERTS. Let the statement be included and you may proceed as you desire.

Mr. EMMERICH. I appreciate the opportunity to appear before this honorable group to discuss the important subject of mental health. It is a privilege to live in a Nation where the Government and our political leadership make possible this kind of public hearing so information can be obtained to help solve the many problems facing mankind today.

In speaking to this committee on H.R. 3688 and H.R. 3689, I am appearing in a dual capacity. As chairman of the Health and Education Committee of the National Association of County Officials, I am speaking on behalf of the 3,043 counties in this country.

As chairman of the Board of Commissioner of De Kalb County, Ga., I am speaking as an official in one of the 212 metropolitan areas in our country. De Kalb is a vital part of the five-county complex that composes metropolitan Atlanta.

The National Association of County Officials—NACO—has a staff in Washington which keeps its members fully informed on all national legislative, administrative, and judicial actions affecting county governments. NACO prepares reports on major happenings in Washington and throughout the Nation which are of common concern to counties.

It also makes every effort to see that county representatives are appointed to appropriate national advisory study groups to insure the proper portrayal of the county viewpoint.

A definite stand in favor of Federal assistance in the field of mental health is one of the key positions in the American county platform. It states:

> The Federal Government of these United States is urged to provide the necessary and essential funds to provide sufficient and immediate mental health services, including mental health clinics and professional services in schools, courts, et cetera, throughout the Nation.

In addition, NACO's Committee on Mental Health is directed—

> to cooperate with statewide and nationwide accredited mental health associations in preventive programs designed to provide more care, protection, and aid for the mentally ill.

I shall not attempt to dramatize the importance of the need for the objectives contained in H.R. 3688—the Community Mental Health

Centers Act of 1963—and H.R. 3689—the Mental Retardation Facilities Construction Act of 1963.

But, I would like to repeat these facts: Mental health is considered by many of our citizens to be the Nation's most urgent need in the area of health improvements, especially the mental health fields of mental illness and mental retardation.

These mental conditions occur more frequently, affect more people, require more prolonged treatment, cause more suffering by the families of the affected, wastes more of our human resources, and constitute a larger financial drain on individual families and the public than any other single condition.

Institutions in our Nation now house more than 600,000 patients suffering from mental illnesses. Each year 1,500,000 people receive treatment in institutions for the mentally ill and mentally retarded.

I believe throughout the United States it is very evident that the problems of mental illness and mental retardation require special emphasis and action at all levels of government in order to provide for the realization of the maximum potential of all mankind.

Mental illness and mental retardation create in the economic loss of productivity and the cost of treatment an expense we can ill afford.

Based on the information received on H.R. 3688 and H.R. 3689, the proposed facilities and programs outlined in these bills should be considered as a bold new approach to mental health problems. I believe this new approach is tantamount to a breakthrough in the field of mental illness.

In time, if the programs described in these bills become realities, it should greately reduce the effects of mental illness and have definite, positive impacts on our entire economy.

I am particularly pleased with the approach recommended by the President in his message on mental illness and mental retardation because this approach is identical with the findings of a local committee formed in De Kalb County more than a year ago.

This committee, composed of laymen and repesentatives from several areas, have carefully studied the mental health problem and especially its effects on our young people.

Although this proposed mental health program represents a new trend of thought, it should be noted that State and local governments in the past have been interested in and have helped to finance health and welfare programs. In De Kalb County, where the per capita income of its 285,000 citizens is much higher than the State average, we still spend approximately $1 million each year for the treatment of the indigent ill.

I see no reason why this new program should be treated differently. Local governments, in my opinion, will welcome the opportunity to cooperate with the State and Federal governments in this new and very important undertaking.

At this point I think it is appropriate to point out that our Nation is suffering at all levels of government from juvenile troubles and juvenile delinquency. We all recognize that mental illness and mental retardation are contributing factors to the juvenile problem.

School boards, health department officials, and county officials would welcome a chance to step up efforts which would contribute to the solving of this problem—a problem that is costly in terms of young lives

being twisted and ruined and of property being damaged and destroyed.

Of equal importance is unemployment, which seems to be our top economic problem and which is greatly affected by the mentally ill and retarded. Through this program, many of our citizens would be helped to the extent they could find satisfactory and useful employment and, therefore, become assets and not burdens to their communities.

If we had been successful in dealing with mental health problems in the past, there would be no need for me to speak to you today or even for this committee to meet. But, we are all aware of our failures in handling mental health problems at the local, State, and National levels.

The emphasis these bills place on the problems of mental illness and mental retardation will give direction to the governments and will stimulate additional action by all levels of government.

We recognize the program will cost our taxpayers at the local, State, and National levels. But we feel the tremendous importance of this program will bring favorable action and solid cooperation. All of us realize that the mental health problem has never been faced adequately, and that this bold new approach represents an earnest desire to provide answers to situations which previously have been largely unanswered. If the Federal assistance outlined in these bills can be made available, certainly the leadership in all levels of Government should be interested and concerned.

The proposal to approach mental health problems at a local level points to a belief that much of the previous stigma felt by the families involved can be removed successfully.

At present, the State institutions are, in most instances, custodial in nature. The State hospitals are becoming more and more places of confinement, which are too large to provide adequate individual treatment and consultations.

In addition, it frequently is necessary for humans to degenerate to certain specified low levels of mental understanding and mental ability before the facilities of the State hospitals are available. The essential and demanding need, then, is to approach this problem on the community level.

I mentioned earlier the De Kalb County Mental Health Council, established early last year as an advisory board to the local government. In selecting members to the council, careful consideration was given to the procurement of capable people in various professional fields so the problems of mental health could be studied objectively in relation to all aspects and elements of the whole person.

The chairman of the group is the Honorable James A. Mackay, an attorney and a State representative. He recently headed a legislative committee that studied the problems of youth in Georgia. The result was a bill presented by Representative Mackay that was passed by the General Assembly of Georgia to establish a State department of youth. Other members are:

Rev. Thomas H. McDill, who is vice chairman of the council. He is professor of practical theology and pastoral counseling, Columbia Theological Seminary.

Jim Cherry, superintendent, De Kalb County school system. Mr. Cherry is widely known as a leading educator and his school system,

which is one of the fastest growing in the Nation, is recognized as a leader in providing quality education.

Mrs. Caroline Clarke, director, De Kalb County Department of Public Welfare.

Dr. John T. Doby, associate professor of sociology, Emory University.

Dr. Bernard C. Holland, professor and chairman, Department of Psychiatry, Emory University.

Dr. James A. Johnson, Jr., professor, Department of Psychiatry, Emory University.

Dr. Freeman Simmons, M.D., Decatur, Ga. He is the representative of the De Kalb County Medical Society.

Dr. Thomas O. Vinson, director, De Kalb County Department of Public Health.

Walter L. Purcell, director, De Kalb County Department of Community Services. To minister to human needs, this department coordinates in De Kalb the work of private and public agencies who cooperate with the county and the work of county departments.

Brince Manning, Jr., judge, De Kalb County Juvenile Court. De Kalb County and Fulton County, of which Atlanta is the county seat, are the only counties in Georgia with full-time juvenile court judges.

As chairman of the board of commissioners of De Kalb County, I am the 12th member of the council.

The composition of the council permits knowledgeable discussions of the whole person—physical, spiritual, and emotional. This group was unanimous in its declaration that the present bigness of our State institutions and the obvious essential expansion in the coming years render them inadequate to meet the needs in the field of mental health at the present or in the future.

The problem of mental health is a very personal problem and for maximum effectiveness, treatment must be approached on a personal basis. Therefore, it was our opinion that the most effective results can, and must, be obtained at the local level.

I feel the community mental health center—which represents a facility to provide service for the prevention or diagnosis of mental illness, the care and treatment of mentally ill persons, or the rehabilitation of such persons—is the most realistic and practical approach to this tremendous responsibility.

Providing these services for people in or near their own communities should bring new hope to millions of people throughout the Nation.

In closing, I would like to point out again it is our belief that these bills represent a new and vigorous approach to an old and unsolved problem. It is my firm belief as the chairman of NACO's Health and Education Committee and as chairman of the De Kalb County Commission that H.R. 3688 and H.R. 3689 should be passed.

Probably the only question remaining in our minds is the scope of the program. It would appear that the importance of this new approach and the potential service to be rendered through the program would prompt our Congressmen to consider increasing the proposed financial appropriation of the bills so the program could be enlarged.

I know this committee has studied the problem of mental health for many hours and are cognizant of the needs in this area. A real

breakthrough in the fields of mental illness and mental retardation would be a major step in the advancement of mankind.

I appreciate the opportunity to appear before this honorable committee.

Thank you.

Now, the first observation I would like to make is that NACO itself has an American platform and in this platform they have a statement which covers this particular item. It is only about three lines long, I would like to read that particular statement.

One of the key positions in the American county platform is a definite stand in favor of Federal assistance in the field of mental health.

> The Federal Government of these United States is urged to provide the necessary and essential funds to provide sufficient and immediate mental health services, including mental health clinics and professional services in schools, courts, and so forth throughout the Nation.

Now, I would like to elaborate on this. Throughout the platform we are not in favor in every case of the Federal Government taking over all the responsibilities but in this case since we do not know where to go, we knew it was an area of great concern, we have in the past years adopted this same statement and we still think it is apropos here today.

These new bills are being studied throughout these many counties in our country today and we at this point wish to declare ourselves as being in favor of the bill as written. I would like to discuss a few of the points. We like both bills, we think they are well done and we hope that they will be passed.

I don't want to dramatize the importance of these two bills and what they might do for our Nation, but I would like to repeat from the President's statement to the Congress at least one or two lines which I think sums up our feelings.

> Mental health is considered by many of our citizens to be the Nation's most urgent need in the area of health improvements, especially the mental health fields of mental illness and mental retardation.
>
> These mental conditions occur more frequently, affect more people, require more prolonged treatment, cause more suffering by the families of the affected, wastes more of our human resources, and constitutes a larger financial drain on individual families and the public than any other single condition.
>
> Institutions in our Nation now house more than 600,000 patients suffering from mental illnesses. Each year 1,500,000 people receive treatment in institutions for the mentally ill and mentally retarded.

At this point I would like to point out that we feel that the bills bring to the attention of the American people a new concept as far as treatment is concerned. We know that we have tried at the State level and the local level as well as the national level to meet this challenge.

We probably thought we were doing right but we feel that this bill points out a great ray of hope for the American people and we hope that this bill will be passed so that leadership at this level can be known and that we can rally around it at both the local and State level.

I think we admit that our present plan is not operating satisfactorily. If we had all the money that a man could dream about, we could not get enough to handle this problem the way we are now handling it. This new concept must be tried.

I think it is important too that for more than 1 year a local committee in De Kalb County, a county of approximately 300,000 people, have been studying this very problem, especially from the standpoint of young people. It was a very strong committee. We had on this committee representatives of course, of the church, the juvenile judge. We had sociologists from Emery University, psychiatrists from the mental organization, De Kalb County had its doctors represented there too. We had sociologists and psychiatrists on the committee and for over a year we reviewed papers, we did research and we too came up with the same conclusion, that this problem had to be handled on the local level.

We also found some other things too which bothered us, that we need many, many more trained people in the professional area in a technical area. This means that we believe our colleges and universities are going to have to help in this program to help provide some of this staff.

We found also that with this new concept and new idea that more research should follow quickly, because if we get started on this program we are going to need much more knowledge than we have available at this time.

I might point out too that local governments for many years have been interested in helping to finance health and welfare programs. In De Kalb County we spend approximately a million dollars each year on the indigent ill. I recognize our county has an average income of that much greater than the State as an average.

We are willing to do something on the local level but this needs help at least for a while from the national level. I believe that local governments throughout this country will rally around this program and will try to see that it gets off the ground quickly and with speed and will carry their part of the burden.

It also seems important to mention that America is suffering from juvenile troubles and we feel that this contributes in that area. Any approach that will soften the problem of juvenile delinquency will be an asset, we feel, to almost every community in America.

The schools have recognized this for many years. They recognize the importance of retardation to its students. They, too, would rally around such a program.

I might point out that unemployment is affected by this same disease. Unemployment now which has for the last 60, almost 62 months ranged from 5 to 16 percent is considered probably first or at least second in our national problem list. Probably we might consider the lack of our growth in the national product as being first, but this is certainly second.

Yes when we consider that between 5 and 6 million people are affected by these diseases, which represents approximately 3 percent of our population, you can see that 6 percent of our labor force is about the same in number as this 3 percent would represent. This is important and something that this country cannot be very proud of.

We recognize that this will cost the taxpayers money. I know that it will take courage on the part of our Congressmen to vote this bill into action but we feel that the importance of this bill to the good of this country will prompt them to have the courage and get this thing done.

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Again I would like to remind you that we feel this is a new approach. It would be a new day and would certainly be something that would make us proud to participate in at all the county levels.

Now I would like to quickly at this point sum up my statements.

I say first the need is great, it can't be postponed. I hope you do everything possible to see that this bill is passed this time, that it is not delayed. We waited too long. We see how we can do it, we believe it can be done, and we encourage you to do everything possible to get this out of the committee and into action.

We would like to also point out that we need the national leadership which the Congress can give us by passing this bill. It will give us the heart back home to rally around such a program. This seems to be important.

Again I would like to say that the local and State governments are willing to help. We see the need and we want to help.

Again, this is a new approach to handling a very, very bad problem. Someone is to be congratulated for bringing this to the attention of this group.

Mental health and retardation is as great in number as unemployment. In other words, these two problems are about as bad except generally when you have a retarded child in the family it is something that is even worse than somebody being unemployed.

I believe that for every mental person there are at least 10 people that are disturbed. If you have as many as 5 and 6 million people, you are talking about 50 or 60 million Americans that are affected by this particular disease.

We believe that local facilities are needed. We would like the comprehensive plan which you have described. We need university level programs, additional work in research, again we feel that we do not wish to make any modifications but certainly in this period of 5 years we have had time to look over the program, and if we can find weaknesses at that point we would try to make changes.

We are pleased that the program will be handled by the Secretary of Health, Education, and Welfare. They have done a marvelous job in this country and are doing a good job and we believe by handling through this particular agency it will be handled as it should be.

We agree that the Public Health Service Act should be amended to enlarge the committee of eight of the Federal Hospital Council.

We might point out that since eventually much of this will be financed by local governments, of which you have in the neighborhood of 20,000 in this country, that you might consider putting one representative from local government on the committee. This I think has a great deal of merit.

The last thing I would like to say is that NACO is in favor of both bills and we would like to see both of them pass without much modification.

Thank you, sir.

Mr. ROBERTS. Thank you, Mr. Emmerich. It is certainly refreshing to this committee to have a man of your standing and experience in local government to reaffirm your faith in the role of the Federal Government and to express your willingness to cooperate, particularly in your local capacity and also in your capacity as chairman of the committee in the connection which you have in NACO.

Mr. EMMERICH. Thank you, Mr. Roberts.

Mr. ROBERTS. We get very little of that kind of testimony.

Most of the time it is when one says, well, every time we have a problem back home everybody rushes up to Washington to get the Federal Government to do the job. I have the same viewpoint you have.

I come from an area where we believe in the strength of local government but we think this is a national problem. There are many instances where the Federal Government in the partnership of this kind with the State and local governments can accomplish many things.

Of course, there is money that will be channeled into these centers of research, training. It is very small when we think of the tremendous amounts that have been spent already. I am sure that in your capacity as chairman of the commissioners of De Kalb County you are not the person who makes the decision as to the applicant going to the State mental institution.

You are well acquainted with the frustration that sometimes comes about when the family realizes that a member of that family must be committed to a State institution.

I believe from your testimony that you believe there is a new attitude on the part of the people and if they had these services available locally that many of them would not require any court action, would not require any official commitment but would avail themselves to do something about the situation.

Mr. EMMERICH. I think they would.

Mr. ROBERTS. We are certainly grateful for your support and for your statement.

Mr. EMMERICH. Thank you.

Mr. ROBERTS. Mr. O'Brien?

Mr. OBRIEN. No questions.

Mr. ROBERTS. Thank you very much.

We appreciate having you.

Mr. EMMERICH. Thank you.

Mr. ROBERTS. Our next witness is Mrs. Margaret K. Taylor, executive director, the American Parents Committee, Inc., 20 E Street NW., Washington, D.C.

STATEMENT OF MRS. MARGARET K. TAYLOR, EXECUTIVE DIRECTOR OF THE AMERICAN PARENTS COMMITTEE, INC., WASHINGTON, D.C.

Mrs. TAYLOR. Mr. Chairman, I am appearing in support of H.R. 3689. I have a short statement which I believe I could read more quickly than I could discuss it.

Mr. ROBERTS. Proceed.

Mrs. TAYLOR. I am Margaret K. Taylor, executive director of the American Parents Committee, Inc., a nonprofit, nopartisan, public service organization.

Since its formation in 1947, the American Parents Committee has worked exclusively for legislation in behalf of America's children. Through the office of the chairman, Mr. George J. Hecht, who is also the publisher of Parent's magazine, and the Washington office, it keeps abreast of a wide range of legislative proposals affecting children.

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The board of directors and national council, composed of 115 outstanding leaders of National, State, and local child welfare organizations across the country, determine by majority vote the position of the committee on legislative proposals.

The American Parents Committee shares with you a concern about all situations in which the prospects for normal development of any of our children are imperiled, and a particular concern for those children for whom preventive measures are now already too late. For this reason, we have placed high on our list of legislative goals for 1963, "an expanded program on mental retardation as recommended by the President's Panel on Mental Retardation." We commend to you the excellent report just issued under the title, "A Proposed Program for National Action To Combat Mental Retardation."

It is clear that we must have coordinated action on a number of fronts, within and outside the Federal Government, to achieve the various objectives set forth by the Panel. While bricks and mortar do not make a program, without them programs everywhere are seriously hampered.

The bill sponsored by Representative Oren Harris (H.R. 3689), providing as it does for the construction of facilities for research and services for the mentally retarded, constitutes an important basic step in upgrading existing programs and making possible new ones for this disadvantaged group.

Those familiar with the fields of knowledge basic to the study of mental retardation know that many sciences must interdigitate, in order to shed light on the causes of this condition and on the combinations of environmental conditions, stimuli, experiences, and treatments which will enable each mentally retarded child to make the maximum possible progress.

Today, even with all our modern instruments of communication, the face-to-face contact between scientists still affords the best opportunity for the communication or verification of nascent ideas from which new discoveries emerge. Some important work relevant to mental retardation is done in laboratories by men who never see or talk to a mentally retarded child, but much needed research requires that mentally retarded persons be available as subjects. To foster such research, therefore, it is necessary to provide the physical facilities in which scientists with various disciplinary backgrounds find it convenient to work and communicate with one another and also to establish contact with retarded subjects. At the same time we must make sure that these same mentally retarded children and adults are themselves provided with the most favorable environment for their own growth and development, even as they are being observed and studied.

Such research and clinical facilities especially designed to foster this kind of work are almost nonexistent in this country today. While we can applaud the perseverance and devotion of those investigators who may manage to produce results under unfavorable conditions, we must recognize that it is the mentally retarded who are paying the price of the inefficiencies and delays which inevitably ensue.

Likewise, the services needed by the mentally retarded are varied. Around the country parents have been organizing programs for their children, housing them where they could, in church basements, in

abandoned school buildings, on sufferance in settlement houses out of hours, and in war surplus sheds. These children deserve more at our hands. Surely an attractive and appropriate building is the most tangible and obvious evidence that a community and a nation does care. Yet the grants-in-aid available under the hospital and medical facilities construction program, of which your committee has such just reason to be proud, cannot properly be diverted to day care centers, group homes, imaginatively conceived programs of residential care, sheltered work or activity centers and the like.

Moreover, in view of the continuing need and demand for hospital, nursing home, and clinic facilities for the general population, it is clear that special facilities for the mentally retarded will not receive the needed support and participation from the Federal Government unless Congress makes clear its intent that funds be specifically allocated to be used for precisely such purposes.

We believe that H.R. 3689 is well drafted to stimulate construction of physical facilities for research, service, and training of personnel, in this neglected field. We recommend its early passage, not only as a sign of congressional belief in the dignity and rights of the mentally retarded, but also a point of departure from which planning at the State and community level can proceed without further delay.

Thank you, Mr. Chairman, for giving me this opportunity to present our views to you and your committee.

Mr. ROBERTS. Thank you, Mrs. Taylor. I appreciate your statement.

I just have one question and it will be very brief.

Do you believe that it would be wise to provide some Federal staffing for the facilities under H.R. 3689 as we do in the mental health bill, at least for a short time?

Mrs. TAYLOR. Yes. For a short time in order to get it started.

Of course, there are provisions in other legislation for training of personnel but there is a great gap to be filled.

Mr. ROBERTS. I am of the opinion that, as you say, the people who do a lot of volunteer work in this field are certainly entitled to a great deal of credit. It is my feeling that it makes just as much sense to provide some staffing for the mentally retarded situation as it does to the Federal Government in the field of mental health for a period until we can get off the ground.

Mrs. TAYLOR. Yes. I think especially with the new approach which was mentioned by the speaker just before me, Mr. Emmerich, this new approach which was also emphasized by the President in his message to Congress for both mental health and mental retardation problems.

We feel that this bill probably is the first step in providing for this new approach which is buildings, and certainly they must have manpower to go along with them.

Mr. ROBERTS. Thank you very much. We appreciate your statement.

Mr. O'Brien.

Mr. O'BRIEN. I have no questions, Mr. Chairman, except to compliment the witness on the statement and express my agreement with the need for some staffing.

I have observed in my community the heroic efforts of these parents you mentioned, the tremendous work that they do. I have also

noticed that they are more successful when they can revolve around some trained personnel.

With that as a core I think that we can make even greater use of the charity and kindness of the parents and other volunteers.

Mrs. TAYLOR. I certainly agree with you, Mr. O'Brien.

Mr. ROBERTS. I think we have some precedent for it.

I remember when we passed the migratory workers bill, most of that work was begun, of course by local people but we in that field do provide that the Federal Government will be responsible for the leadership and technical assistance, teams to go out and help to get the ball rolling.

I would hate to see us try to go out and build a lot of buildings. I think the personnel will be a lot more important. I would much rather see some trained people operating in maybe a building that had been used for a school house or some other purpose, I would much rather see real competent people directing a program of real help than to see a beautiful structure and no research workers or no trained people there in charge.

These people started with it.

Mrs. TAYLOR. I think we had some experience with that in the beginning of the Hill-Burton Act where buildings were built and then they did not have the staff for these hospitals.

Mr. ROBERTS. I have seen that same situation.

I recall in one part of my State we had a beautiful hospital and the day it was dedicated they did not have a staff that was able to take care of the people in the hospital.

Mrs. TAYLOR. I think along this line you may want to consider instead of having 8 or 10 large facilities it may be better to have more smaller ones in the communities where they are needed and then it might be less difficult to get the staff.

Mr. ROBERTS. I certainly appreciate your statement, and I think this particular part is something this subcommittee will take very serious note of.

Mrs. TAYLOR. Thank you.

Mr. O'BRIEN. May I ask a question of the Chair before we have the next witness?

Mr. ROBERTS. Yes.

Mr. O'BRIEN. Have any opponents of this legislation requested the opportunity to appear before this subcommittee?

Mr. ROBERTS. Not to the knowledge of the chairman. So far, we have had no witnesses in opposition. You remember the witness this morning but he spoke for the bill as a member of the council of AMA. To my knowledge, we have had no opponents.

Mr. O'BRIEN. May the record show, Mr. Chairman, that the question was asked.

I have been impressed up to this point in the hearings with the broad sweep of the occupations and interests of the witnesses who have spoken for this bill, some with suggested amendments but in the main, for the legislation.

I would urge, Mr. Chairman, that if any people, whoever they may be, are contemplating an attack upon this legislation at some later time, that they notify the chairman of their desire to testify before

the hearings are concluded so that we may ask them the proper questions.

You know and I know that very often we go in with legislation of this kind. People who have remained on the sidelines start waving cash registers and reading statements at us, ignoring all of the pertinent matters which are before the committee.

So, I would like to more than invite, Mr. Chairman, I would like to challenge those who are opposed to this legislation to come before this subcommittee where they can be heard and properly questioned.

Mr. ROBERTS. I think that is an excellent suggestion. I might say that while we are very anxious to get this bill out, if there are people who are opposed to it we certainly would be willing to schedule additional time to hear them, but I am so pleased with the unanimous support that the bill has had up to this point that I do not know whether I want to take a searchlight and go out and look for opponents or not.

Mr. O'BRIEN. I do not either.

It becomes a little frustrating at times when the committee, which has the greatest knowledge of the legislation is not confronted with the opposition, the opposition suddenly appears before some other group which has not listened to any of the testimony.

I think that if they are going to attack it later on, that there is to time like the present. I have no knowledge of any people who do, but my questions throughout have been devoted to answers to possible attacks later on.

I have become convinced from what I have heard here, if I did not have a single humanitarian instinct in my makeup, that I could make a case for this legislation from a strictly economic viewpoint.

Mr. ROBERTS. I think you could well demonstrate that these two bills would save a great deal of money, certainly a lot of money at State level. It all amounts to the same thing, it is the same group of taxpayers that is paying the bill. Certainly I think, as far as the testimony we have had, that it would not only mean perhaps a lot more activity as far as the private practice of medicine is concerned, but it would mean that the custodial care will probably be decreasing all the time and you will have this done at a community level where you can do something about it, more than simply a case of providing custodial care.

Mr. O'BRIEN. I just do not want this to become a cost item in an unbalanced budget. I think it stands on its own feet and should not be swept aside by any concern about its impact.

If we are going to make cuts, Mr. Chairman, this is the last place that I would suggest it.

Mr. ROBERTS. I certainly agree with you.

Mr. O'BRIEN. I do not want to prolong my statement here but we did have one statement from one witness who suggests that these public hearings be slowed down considerably and extended for at least a year. I understand we are going to hear that witness testify. I am pleased to hear that because maybe we can have some answers.

Mr. ROBERTS. Mr. Harold Edwards of the Pure Food Association.

STATEMENT OF HAROLD EDWARDS, EXECUTIVE SECRETARY OF THE PURE FOOD ASSOCIATION OF AMERICA, WASHINGTON, D.C.

Mr. EDWARDS. I would like to preface my formal statement with just a few remarks, particularly in regard to the availability of teachers, instructors and interested people who will do the handling of the mentally retarded.

I happen to be very closely associated with a gentleman that is doing a wonderful job in trying to answer this problem. He is trying to get educational facilities set up in at least one nationally known university and his problem, of course, his great problem is money, getting the funds.

Then, his second problem is selling the size of this great problem to the university heads and others that would have the final word on whether such training facilities for instructors could be set up.

So, although I have some opposition to certain facets of this legislation I want to say emphatically that I know at first-hand that modern facilities are needed. I think my formal statement that I will read will bring out the basis of my appearance here today a little more clearly.

Mr. Chairman and members of the committee: It is indeed a generous thought to provide modern facilities for the treatment and housing of mental patients. You, Mr. Chairman, and members of the committee deserve praise for your admirable concern.

There is great danger, however, that this kind of giant Government plan with all its attendant publicity may interfere with solving the toughest problem of all, and that is, the neglect of mental patients by their relatives and friends.

It is rather well established that such widely heralded proposals can lull the public further into its chronic neglect of a duty, of kindly acts that only individuals can fufill.

Money, buildings, drugs, science, cannot replace this great human need which, we believe, has historically been the biggest factor of all. The continued interest of one individual from the outside supplies more rehabilitating influence than all other factors combined.

I am presently working to get one young man released from a State hospital. His greatest resolve, once he is released, is to organize groups of ex-patients who will know from long experience how to supply this essential human ingredient.

This young man's experience with his doctor in charge points up another serious shortcoming which calls for extended investigation by Congress. We refer to the general caliber of doctors directly in charge of patients. In this instance the stodgy, old-fashioned-type doctor conducts himself in the manner of a tyrant.

He has almost completely undone the good work that has taken 2½ years to achieve—I should have explained, with this one individual. It is well known that the caliber of doctors in this work leaves much to be desired. They are all too often misfits, incompetents, or alcoholics.

We are going to try to list briefly as possible the several salient features of our remarks intending them as constructive information to aid your honorable members in their determinations.

(1) We earnestly suggest that these public hearings be slowed down considerably and extended for at least a year. Mental health and

retardation seem far too serious, far too comprehensive to be decided in this short space of time. We are thinking particularly in terms of mental retardation and certainly there were an awful lot of unanswered points raised and an awful lot of unanswered questions raised in regard to this rapidly exploding matter of mental retardation.

(2) It is our sincerest conviction that an entirely separate set of public hearings be instituted for the retardation bill. Too little is known and there is far too much ground to cover to limit the retardation issue so briefly.

As an aside I do believe these bill were introduced on February 11 and the Senate has already completed public hearings on them and now we are drawing to the close of these hearings. I think emphatically that more time should be requested on this issue of mental retardation, Mr. Chairman.

(3) That in line 7, page 1, of H.R. 3689, be amended to eliminate the words, "And related aspects of human development," and that in lines 19, 20, 21, and 22, the words, "or research and related purposes, relating to human development, whether biological, medical, social, or behavioral, which may assist in finding the causes, and means of prevention, of mental retardation," since they are vague and irrelevant.

(4) The concept of psychiatric beds in general hospitals will compound the "hospital treatment" atmosphere that has long handicapped efforts toward reform. Homelike facilities are a must for both mental health and retardation facilities proposed here.

(5) Too little has been brought out to date on the results of continued tranquilizing drugs. While simplifying one of the major problems in daily control of patients they have contributed little in reducing the number of patients. This is brought out in the high readmissions.

(6) The forward looking suggestions of State mental health tribunals must be incorporated into any legislation of this broad, comprehensive plan. Such entirely independent patient appeal boards are quite indispensable to an improved outlook. A description of the British system is included in the body of this statement.

(7) Provision must be made for religious belief, religious practice, which occupy so important a place in mental health. The newer homelike facility can contribute importantly here.

(8) To help solve this gargantuan retardation problem about which so little is admittedly known, a separate medical organization must be conceived of. This should be entirely separate from the present, traditional concept. Retarded youngsters do not respond to psychiatry like adults, nor to drugs—they do respond so wonderfully to love, affection, kindly interest, and human warmth.

These cannot be considered products of a modern medical school. Yet, a limited medical training should be available to a minority of workers in this brandnew field. Although the word "nutrition" has been suggested in this present instance, nothing is being carried through.

So, let us begin from the ground up where a short term medical training shall be on an even footing with advanced, modern nutritional training for workers. Obstacles to this should be few since it is admitted on all sides that little or nothing is known as to the cause of the condition.

Dr. Tom Spies, famous nutritional researcher, made a most thorough study of the mental-nutritional relationship at the University of Alabama and again at Northwestern. The pattern established at these great universities are still readily available despite Dr. Spies' untimely death some 2 years ago.

Over 30 years ago Henry Ford was quoted in one of his famous interviews on the subject of intelligence and morals, and worth noting here. Mr. Ford states, "First discover the vital connection between food and attitudes of mind, between food and the images of mind and body, then experience a proper course."

Although he was far from a scientist, Mr. Ford's views were ably seconded by the famous Dr. Royal S. Copeland, at that time, a U.S. Senator from New York.

We may look to Great Britain for admirable progress in mental health. It is true we have a few notable institutions here, such as the great Massachusetts Mental Health Center in Boston. In Britain they believe there should be no formality about entering a mental institution, and that the number of people in mental homes has been higher than it need be.

To implement this view they have set up practical mental homes, and hostels. As an example, there is Cassel Hospital at Richmond, outside London; here "depth psychology," or "talking treatment" is practiced.

Drugs are hardly used. The average monthly drug bill for the entire hospital, including tranquilizers, is $4.20. Instead, treatment at Cassel concentrates on helping the patient cope with his ordinary day-to-day problems.

At our St. Elizabeths, here in Washington, tranquilizers are a must three times a day. A patient who might try to avoid the drugs has them administered forcibly.

At Cassel mothers are encouraged to bring their newest born with them, to avoid the difficult readjustments resulting from neuroses already present. Husbands spend weekends with wives and vice versa. These innovations do much to ease the lost and lonely feeling that is so much a part of mental depression.

Once released, patients are encouraged to come back for periodic talks with their doctor whenever things get out of hand for them, even to spending a night or two at the hospital.

Cassel patients do most of the day-to-day running of the hospital. They prepare menus, serve meals, and arrange the social activities. There is a special playroom for the children. Nurses wear ordinary clothes, to make the atmosphere as much like home as possible.

Over there, in general, patients suffering from mental illness can consult their family doctor or receive specialist advice at hospital outpatients' clinics, as they would for any other kind of illness, and if they need to enter a hospital for treatment they can do so without formalities.

If patients or their relatives are unable or unwilling to make the necessary arrangements for admission to a mental hospital, it is the duty of a mental welfare officer of the local health authority to do so.

Where necessary in the interests of society or of the patients themselves, mentally disordered patients can be compulsorily de-

tained. However, compulsion is regulated in England and Wales by the Mental Health Act which supplies clear-cut guidelines.

The patient, or his relatives, may appeal against detention to a mental health tribunal, an independent body appointed not by the Minister of Health but by the Lord Chancellor, a top government official who is Chancellor of the House of Lords.

In Scotland, the system of safeguards and legal responsibility are even more extensive. When a patient is to be compusorily admitted, or held, or placed under guardianship, an application is made to the hospital management board, and this must be approved by a judicial authority, or sheriff.

A patient with a grievance can appeal to the sheriff or complain to the Mental Welfare Commission. This commission is an independent, central body. It has a right to discharge patients from detention at any time, or to investigate wrongful detention or improper treatment.

This system has happily governed the British approach to mental health administration for more than 50 years. It has materially lessened the entire mental burden over there, and it illustrates the charitableness and human understanding that has long guided their thinking. (Any letter or appeal sent to the commission is not subject to censorship.)

I would like to add here, Mr. Chairman, I cannot think of any reason why it could not be stipulated in this present legislation that guidelines and safeguards in these present plans be set up because we do not have anything here in this country.

The real authority over a patient, and I am thinking of this young man that I mentioned earlier, the authority and the only authority that he can appeal to directly is the doctor that is immediately in charge of his residence where he lives.

Resuming the formal statement, in contrast, we most often treat Americans, with ordinary neurotic problems, the same as common criminals. The sheriff moves in with the warrant, the mental suspect is locked in the county jail, behind bars, alongside jailbirds of every stripe.

It is not that these people are considered dangerous, we simply do not have any better system of handling them while they await probate court action on their commitment.

Furthermore, it has been the almost universal practice of administering shock treatment of some type once detention begins, although there has been a lessening of this since the advent of the tranquilizer drugs. However, this is still the system in general.

At this point, some way must be found to change public understanding of the mental problem. A highly organized system of public information, and a cult of so-called science writers is greatly responsible for creating an almost failure-proof health image.

With the development of the tranquilizers and the drive for ever bigger, annual Government research budgets, the public relations expert has built up a concept of scientific mental health treatment and competence all out of proportion to the ability to deliver. Truly the American public has been sold a bill of goods—that medical science, psychiatry, and modern drugs have eliminated mental health as a serious problem.

We note that limited reference has been made in the hearings to nutrition and metabolism in mental health. The Thalidomide tragedy firmly established that the intake of chemical substances does vitally effect glandular activity in reproduction and growth.

There is nothing new about this understanding, it is simply that the facts have been conveniently ignored in our monopolistic system of producing only more drugs for more and more ailments. There is plenty of authoritative, scientific fact accumulated in actual experience with people.

The Pure Food Association believes we already have enough proof of the link between mental health and nutrition to slow down this retardation explosion. When we say nutrition we include, of necessity, all beverages, use of tobacco, the wide use of proprietary and prescription drugs, vitamins, and so forth.

But this legislation indicates the "experts" are continuing to ignore long-established scientific fact that chemicals, along with the principals of modern, informed nutrition do count importantly in mental health, and seriously so in retardation.

In behalf of this committee's deliberations we shall list a few of the well-known researchers in this field whose works are readily available. One of the early, famous researchers was Dr. Ancel Keys. Impressive work has been contributed by Dr. Seale Harris, at University of Alabama; by famous Dr. Tom Spies, at both Alabama and Northwestern Universities (as mentioned above); by Dr. Sidney Portis, at University of Illinois; Dr. Harry Saltzer, at Cincinnati University; and Dr. Stephen Gyland.

(Some articles by Dr. Spies may be found following Mr. Edwards testimony.)

Also, in dentistry, the fine work of Dr. Melvin E. Page and Dr. Weston Price. Many more famous names can be added to this list along with their works. Not the least of these should be Dr. E. M. Abrahamson, and his great work, "Body, Mind, and Sugar," written expressly for the layman.

We shall be glad to add to this list, as you may desire, from time to time.

Mr. ROBERTS. Thank you Mr. Edwards.

Among the authorities you mentioned, of course I knew quite a bit about the work of Dr. Tom Spies while he was in Birmingham, Ala., in the field of pellagra, which he conquered with his knowledge of nutrition and, of course, I know Dr. Harris personally.

Mr. EDWARDS. You knew Dr. Seale Harris?

Mr. ROBERTS. Yes; quite well.

Mr. EDWARDS. A real pioneer in this field.

Mr. ROBERTS. He came from a really fine family out of the northwestern part of Georgia near my home. I believe his brother is a long-time senator from the State of Georgia and Dr. Harris practiced in a hospital in Birmingham.

I have gone along with some of the things you point out in your statement, but it seems to me that in many parts of your statement you make some very strong arguments for the bills.

Mr. EDWARDS. We intended to, Mr. Chairman, but with the suggested amendments.

Mr. ROBERTS. I hope I did not get the wrong impression. I agree that there is a great deal of help I think that we could get that we have not gotten, more information in the field of nutrition and its relative value and effect on mental and physical health and so forth.

It seems to me that we have been pursuing this legislation for many years, as has been mentioned earlier. The studies started on the Mental Health Act of 1956 under the leadership of Mr. Priest. I feel that while there is a lot we do not know, that if we put this off until we know more you may simply complicate the problem.

It seems to me that now is the time for this legislation, is about as good as you are going to get. For a long time we could not, I think, have received the support that we have had because we had to wait for the public to change its mind. Now you mention many instances of the treatment in hospitals such as Saint Elizabeth's, and I suppose it is probably typical of many of the similar institutions.

It seems that what we are trying to do with these bills is to do exactly what you say. We are trying to keep the patient in an environment of his home, near his relatives, near the things that he is accustomed to.

You point out that in some of the English institutions there are these visits between husbands and wives. They run the institutions, the patients do themselves. It seems to me that we are trying to do exactly what you want done in these bills.

Now, I agree with you that I think some of the treatment that mental cases get in county jails, I am acquainted with the fact that many times veterans are put in jail until they can get a bed in a veterans' facility, which in the case of the non-service-connected veteran may never get one with the crowding that we have.

I feel that it is cruel, it is not warranted, it is the worst situation I know anything about, to, as you say, put these people who are really just sick as they would be with influenza or typhoid fever and put them and place a stigma that we place upon a criminal, and that is what we do.

I would agree with you on that. I do not know how we will change that except through public education and understanding of the problems that are presented in this field. There again that is a local, State sovereignty proposition with which we in the Federal Government have no way of really getting to it.

I think your statement is certainly very sound in many ways and I want to thank you for it.

Mr. EDWARDS. If I may make one more comment, Mr. Chairman.

I found it a little bit hard to write a good statement, well-balanced statement, and try to deal with both pieces of legislation. That is why I tried to introduce the suggestion that they be entirely separated and separate hearings be held on retardation because there is so much that is undone.

To follow the remarks that Mr. O'Brien made a few moments ago, you know there are a lot of people that will come to Washington but they are individuals and they are not sponsored and they don't have their railroad fare paid, and so forth, and it takes time for them to get organized.

Now, I have several expressions of people like that and they are not necessarily in the crackpot class, either, I mean they are people

of substance. Particularly, I think we can have people here that will elaborate on this nutrition-mental proposition, you see.

Mr. ROBERTS. Well, I think you have a point.

One of the things that I suppose you noted in some of my questions, I indicated that I do not want to see the mental retardation problem minimized. I think it may be the more important of the two problems, in my opinion.

Mr. EDWARDS. It is growing faster than the other.

Mr. ROBERTS. That is correct.

In some of the cases, particularly the child, you have an opportunity here of restoration, and in many cases, in my opinion, a large majority of the cases, those that are well known in needs or have been victims of some chronic type of illness along with this.

So, I do think that you have performed a valuable service to the community in pointing up the fact that we must not neglect this other problem.

Mr. EDWARDS. You are very fine, very broad, very generous, Mr. Chairman.

Mr. ROBERTS. I am going to see that that is kept in the record.

Mr. O'BRIEN. I might say I did not have in mind the individual who might have thoughts, I had in mind the practice of some people who intend to make their views known but fail to do it before the committee with the primary jurisdiction, sort of bide their time when we are before a committee which might not be as fully acquainted with the problem as the committee with original jurisdiction.

I want to join with the chairman and I think that what you suggest is that the bills would go along the path you have in mind but that you believe that there are certain unknown or unresolved elements that might require longer consideration.

Perhaps I am an exponent of the half loaf. I thought that as long as we are moving in the direction you have in mind, why not accept that blessing with the full realization that the committee will still be in business and that perhaps at some future time after we have resolved part of the problem we can look into the matters in which you have an interest.

Mr. EDWARDS. That, I think, would be particularly true in regard to the training of competent teachers for mentally retarded children. I am just thinking that is perhaps what you have in mind.

Mr. O'BRIEN. Yes.

Mr. EDWARDS. I would like to emphasize that again, that that should be the No. 1. I mean it seems very logical; at least it should be, the No. 1 effort is to insure that these competent people do get competent training.

Mr. O'BRIEN. I think, too, Mr. Edwards, if we can bring this full problem closer to the community level that we might have a greater public demand for some of the better things that you have in mind than if we continue to shove these people off into what I have described as "windswept moors."

There is a tendency to brush it under the rug. If you get at the community level where you are actually considering the staffing of these facilities, I think that there would undoubtedly be a demand before the local community council or the State legislature, that these people who staff these facilities, will not be of the type you describe.

Mr. EDWARDS. That is a fine thing, Mr. O'Brien, but it is not going to come into effect quickly and we are still going to have to live with the old pattern for many, many years to come.

Mr. O'BRIEN. That is right.

Mr. EDWARDS. I tried to incorporate that without making it too lengthy in my statement.

Mr. O'BRIEN. That is right and that is one reason why I would like to do something now so that we won't have to put up with the old pattern in its complete present form any longer.

I think that the problems you mention will continue to exist.

We are still going to have these State institutions, we are still going to have the problem of the caliber of the attendants, and I am sure that you didn't mean that all of the fine doctors in these institutions are misfits, incompetents or alcoholics.

Mr. EDWARDS. Not all, but a rather sizeable proportion, Congressman, I regret to say.

Mr. O'BRIEN. I am in no position to judge the accuracy of that statement.

But, I would think, that if we had a facility in my hometown where a substantial percentage of the physicians or the attendants were misfits, incompetents, or alcoholics, that you would get a very loud, quick, scream of protest about it.

So, I do not think that we are too far apart, Mr. Edwards. That is what I am trying to say.

Mr. EDWARDS. Thank you.

Mr. ROBERTS. Thank you, Mr. Edwards.

Mr. EDWARDS. Thank you.

(The following material was supplied for the record by Mr. Edwards:)

[From Postgraduate Medicine, March 1955—Guest editor, Tom D. Spies, M.D.]

PELLAGRA—SECONDARY TO ANTIOBESITY DIET

A 36-year-old white woman was brought to the hospital with a "nervous breakdown." She was in good health until eight months previously when her physician advised her to lose some weight. She could not afford lean meats and fruits. Her diet consisted chiefly of carbohydrates, refined fats and small amounts of proteins. She lost weight rapidly, but after eight months she was extremely nervous and irritable. Dermal lesions diagnostic of pellagrous dermatitis appeared on the anterior aspects of both ankles (figure 54). Response to 100 mg. of nicotinic acid five times a day was prompt, and she was discharged feeling physically and mentally well.

Comment: Obesity is always tragic, and its hazards are terrifying. One of the most pitiful and perhaps unnecessary hazards is in prescribing antiobesity diets with little concept of the severe metabolic disturbances which may result. While no one questions that it is desirable for an obese person to lose weight, so often physicians prescribe a low fat or low sodium diet without considering that the patient has a low income and that such diets usually are relatively expensive. Few physicians pay any attention to the change in disposition, the development of strange new symptoms, or the feeling of depression and irritability which often follow dietary restrictions in the obese.

HYPERTHYROIDISM

(Case 29)

A 27-year-old Negro woman was brought to the hospital complaining of "swimming in the head, nervousness and jumping of the heart." For more than a year she was unable to stand noises or get along with her family. She "went to pieces"

easily, cried almost constantly, wanted to kill herself, was unable to sleep, and was so warm on even the coldest night that she could not use bedclothes. She lost 45 pounds in a year. Her doctor thought she had high blood pressure and "kidney trouble," but when she did not improve she stopped going to him. Some months later she noticed "popping of the eyes." From the photograph in figure 84 it can be seen that her thyroid was enlarged and she had exophthalmos.

Physcial examination showed a well-developed woman with obvious acute hyperthyroidism. Her blood pressure was 130/80 and her pulse 128 or above. Her basal metabolic reading was about plus 90 percent. A surgical consultant was called, and she was given two 50 mg. tablets of propylthiouracil three times a day and 10 drops of Lugol's solution twice a day. Four months later she felt completely normal; her only remaining symptoms were exophthalmos and the thyroid enlargement. She was in excellent condition for surgery.

Comment: Nutritional and metabolic demands are greatly increased in hyperthyroidism, and most patients do what they can to satisfy their voracious appetites if they can get the food. This, in part, helps to maintain body weight and chemical balance. This case helps to support our working concept that health is the accurate, harmonious and constant integration of all the necessary biochemical factors in the body. While the primary disturbance was of endocrine balance, the vitamin balance, electrolyte balance, control of the body temperature and the supply of oxygen to the cells were affected and the harmony of the cells was disturbed. Disturbance of mental processes and physiologic phenomena associated with emotion were noted. We cannot discuss all the many syndromes in this group, but it is gratifying to see the secondary disturbances disappear when the primary condition is relieved.

Nutrients in Convalescence and Rehabilitation

It is a fundamental biologic phenomenon that organisms, whether one cell or more, are composed of cells which arise from pre-existing cells. What is this process that starts and maintains the chemical reactions that result in the formation of cells and the elaboration of new protoplasm, and why does it not always satisfy functional needs? All too commonly, disease occurs. Physicians have always sought to ease pain and disability and to discriminate between foods that are good for patients and those that are not. Progress has been made not only through careful observations but also through trial and error.

Brilliant nonmedical investigators have aided the practicing physician. Like the practicing physicians, many of these investigators have been much concerned with illness. Dr. R. R. Williams, in accepting the Willard Gibbs Award, referred to his early contact with beriberi as follows: "In short, beriberi was a principal topic of conversation in scientific and medical circles in Manila during those early years of my enlistment with Vedder in the Philippines."

Those of us who are now concerned with the problems of chemical deterioration and how it can be chemically predicted and rectified are indebted to many famous clinicians who have described their findings. In the picturesque words of C. Lombroso: "If you should traverse the hills of Brianza and Canavese, you would most likely meet some pitiable wrecks of humanity, with eyes fixed and glassy, with pale and sallow faces and arms fissured and scarred as by a burn or large wound. You would see them advancing with trembling head and staggering gait like persons intoxicated or, indeed, as though impelled by an invisible force, now falling on one side, now getting up and running in a straight line like a dog after its quarry and now again falling and uttering a senseless laugh or a sob which pierces the heart—such are the pellagrins, poisoned by the toxins of spoiled Indian corn."

The effect of inadequate nutrition on the nervous system has assumed increasing importance as a result of the rapid accumulation of clinical, experimental and pathologic data. The isolation, recognition and artificial synthesis of a number of components of the vitamin B complex have made available adequate amounts of pure crystalline material for clinical research.

Lombroso's explanation of the mental symptoms of pellagra is simple, though incorrect; unfortunately, he did not know what nicotinic acid could do for the pellagrin. It is difficult to evaluate the status of a nutritional deficiency in man, even when there are no associated mental changes. Even the lay observer associates mental changes with endemic pellagra. The more serious mental involvement manifests itself as various psychoses: loss of memory, disorientation, confusion, excitement, mania, depression, delirium and paranoia.

Patients with pellagra may have delusions ranging from ants, insects and worms to hatchets and knives. Skin lesions may be associated in their minds with insects, pain or filth; crawling sensations and burning pains may be associated with spiders or nettles. These symptoms often precede mania, but are not necessarily associated with a true pellagrous dementia or dermatitis. These patients do not respond well to psychiatric treatment and they are made worse by administering large amounts of carbohydrates or medicines that are not antipellagric. It is significant that pellagra patients generally have poor eating habits.

Pellagrous Psychosis

(Case 38)

A 31-year-old Negro woman complained of weakness and diarrhea of 5½ months' duration. Although the symptoms were insidious in onset, she did note gradual weakness, intermittent diarrhea, abdominal discomfort, loss of weight, and increased pigmentation, roughness and induration over the elbows; she could remember no sequence of these symptoms. Anorexia, nausea and vertigo developed.

Physical examination showed her to be well developed but poorly nourished. Pellagrous lesions were seen on the elbows (figure 106), and the legs were swollen due to fluid retention. She was disoriented as to time, reacted sluggishly, and could not recall even recent events. There were periods of visual and auditory hallucinations, insomnia and confusion. She had no appetite. Figure 107 shows her diet.

We administered glucose parenterally, and she quickly became much worse. We then gave her 50 mg. of niacin amide each hour in glucose and kept the glucose intake constant. Within 48 hours her mental symptoms and edema had disappeared; appetite, strength and general condition had improved remarkably, and she became a responsible person.

Polyneuritis—(Beriberi) Due to a Deficiency of Vitamin B_1

(Case 39)

A 40-year-old white woman was relieved of pellagra after receiving 50 mg. of nicotinic acid 10 times a day. At that time there was no evidence of vitamin B_1 deficiency. She returned home and continued to eat her usual inadequate diet (figure 108) and to take nicotinic acid. Within 6 weeks mild peripheral neuritis developed; 10 weeks later it was so severe she could not sleep, and her memory became impaired. Prompt and complete relief followed the injection of 20 mg. of vitamin B_1 twice a day. She continued to eat her usual diet.

Comment (cases 38 and 39): Certain patients with mental diseases or psychoses can be relieved by chemical means. Many pellagrins complain of "burning of the feet and hands" and pain and pressure over the peripheral nerves, which indicate peripheral nerve involvement. We have shown that this is a form of true beriberi. Nicotinic acid or substances which act similarly relieve the pellagra but do not affect the nerve involvement. If vitamin B_1 is not given and if the patient continues to eat his usual deficient diet, some impairment of memory, sharp shooting and aching pains, weight loss, general weakness, and in some instances cardiac palpitations on exertion develop. Peripheral nerve biopsies show that the myelin sheaths do not stain with osmic acid. At first the tendon reflexes are hyperactive, and as the disease develops they disappear. Administration of vitamin B_1, at this stage brings prompt improvement in sensorium, disappearance of pain, and increased appetite.

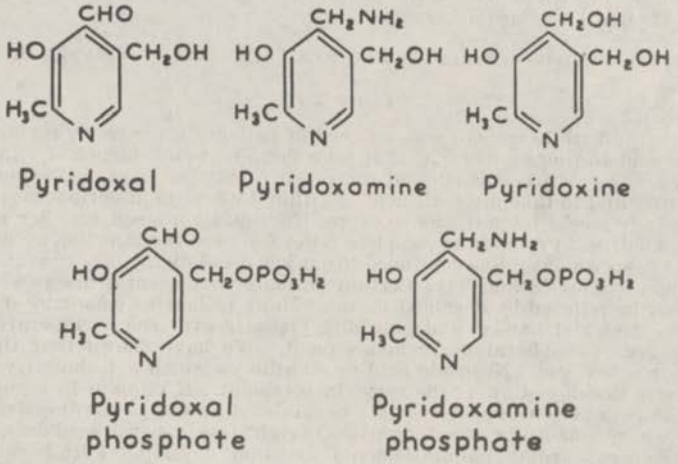
The polyneuritis pellagra is in effect the same as beriberi, since it is relieved by large amounts of vitamin B_1. Beriberi and pellagra operate simultaneously in the same patient. The deficiencies of the B group of vitamins tend to be multiple; i.e., when a pure vitamin relieves certain symptoms diagnostic of the syndrome for which that vitamin is specific but does not relieve associated syndromes, and the diet remains constant, there obviously is a lack of more than one vitamin. The dietary assessment in case 39 is in keeping with this working hypothesis (figure 108).

Pyridoxine has never received the consideration it deserves. It has had wide interest in animal and human nutrition since its description by György in 1934. The free and bound forms are shown in figure 109.

After we had shown that riboflavin deficiency occurred naturally in association with pellagra and beriberi, we directed our attention to vitamin B_6. We noted that irritability, insomnia, nervousness, vomiting, weakness, and difficulty in locomotion and coordination developed in pellagrins who received adequate nicotinic acid, vitamin B_1 and riboflavin but continued to eat a highly deficient diet. In 1939 we administered 50 mg. of synthetic vitamin B_6 parenterally to a selected group of such patients. There was prompt improvement within 24 hours, with conspicuous gain of strength and well-being and disappearance of nervous irritability and incoordination.

As early as 1940 Harriette Chick in England described convulsions in rats and pigs restricted to a diet lacking in pyridoxine. James Rinehart's work showing that monkeys on pyridoxine-deficient diets tend to develop arteriosclerosis has never received the attention it deserves. In 1950 Synderman and associates induced in a human infant convulsions thought to be due to a pyridoxine-deficient diet.

In 1951, 1952 and 1953 a mysterious and peculiar disorder of infants occurred in many parts of the United States, characterized by epileptiform convulsions unassociated with any etiologic findings. These infants had normal birth histories and grew and developed normally until 4 to 8 or more weeks of age when sudden generalized convulsions occurred. None of them had been breast-fed (mother's milk has a high concentration of pyridoxine). They had been given a proprietary formula, consisting chiefly of defatted cow's milk, vegetable and animal fats, iron, and certain vitamins, but not containing pyridoxine at that time. When the infants were fed another milk formula or were given any supplementary food, they became free of convulsions. In time Molony, Parmelee, Coursin an others showed that the convulsions were due to a diet deficient in pyridoxine and were relieved by substances containing this vitamin. The infants remained free from seizures as long as they obtained adequate pyridoxine.



CHEMICALLY IDENTIFIED free and bound forms of Vitamin B_6

An oral dose of 2 mg. of pyridoxine a day seems adequate to cure seizures caused by vitamin B_6 deficiency or to prevent seizures. Biochemically, pyridoxine deficiency can be measured by xanthurenic acid excretion following a trpytophan load.

Each person with an endemic deficiency disease has had prolonged deprivation of dietary essentials. Before the diagnostic stage is reached, much less the terminal stage, he has one or more symptoms which might be considered those of a neurosis. One must be extremely wary in evaluating in the pellagrin what might be termed "neuropsychiatric disorders." In cases of pellagra with impending relapse we have injected sterile saline without relieving the fatigue, anorexia, vertigo, palpitations, nervousness, anxiety, headaches, forgetfulness,

apprehension and distractability. Yet these symptoms disappeared promptly following the addition of nicotinic acid to the injection, and all patients remained symptom-free as long as it was administered frequently. In most instances symptoms recurred if the nicotinic acid was discontinued without the patient's knowledge.

For many years the psychotic changes have been associated with severe pellagra, but we have learned that subclinical and mild pellagra frequently present symptoms which are diagnosed as hysteria, neurasthenia or anxiety states. The study of thousands of cases has shown that these symptoms often have certain characteristics which are useful in an early diagnosis of deficiency disease. They disappear dramatically following specific therapy only to return eventually if the patient remains on his usual inadequate diet without a supplement.

Physicians still confuse what we call the initial nervous syndrome with symptoms of simple depression. Nearly all physicians see patients who are depressed, and their symptoms vary greatly in severity. The depressed patient with vitamin deficiency may consider suicide, and this possibility should never be ignored. Physicians who think in terms of severe depressive psychosis may not recognize early cases of deficiency disease for what they are but consider them manifestations of so-called simple depression (although we can see nothing simple about it). These patients lack almost completely the ability to hope, their fatigue is beyond comprehension, and they complain chiefly of insomnia, loss of appetite or lack of self-confidence. Often they are unable to make decisions, and on the whole they tend to hold back or minimize what distresses them. In such cases diagnosis should be precise and treatment early.

It is noteworthy that the psychoneurotic syndromes or anxiety states draw ther contents from the life of the patient, i.e., from his experiences and traumas; hence the basis will vary greatly from person to person. Despite this, the mental syndromes are amazingly uniform. We have classified the common symptoms with their elementary features as follows:

1. Elementary syndrome—
   (a) Psychosensory disturbances
   (b) Psychomotor disturbances
   (c) Emotional disturbances
2. General symptoms of the central nervous system—
   (a) Weakness and increased fatigability
   (b) Sleeplessness
   (c) Headaches

The symptoms of what we term the elementary syndrome are similar to those that may be found in diseases affecting the thalamus and basal ganglia; those of the second group characteristically accompany general disturbances of the central nervous system.

The psychosensory disturbances cause these patients to dislike bright lights and bright colors. Noises annoy them to the extent that a door slamming or a child screaming produces serious emotional shock. As the disturbances become more severe, noises become unbearable, and odors so disagreeable that they produce nausea and vomiting. Odors previously unnoticed or merely unpleasant produce acute distress, and foods once relished are disliked. Patients are "on edge" and "uneasy," and "something is bothering or hurting" them. They complain of great weakness and dizziness, and abnormal skin lesions may or may not be present.

Psychomotor disturbances likewise are pronounced, even in the early stages. Patients describe themselves as "jittery, restless on the inside and tense" or say they are "going to have a quarrel" or that "a flash of light makes me jump and twitch." Many state that they are apprehensive, and their appearance indicates an anxiety state. As a rule, the emotional reactions are increased, and they are depressed and sad. They have phobias and fears, although they make a conscious attempt to suppress them. Two-fisted men say, "I am scared to death," and yet do not understand why. They constantly expect some sort of impending disaster to occur.

The more one studies these symptoms, the more one is impressed that they are as fundamental to pellagra as are dermatitis, glossitis and dementia. Sometimes classed as physical and sometimes as mental, these emotional disturbances frequently are the only evidence of altered bodily function which is present relatively early in deficiency states. They respond to specific vitamin therapy, whereas similar symptoms occurring in persons without deficiency states do not.

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Persons who express pleasant emotions do not come to us as patients; hence when we use the word "emotional" it connotes an unpleasant experience. The most frequent emotional outbursts are concerned with fear, apprehension, anger, hostility, depression, extreme sensitivity, and general emotional instability. Sometimes these persons appear to have what physicians might call "simple anxiety states," or the picture may be that of "anxiety neurosis" or "anxiety hysteria." Nearly always such persons have insight, and in discussing what we call their pseudo-hallucinations they often state, "It was just my imagination." Almost without exception, patients complain of a poor memory—a mother forgets where she left her child; a housewife cannot remember how to prepare a dish she has made many times. Saline injections produce no benefit, but administration of thiamine and nicotinic acid results in truly amazing personality changes. Within 30 minutes to 20 hours a timid, apprehensive, shrinking person becomes a smiling and cooperative individual.

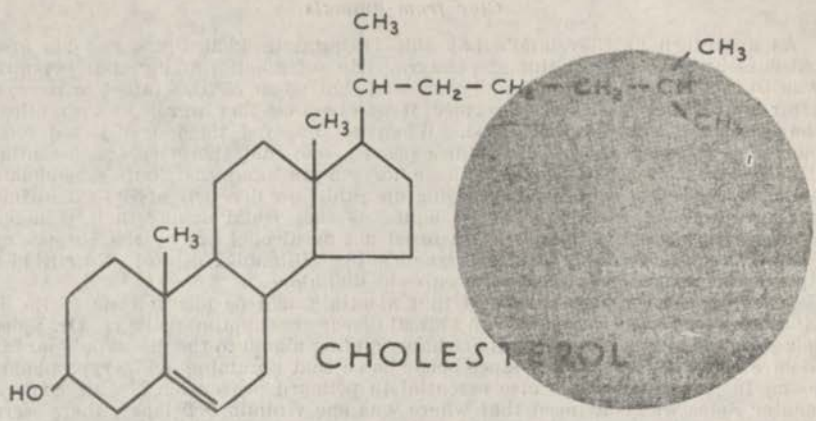
We demonstrated that in neuropathy of vitamin B_1 deficiency associated with endemic pelagra, cerebral uptake of oxygen is less than normal and glucose utilization is greatly decreased. These persons also have structural changes in the peripheral nerves. These studies were the first to show that the cerebral cortex does not function normally on a chemical basis in human beings with vitamin B_1 deficiency. From the prompt responses one must consider that there are minimal structural changes; we call them "biochemical lesions." They are not structural to gross examination and are reversible with prompt and adequate therapy.

We have also studied patients with psychoses unassociated with clinical evidence of deficiency disease. Their response to treatment is unpredictable, irregular and not too satisfactory. Striking improvement in some cases makes us wonder if there is coexistence of a mild deficiency state and an organic psychosis. We know that cerebral arteriosclerosis eventually results in decrease in the size of the brain, narrowing of the convolutions, loss of ganglion cells, atrophy of the glia and, of course, prominence of sclerotic vessels. The patient may be irritable, obstinate, penurious and morally lax, and it is well known that he tends to have failure of recent memory. This may advance to the point of his becoming confused, agitated, paranoid or delirious.

The rising tide of longevity among our population with its accompanying tragedies increases our medical responsibility in relation to senile psychoses. We must understand what goes on and how to correct it. Many of these troubled, tired, devitalized, and mentally confused older people can be aided by someone's making certain they have an adequate diet rich in vitamins and minerals in a suitable, edible form. They should have vitamins and additional medication for coexisting diseases. It must be kept in mind that they cannot be depended on to eat properly or take medicine regularly. Detailed application means a hopeful outlook for many of them, and also that many will not have to go to homes for incurables or institutions for the legally insane.

We will comment briefly on cholesterol and its association with disease due to faulty internal glandular function. Cholesterol is extensively distributed throughout all tissues and is thought to be an essential component of all cells, although its premise function is not known. It occurs in a free form and as esters with fatty acids. Cholesterol as seen in figure 110 is an alcohol. The total quantity in man is about 0.3 percent of the net weight of the body, the largest amount being in the skin and the next largest in the nervous tissue. The adrenal gland has a high concentration of cholesterol (4.5 percent), the muscle, a low concentration (0.14 percent). In the human body cholesterol comes from biosynthesis and diet.

Does cholesterol play a key role in the transport of fat or in the functions of the adrenal gland, the nervous tissue, or the skin? What is its relation to the steroid sex hormones and the cortical hormones? Is it possible that it serves as a precursor of these hormones and of vitamin D_3?



A number of pathologic conditions are indicated by the concentration of cholesterol in the blood, which normally may vary from 100 to 200 mg. per 100 cc. Cholesterol is involved in the formation of gallstones and in arteriosclerosis. The sterol content of an arteriosclerotic aorta may be 50 times that of a normal aorta. There is an inverse relationship between the total blood cholesterol concentration and the degree of thyroid activity. Myxedema, which produces strange and bizarre mental disturbances, is due to hypofunction of the thyroid gland and is characterized by a lowered basal metabolism and an increased blood cholesterol. Likewise diabetics have a predisposition to arteriosclerotic changes and symptoms. In uncontrolled diabetes the cholesterol concentration is increased. During pregnancy the cholesterol content of the blood tends to increase. Pernicious and other anemias often are associated with low cholesterol values.

Normally the cholesterol content in the human body is fairly constant. Because cholesterol can be made from acetates, the dietary restrictions prescribed by many physicians are not justified, in our opinion. Some families have a hereditary tendency to maintain a high concentration of cholesterol in the blood and tissues, as shown in the following case:

NUTRITION AND ITS IMPORTANCE IN TREATMENT AND PREVENTION OF MENTAL DISORDERS—BEING THE LIFETIME WORK OF TOM D. SPIES, M.D.

[Article reproduced from Time magazine, June 17, 1957]

VITAMINS AND THE THREE M'S

When Tom Spies was a rawboned youngster in the cotton, corn, and cattle country of northeast Texas' Red River Valley, there was enough food (Tom grew to burly quarterback build), but the average farm diet was deadly monotonous. It consisted of the three M's—meal, meat, and molasses, the meal being cornmeal and the meat fatback or side meat. A related fact—though no one at the time suspected the connection—was that every year the South had 400,000 new cases of pellagra (Italian for rough skin). The victims' feet and hands (sometimes neck and face) burned with red, scaling patches; their tongues and mouths were so inflamed and sensitive that they could hardly eat; they became lethargic and nervous, often to the point where they were sent off to mental hospitals.

Making the rounds with a doctor uncle, young Tom saw many such cases. The mother of one of his best friends died of pellagra. Tom decided to be a physician.

Last week the A.M.A. gave its Distinguished Service Award (gold medal plus citation) to Dr. Tom Douglas Spies (rhymes with fees), an eccentric bachelor who, at 55, has no home, but lives out of a suitcase in a hotel wherever he happens to be working. About 8 months of the year this is Birmingham; for 2 months it may be Havana or San Juan; the rest of the time it is Chicago, where Spies heads Northwestern University's Department of Nutrition and Metabolism. Since his school days, pellagra has been almost completely banished from the United States. And, for this gain in health, his boyhood neighbors have nobody to thank more than Tom Spies.

Clue from animals

As an intern at Cleveland's Lakeside Hospital in 1930, Spies lost his first patient—an alcoholic victim of pellagra. He set about proving that pellagra was the result of a diet deficiency, showed that when victims failed to recover after a good diet had been prescribed, it was because they were so soremouthed that they did not eat their food. When he force-fed them or injected food elements, they got better. Dr. Spies proved, too, that there was no essential difference between the North's "alcoholic pellagra" and the South's "endemic pellagra." He did this first by feeding up Skid Row derelicts at the same time as he allowed them as much corn liquor as they could drink; their pellagra cleared, showing that it had been caused not by alcohol but by the absence of essential food factors. At Birmingham's big Hillman Hospital, Nutritionist Spies worked seemingly miraculous cures by diet alone.

When other researchers showed that nicotinic acid or niacin (one of the B vitamins) was effective against an animal disease resembling pellagra, Dr. Spies seized on the clue, soon proved that simply adding niacin to the diet would go far to cure many cases. (It has since been shown that an amino acid, tryptophane, found in protein foods, is also essential in pellagra prevention.) But Experimenter Spies was convinced that where was one vitamin deficiency, there were likely to be others. He advocated supplements of several vitamins, was sharply criticized for "shotgun" treatment, has been fully vindicated by later findings.

Magic through vitamins

Dr. Spies did much to prove the effectiveness of folic acid, another vitamin, in treating several forms of anemia, including early cases of pernicious anemia. Next, at the University of Havana's Calixto Garcia Hospital, he gave folic acid to victims of tropical sprue, a wasting, debilitating deficiency disease of which anemia is one symptom.

EFFECTS OF MALNUTRITION AND UNDERNUTRITION ON NERVOUS SYSTEM

[Reprinted from the Journal of the American Medical Association, June 7, 1958, vol. 167]

We all know that mental illness is a major medical problem. I wish to discuss briefly with you some of the effects of malnutrition and undernutrition on the nervous system. Think of the loss of creativeness and productivity caused by this type of illness alone! Who can estimate its cost in terms of human misery?

In the past mental illness has been considered a social, moral, or legal problem. To me, the medical profession has the responsibility of treating patients who are mentally diseased, and of preventing mental illness. As physicians, we all know that mental disorders may be an alteration of social behavior, an abnormal emotional response, a neurosis, or a psychosis. The patient may be slightly incapacitated or he may be stricken with a major psychosis that makes hospitalization necessary. It is well to remember that mental disorders are prevalent wherever human beings exist.

Some of the custodial institutions for mental diseases are doing better and better work, but I sometimes wonder if others should not be called "containers of sick people" or "storehouses of sick people." At any rate, the problem is great. Ever since insane asylums have existed, the pellagrin has been pushed into them. These patients were not recognized as pellagrins. Usually the diagnosis was "psychogenic" psychosis. They may have been mistaken for a "schizophrenic," a "manic depressive," or some other classified type of psychosis. Having trained myself more as a nutritionist than as a psychiatrist, I was more impressed by the prolonged dietary deficiency of these patients than by their psychic alteration. Eventually my associates and I found that a lack of niacin in their diets allowed the mental symptoms to arise. After its administration, these symptoms disappeared. Thus we showed that the relief of one particular kind of undernutrition or malnutrition could produce complete relief of mental symptoms. Until this time pellagra was viewed as a mental illness practically incurable. Thanks to the recommendation by the American physician of widespread use of niacin, the disease has practically disappeared.

My associates and I are now in the process of making a 20-year appraisal of niacin as a therapeutic agent. An effect on the second generation is already apparent and can be visualized by means of the following brief case history of a mother and her daughter.

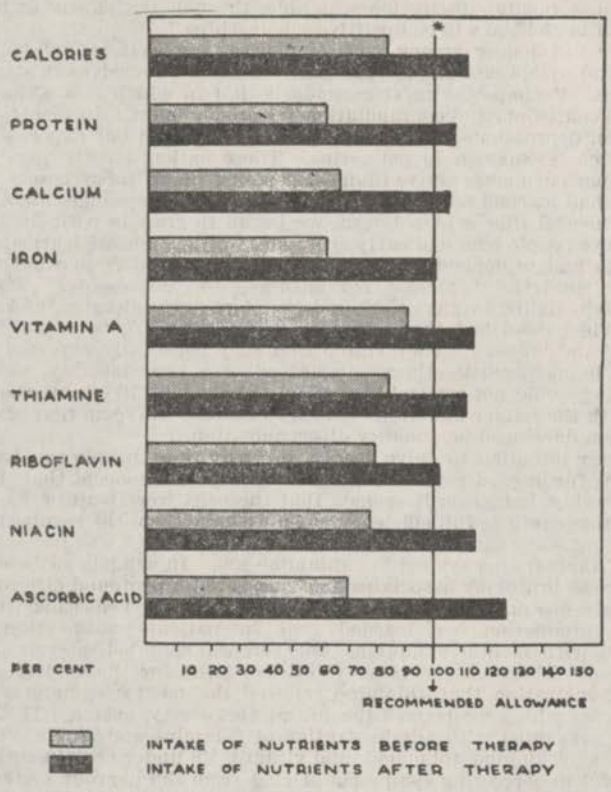


Fig. 20.—Comparative intake of nutrients before and after therapy with prednisolone and aspirin in patient with rheumatoid arthritis. Asterisk indicates allowance recommended by Council on Foods and Nutrition, National Research Council.

"CASE 11.—The mother was born in north central Alabama and was of Anglo-Saxon stock. She married a hard-working young man who also was of Anglo-Saxon extraction, and they were in good circumstances until the "depression" closed the coal mines in 1929. The husband said, "When the mine shut down, I was thrown out of work." From that time on the diet consisted of corn bread, "fat back," syrup, and occasionally beans or an egg. The wife began losing body weight, and after the birth of each child she found herself weaker and weaker. In 1933 she began having "pellagracy" each spring. This "breaking out" of the skin appeared on her ankles and forearms and each year it was associated with "nervous crying spells." Her husband said that in 1936 she suddenly "went right out of her mind," and in February of that year she was committed to a mental institution.

"Four months after the mother's admission, the above-mentioned child was born. It is this child, literally born in a mental hospital, whom I would like to tell you about now. The mother, who was treated with niacin and a better diet, took this child home, and at an early age this child did some of the housework and, when two younger children were born, helped with them. In time she went to high school, where she was an excellent student, and her teacher stated, 'She is talented and very responsible.' She graduated from high school and also graduated from the university, where she won a number of competitive scholarships.

"Comment: In summary, certainly the mother could not have been released from the institution without treatment, and it is doubtful that she could have worked hard and continued to have children if she had not had treatment from time to time in her home. But, even more impressive to me is the fact that a

baby born in a mental institution was able, through the efforts of her mother and, later, of herself, to win competitive scholarships."

The older physicians among you, of course, are well acquainted with the severe mental symptoms of pellagra that manifest themselves in various types of psychoses. Perhaps the most common is that in which loss of memory, disorientation, confusion, and confabulation are predominant. In some types excitement, mania, depression, and delirium predominate. In our experience a paranoid condition is common in pellagrins. These patients, acting on their paranoied delusions, are more active than other pellagrins with psychoses.

After we had learned how to correct the baffling brain changes associated with the severe mental illness of pellagra, we began to grapple with the problem of how to relieve people who had early symptoms only. Soon we learned that many persons who had prolonged dietary deprivation suffered from what was called "hysteria," "anxiety," "extreme nervousness," or "depression." These people disliked bright lights, bright colors, noises, odors once tolerated, and foods once relished. They described themselves as being "jittery," "nervous," "restless," "fractious," and "tense." They stated that they constantly expected something terrible to happen. Still others complained of a poor memory, a memory so poor that they could not remember even what happened 10 minutes before. The patients with the milder afflictions tended to become worse as time went on, and many of them developed personality disorganization.

It is not my intention to delve deeply into why these people could not satisfy their longing for inward peace. I could not accept the concept that their brains were irreparably damaged; it seemed that the cells were waiting listlessly and would function again at full efficiency when we gave them the required nutrients. To make a long story short, we showed that not only niacin was necessary for the integrity of the nervous system but thiamine too. In samples of blood entering and leaving the brain, my associates and I observed a profound alteration in the content of glucose and lactic acid. By studying the oxygen utilization and the lactic acid production, we learned that in patients with vitamin B_1 deficiency and with mental symptoms, the cerebral metabolism was diminished by 60 percent. These observations afforded a basis for the explanation of our clinical demonstration that thiamine relieved the mental symptoms in a syndrome complex which we termed the initial nervous syndrome. This syndrome can now be prevented with administration of thiamine and niacin. Other vitamins, such as pyridoxine, folic acid, and vitamin B_{12} under certain circumstances may be useful in correcting symptoms arising from the nervous system. Today it is with prevention that you and I, as physicians, are primarily concerned.

Our group long ago learned that the emotional disorders of older people can sometimes be overcome or relieved through the science of nutrition. So many of the older patients have an initial complaint of mental fatigue. They learn that by renewed effort they can adjust, but the process of compensation worries them and anxieties and depression may develop. They feel they are no longer needed, and many of these people have no incentive for living. They resist changes and their habits become fixed. In many the personality becomes disorganized or rigid and the judgment poor. They lise insight and accept flattery hungrily. Some of them let reality slip away. All too often they confuse manliness and sexual ability. They may develop insomnia and later may become disoriented as to time, place, and, finally, person. It is in this manner that aging brings to them accumulated emotional trauma. All too often the patients have a diagnosis of cerebral arteriosclerosis with psychosis, using age as the only criterion. In trying to aid these people, we assume that their personality is the result of their hereditary factors and their experiences, and that their incapacitation, whether due to a mild neurotic disorder or to a major psychosis, is not necessarily irreversible. Whatever their permanent cerebral incapacity may be remains to be established, but the physician must not accept it without trying to do something for the patient.

Whether among the old or the young, symptoms arise from damaged tissues. In general, we stress that the processes of protection or of repair will be impeded in tissues that are nutritionally deficient. Mere duration of life is not enough. From time to time we have given you examples of the cells being damaged but not being finished. Give them what they need and they will muster strength and come back. We do not have enough information, of course, to know all they need. The science of nutrition has only scratched the surface, but it has made some progress toward a real solution of mental illnesses.

We know that many nutrients are necessary for the integrity of the nervous system. Yet many persons with anxiety and tension states do not have their

neuroses relieved by application of any or all of the nutrients now known. Accordingly, it seemed imperative that we study the so-called tranquilizers or ataractic drugs from the viewpoint of their effect on nutrition. This study is still under way, but we can say that there is, under certain circumstances, a loss of nutrients when these drugs are used and that the safest and best way of using them generally is to be certain that there is a platform of solid nutritional therapy instituted to protect the nervous system. The tranquilizing drugs certainly are an effective aid in managing severely disturbed, hospitalized psychotics, but special attention should be given to the nutrition of these patients because some of them can be helped by nutritive methods. In the past 20 years we have relieved many persons of symptoms arising from the nervous system with synthetic vitamins and a good diet. Yet these persons had no clinical evidence on which a definite diagnosis of deficiency disease could be made. On several occasions I have talked with Dr. John T. Ferguson, who is studying this aspect intensively, particularly in older people. It occurred to me that in our clinic we could be of most service in working with the milder afflictions.

The great majority of people with nutritive failure and "functional" mental disorders respond promptly and completely to adequate nutritional therapy, but there are some who have anxiety states that cannot be corrected entirely by nutritive therapy alone and it is with those people that this particular study is concerned. Conversely, some "functional" mental symptoms arising from nutritive disorders are not corrected adequately by giving the tranquilizers alone—that is to say, vitamin therapy does not replace tranquilizers and tranquilizers do not replace vitamin therapy, but, when indicated, they should be used properly together for the benefit of the patient. Obviously we could not study all the tranquilizers so we chose meprobamate (Miltown, Equanil) because it is well tolerated, orally effective, and suited for prolonged therapy. The following brief case history is illustrative of what can be done by the judicious use of vitamin therapy and a mild tranquilizer.

"CASE 12.—A 49-year-old white man was first brought to the Nutrition Clinic of the Hillman Hospital in 1940 complaining of weakness, weight loss, photophobia, soreness of the mouth and tongue, pain and burning of the legs and feet, forgetfulness, and depression. Physical examination showed a man with nutritive failure. He had pellagrous glossitis, great dilatation of the conjunctival vessels associated with photophobia and lacrimation, excruciating tenderness in the nerve trunks of his legs, and hyperactive Achilles and patellar reflexes. His diet for many years was composed chiefly of refined carbohydrates and fats. He rarely ate protein in the form of meat, milk, or eggs. In a period of some 10 years he lost 25 lb. (11.3 kg.) in body weight. He was worse in the spring and fall of the year, and, although his course was not steadily downhill, his symptoms were somewhat more severe with each recurrence. Because of the severe pain in his feet and legs and his sleeplessness, he was given an injection of thiamine. Within 6 hours the pain had disappeared and that night he slept better than he had for a long time. We then decided to give him sterile saline solution as a placebo. The pain in his feet and legs returned within 48 hours and it was not relieved by saline solution. Without his knowledge the saline solution was replaced with thiamine, 10 mg. parenterally twice a day for a week. Again the pain was promptly relieved and he was able to sleep. For the following month he was given by mouth 10 mg. of thiamine daily and 50 mg. of niacin 10 times a day. Within 48 hours after this therapy was started his pellagrous glossitis disappeared, his appetite increased, and his forgetfulness and depression were relieved. The symptoms arising from his eyes were not relieved, and we decided to give him injections of riboflavin, 10 mg. twice a day for a week. The dilatation of the conjunctival vessels, the lacrimation, and the photophobia began to decrease on the second day of therapy, and by the 7th day the eye symptoms were greatly relieved. This patient's diet improved, but it has not always been completely adequate and he has required treatment from time to time. In the fall of 1957 he had influenza, and since then has complained of sleeplessness and a 'sick stomach.' Thiamine or niacin gave him no relief. It was decided to give him meprobamate, 200 mg. every 12 hours. After 5 days he volunteered that he was sleeping much better, and he no longer complained of having a 'sick stomach.' In the 2 months that he has been on this therapy he has had no recurrence of these symptoms."

It is important, as can be seen by this case history, to realize that the mere fact a person has nutritional deficiency does not mean that he cannot have other types of disorders also.

SUMMARY AND CONCLUSIONS

I have discussed with you a few of the many advances which have been made in nutrition in recent years. You have seen that what patients eat has much to do with their health and with their recovery from ill health. Primary or secondary nutritional disorders produce or complicate all the problems of the sick. I have stressed that we should be concerned with the prevention and with the earlier stages of disease when the disturbances are almost imperceptible and that we should not wait until these disturbances bring tremendous burdens and stark tragedies.

In the beginning man's main concern was the obtaining of food. He did not know that bodily functions are impaired when the cells and tissues of the body are deprived of essential nutrients. Of necessity, our ancestors had to obtain all their vitamins and essential nutrients as they were produced by nature. We have learned that, when fruits, vegetables, eggs, milk, fish, meat and other foods are not available in adequate amounts, or for any reason are not satisfactory, we must recommend methods of maintaining tissue integrity. We have shown how this may be done by supplementing what foods are available with certain synthetics and food concentrates. This means that the goal we are seeking is to devise methods of achieving biochemical independence for people. To do this, we know that excellent nutrition is basic, that disease is chemical in its origin, that the body cells can fight back to an amazing degree, and that our tissues, when properly replenished, can come into their own again. A number of examples are reported of how this works in actual practice. Above all, we must realize that, as physicians, we are properly the guardians of the health and nutrition of our patients, and it is for us to prevent or treat disease so as to increase their vigor, strength, and happiness.

[The studies in nutrition were done at the Nutrition Clinic, Hillman Hospital, Birmingham, Ala., at the Department of Nutrition and Metabolism, Northwestern University Medical School, Chicago, at the Hospital Mimiya, Santurce, Puerto Rico, and at the General Calixto García Hospital, Havana, Cuba.

[This paper is based to a considerable degree on concrete data obtained by the associates of the author working in Alabama, Illinois, Cuba, and Puerto Rico.]

REFERENCES

1. Spies, T. D.: Rehabilitation Through Better Nutrition, University of Cincinnati Studies in Nutrition at Hillman Hospital, Birmingham, Ala., Philadelphia, W. B. Saunders Company, 1947.

2. Spies, T. D.; Hightower, D. P.; and Hubbard, L. H.: Some Recent Advances in Vitamin Therapy, J. A. M. A. 115:292–297 (July 27) 1940. Spies, T. D.: Diagnosis and Principles of Treatment of Dietary Deficiency Diseases, Texas J. Med. 38:427–431 (Nov.) 1942.

3. Spies, T. D.; Bean, W. B.; and Stone, R. E.: Treatment of Subclinical and Classic Pellagra: Use of Nicotinic Acid, Nicotinic Acid Amide and Sodium Nicotinate, with Special Reference to Vasodilator Action and Effect on Mental Symptoms, J. A. M. A. 111:584–592 (Aug. 13) 1938. Spies, T. D.: Degenerative Diseases with Nutritional Interrelationships, South. M. J. 46:238–247 (March) 1953. Nutrition and Disease, T. D. Spies, editor, Postgrad. Med. 17:1–96 (March) 1955.

4. Mann, A. W.; Dreizen, S.; Pyle, S. I.; and Spies, T. D.: Red Graph and Wetzel Grid as Methods of Determining Symmetry of Status and Progress During Growth, J. Pediat. 32:137–150 (Feb.) 1948.

5. (*a*) Spies, T. D., and Stone, R. E.: Pituitary Adrenocorticotropic Hormone (ACTH) as Tool of Clinical and Laboratory Research, Lancet 1:11–14 (Jan. 7) 1950. (*b*) Stone, R. E., and Spies, T. D.: Further Observations on Cortisone and ACTH as Therapeutic Agents, South M. J. 45:885–896 (Oct.) 1952. (*c*) Spies, T. D.; Stone, R. E.; and Spies, H. A., Jr.: Metacortandracin and Delta 1 Dehydro-Hydrocortisone in Rheumatoid Arthritis, GP 12:73–78 (July) 1955. (*d*) Spies, T. D., and others: Prednisone and Prednisolone as Therapeutic Agents: Progress Report on Their Integration into General Medical Practice, J. A. M. A. 159:645–652 (Oct. 15) 1955.

6. (*a*) Spies, T. D.: Influence of Nutritional Processes on Aging, South. M. J. 50:216–225 (Feb.) 1957. (*b*) Reference 5*d*.

7. Spies, T. D.; Aging, C. D.; Gelperin, J.; and Bean, W. B.: Mental Symptoms of Pellegra: Their Relief with Nicotinic Acid, Am. J. M. Sc. 196:461–475 (Oct.) 1938.

8. Himwich, H. E.; Spies, T. D.; Fazekas, J. F.; and Nesin, S.: Cerebral Carbohydrate Metabolism During Deficiency of Various Members of Vitamin B Complex, Am. J. M. Sc. 199:849–853 (June) 1940.

Mr. ROBERTS. Our next witness is Clinton Miller, National Health Federation, 1012 14th Street NW., Washington, D.C.

Mr. Miller.

STATEMENT OF CLINTON MILLER, NATIONAL HEALTH FEDERATION

Mr. MILLER. Thank you Mr. Chairman.

I would like to preface my remarks with a question to Mr. O'Brien. I was not certain whether your remarks a few moments ago were an invitation for me to stand and declare my opposition to the bill or whether they were directed to those who were not scheduled before the committee. It was my understanding you were directing them not at ourselves who come before your committee as we should but those who do not come before the committee to oppose this bill.

Mr. O'BRIEN. I say the only thought I had in mind was that if there were opponents to the bill that we would like to hear from them before this committee instead of hearing about them after the bill has gone beyond our jurisdiction, which I think was a fair and reasonable request.

Mr. MILLER. That was my understanding and that is why I did not stand and say to list me as an opponent. I believe, Mr. Chairman, and committee members, that we find such serious defects in the trend of this mental health legislation that these bills would have to be seriously amended before the National Health Federation could approve them.

As I have stated before in previous testimony to this committee, the National Health Federation is a national organization of thousands of people who believe in freedom of choice in matters of health where the exercise of that freedom does not interfere with the equal freedom of another, and thereby deny him an equal freedom. We apply this rule to mental health legislation.

I should like, today, in deference to the committee's time, to confine my oral statement to a few brief remarks and submit a written statement for the record.

Mr. ROBERTS. Without objection, so ordered.

(The statement referred to follows:)

STATEMENT OF THE NATIONAL HEALTH FEDERATION

In my oral statement, I drew your attention to Dr. Chisholm and promised that I would quote more fully from his writings in my written statement.

Dr. Brock Chisholm, M.D., was the past executive secretary of the World Health Organization Interim Commission. He is considered one of the outstanding authorities in psychiatry. At one time he was a Deputy Minister of Health in the Department of National Health and Welfare, in Canada.

In a series of lectures sponsored by the William Alanson White Psychiatric Foundation of the District of Columbia, published in Psychiatry (February 1946), Dr. Chisholm delivers himself of some unmistakably lucid goals for the human race which are held by many of those psychiatrists who will control the expenditure of Federal funds at the local level, and thereby control those who administer the local falsely labeled "community" mental health clinics.

Following are some excerpts from Dr. Chisholm's lectures, "The Psychiatry of Enduring Peace and Social Progress," Psychiatry, 1711 Rhode Island Avenue NW., Washington 6, D.C.:

"The responsibility for charting the necessary changes in human behavior rests clearly on the sciences working in that field. Psychologists, psychiatrists, sociologists, economists and politicians must face this responsiblity. It cannot be avoided. Even a decision not to interfere is still a decision and carries no less responsibility * * *" (p. 5).

"Certainly the psychiatrists are not in the least backward in staking out their claim to possessing superior intelligence and know-how with which to alter materially and permanently human behavior.

"All psychiatrists know where these symptoms come from. The burden of inferiority, guilt, and fear we have all carried lies at the root of this failure to mature successfully. Psychotherapy is predominantly, by any of a variety of methods, the reduction of the weight of this load. Therefore the question we must ask ourselves is why the human race is so loaded down with these incubi and what can be done about it" (p. 6).

"The only lowest common denominator of all civilizations and the only psychological force capable of producing these perversions is morality, the concept of right and wrong, the poison long ago described and warned against as 'the fruit of the tree of the knowledge of good and evil.'

"In the old Hebrew story God warns the first man and woman to have nothing to do with good and evil. It is interesting to note that as long ago as that, 'good' is recognized as just as great a menace as 'evil.' They are the fruit of the one tree and are different aspects of the same thing.

"We have been very slow to rediscover this truth and to recognize the unnecessary and artificially imposed inferiority, guilt, and fear, commonly known as sin, under which we have almost all labored and which produces so much of the social maladjustment and unhappiness in the world * * *" (p. 7).

"We have swallowed all manner of poisonous certainties fed us by our parents, our Sunday and day school teachers, our politicians, our priests, our newspapers and others with a vested interest in controlling us. 'Thou shalt become as gods, knowing good and evil,' good and evil with which to keep children under control, with which to prevent free thinking, with which to impose local and familial and national loyalties and with which to blind children to their glorious intellectual heritage. Misguided by authoritarian dogma, bound by exclusive faith, stunted by inculcated loyalty, torn by frantic heresy, bedevilled by insistent schism, drugged by ecstatic experience, confused by conflicting certainty, bewildered by invented mystery, and loaded down by the weight of guilt and fear engendered by its own original promises, the unfortunate human race deprived by these incubi of its only defences and its only reasons for striving, its reasoning power and its natural capacity to enjoy the satisfaction of its natural urges, struggles along under its ghastly self-imposed burden. The results, the inevitable results, are frustration, inferiority, neurosis and inability to enjoy living, to reason clearly or to make a world fit to live in." (pp. 7 and 8.)

"The reinterpretation and eventually eradication of the concept of right and wrong which has been the basis of child training, the substitution of intelligent and rational thinking for faith in the certainties of the old people, these are the belated objectives of practically all effective psychotherapy. Would they not be legitimate objectives of original education? Would it not be sensible to stop imposing our local prejudices and faiths on children and give them all sides of every question so that in their own good time they may have the ability to size things up, and make their own decisions?

"The suggestion that we should stop teaching children moralities and rights and wrongs and instead protect their original intellectual integrity has of course to be met by an outcry of heretic or iconoclast, such as was raised against Galileo for finding another planet, and against those who claimed the world was round, and against the truths of evolution, and against Christ's re-interpretation of the Hebrew God, and against any attempt to change the mistaken old ways or ideas. * * * We all recognize these reactions as those of the immature, the inferior, the guilty, which are not found in the mature, integrated personality. Freedom from moralities means freedom to observe, to think and behave sensibly, to the advantage of the person and of the group, free from outmoded types of loyalties and from the magic fears of our ancestors.

"If the race is to be freed from its crippling burden of good and evil it must be psychiatrists who take the original responsibility. This is a challenge which must be met. If psychiatrists decide to do nothing about it but continue in the

futility of psychotherapy only, that too is a decision and the responsibility for the results is still theirs. * * *" (P. 9.)

"Can such a program of re-education or of a new kind of education be charted? I would not presume to go so far, except to suggest that psychology and sociology and simple psychopathology, the sciences of living, should be made available to all the people by being taught to all children in primary and secondary schools, while the study of such things as trigonometry, Latin, religions and others of specialist concern should be left to universities (p. 10).

"Relatively suddenly, over a period of only a few hundred years, more recognizably in the last ten years only, and finally quite unmistakably in the last few months, everyone has become a world citizen * * *" (p. 12).

"Should not the prospective groups of psychotherapists employ advertising and sales organizations in order to drag in customers? Should discounts be offered for treatment of whole families? Should attempts be made by the profession to induce governments to institute compulsory treatment for the neuroses as for other infectious diseases?" (p. 15).

"It must be clear to every person who is able to think in terms of evident reality that we cannot any longer afford to shelter and protect the old mistaken ways of our forebears" (p. 17).

"There is something to be said for taking charge of our own destiny, for gently putting aside the mistaken old ways of our elders if that is possible. If it cannot be done gently, it may have to be done roughly or even violently—that has happened before" (p. 18).

"* * * Let us discard the bromides which have kept us drugged, obedient to the old people and afraid of their displeasure. Let us accept our own responsibility to remodel the world in bolder, clearer, more honest lines. Let us stop prostituting man's noblest and highest development, his intellect, to the service of guilt and fear and shame" (p. 19).

MALNUTRITION—MENTAL ILLNESS—MENTAL RETARDATION

We wish to direct this Committee's attention to evidence supporting the theory that a faulty diet can be a major cause of mental illness and/or mental retardation.

The following story was reported in the Chicago, Ill., Tribune, December 28, 1962. It would seem to indicate that the Federal Government might more wisely spend a major part of the money it has available on programs to investigate the deficiencies in our diets that might be responsible for creating mentally ill or mentally retarded children. The story follows:

"BABY FORMULA IS DEFICIENT; AWARD $125,000

"NEW YORK, December 27 (AP).—A $125,000 settlement was reached today in a half-million-dollar suit that charged that a vitamin deficient baby milk formula caused a child to become mentally retarded.

"Brooklyn Supreme Court Justice Benjamin Brenner approved the offer made earlier this month by American Home Products corporation to Frank and Mildred Cervo, who charged that their daughter, Jo-Ann, now 10, became retarded after being fed the formula. Liquid S–M–A, was produced and distributed by Wyeth Laboratories, a subsidiary.

"The formula was withdrawn in 1953 after the Food and Drug Administration reported that it was deficient in vitamin B–6. The child suffered convulsions eight months after her birth and was taken to a hospital, where her diet was changed and the convulsions stopped. Dr. Snyder Carter, of Columbia Presbyterian medical center testified that the formula had caused the convulsions, which produced a lack of oxygen, resulting in brain damage."

SYMPTOMS OF MENTAL ILLNESS ASSOCIATED WITH DEFICIENCY OF NICOTINIC ACID

In their chapter on pellagra, Drs. Franklin Bicknell, and Frederick Prescott have the following to say:

Mental Symptoms. In pellagrins mental symptoms developed in one-third to a quarter of the cases if untreated. It has been estimated that in Italy, when pellagra was rife, four to ten per cent of pellagrins became permanently insane. Symptoms are exceedingly varied. A feeling of tenseness, irritability, mental depression and emotional instability are fairly common. Patients weep without cause and insomnia is frequent. Melancholia, lethargy, and stupor are common,

but confused states with hallucinations are also seen, as well as excitement, mania and delerium. The mental symptoms, which are often the first to appear, are particularly amenable to nicotinic acid therapy.

The mental symptoms of pellagra have been specially studied by Frostig and Spies (93), who describe the symptoms of the initial nervous syndrome. They are: hyperaesthesia to all forms of sensation; increased psycho-motor drive; increased emotional drive with a definite trend toward depression and apprehension; weariness and increased fatigue; headaches and sleeplessness; loss of memory; and confusion. In general the patients appear to have anxiety states with depressive features. There are also types in which excitement, mania, hallucination and delirium may occur. A toxic confusional pschosis is very common and a clinical picture resembling Korsakow's syndrome has been described. The earlier pellagrologists recorded acute confusional insanity, stupor, hallucinations, acute delirium, catatonia, manic depressive states and dementia.

Psychosensory disturbances occur in all the special senses. Patients dislike bright light and colours, noises cannot be tolerated, music upsets them, odours and tastes may be so disagreeable as to cause nausea and vomiting. The patients can be described as being "on edge," irritable and tense. Many abnormal skin sensations are observed. Prominent complaints are dizziness, difficulty in maintaining balance, flickering stars and dark spots in front of the eyes.

The psychomotor drive is increased—the patient is fidgety, moves about a great deal, and is quarrelsome. He complains that a sudden noise or flash of light makes him jump and twitch. Emotional reactions are increased. The patient is more excitable and sensitive than usual; he is often depressed, sad and gloomy, and he is in a constant state of apprehension. Many patients express various fears, frights and phobias, although they may try to suppress them. The emotional outlook is gloomy and pessimistic and imminent danger is constantly expected.

In spite of the increased motor drive and restlessness the patients complain of weakness and fatigue. They tire readily at their work. There is a conflict between restlessness and fatigue, with the former often prevailing. Sleeplessness is also a common symptom, the patient falling asleep between 12 p.m. and 2 a.m. and waking again at 5 a.m. Sick headaches are common, resembling those of migraine, and occurring suddenly. The pain is localized in the forehead and temples and is accompanied by scintillating scotomata. As in migrains nausea and vomiting are frequent. Developing pellagra often causes a breakdown in personality. Individuals previously strong, courageous and enduring become shaky, weary and apprehensive before clinical pellagra can be diagnosed. Severe pellagrous psychoses occur in ten per cent of untreated pellagrins. The patients may have periods of depression and apprehension followed by confusion, hallucinations, delirium, disorientation, and confabulation. A paranoid condition is often observed. Tremor, jerky movements and rigidity of the body may accompany these symptoms. In cases with severe depression the patient may have a mask-like expression and sit in one position staring into space for hours without moving.

The mental symptoms may precede the other symptoms of pellagra, so that a potential pellagrin may easily be diagnosed as "neurasthenic" or a paranoid. This is important because the mental condition clears rapidly in a few days with nicotinic acid therapy, whereas a case of true neurathenia or paranoia remains unaffected. Early mental changes are due to "biochemical lesions" in the brain. (Pages 360-361, "The Vitamins in Medicine," Bicknell & Prescott, William Heinemann, Medical Books Ltd.)

DR. WESTON PRICE

One of America's greatest researchers was Dr. Weston A. Price. He maintained that our mental and physical illnesses were primarily nutritional.

We note that the primitive races which he visited and found to be free of mental illness and mental retardation were not so because of community mental health clinics. They have no psychiatrists. They do, however, have one thing in common. Their diet habits provide each generation with adequate nutritional requirements for producing and maintaining non-defective racial stocks.

In Dr. Price's book, "Nutrition and Physical Degeneration," he made a convincing comparison of primitive and modern diets and their effects. The book was published by the American Academy of Applied Nutrition, Los Angeles, California. He reported on many isolated races that were free of mental illness

and mental retardation. His 27th chapter contains a suggestion that should be the focal point of the pending legislation.

"NUTRITIONAL PROGRAMS FOR RACE REGENERATION"

"Our modern civilizations are doubly indebted to the primitive races for they have both demonstrated what we might be like in physical form and health and have indicated the nutritional requirements for doing so.

"We will consider these expressions of modern degeneration under two main headings, namely, those caused chiefly by the faulty nutrition of the affected individual, and, those caused in large part, by parental deficiencies which affect function.

"Typical expressions of the former are: dental caries, peridontal inflammations, so-called pyorrhea alveolaris, types of eye inflammations, failing vision, scurvy, un-united fractures, recurring spasmodic fractures, skeletal affections, joint pains, berri berri, pellagra and sterility. Over ninety have been reported by McCarrion.

"The second group of affections are associated with prenatal injuries, caused by parental vitamin and mineral deficiencies, before and at the time of fertilization. These affect the germ cells, thereby producing a defective fertilized ovum and defective fetus.

"In this group are hare-lip, cleft palate, narrow hips, narrow face, constricted nostrils, mental backwardness, juvenile delinquency, skull defects of the face and the floor of the brain, brain defects, mongoloidism, idiocy, etc. These two groups will be discussed and illustrated separately in this chapter.

"At the point of contact of modern commerce with large areas in which the primitive racial stocks have been protected by their isolation , we find degeneration of the human stock in its worst phases" (Page 495).

"Our immediate need is for means to prevent the building of defectives which is primarily a matter of education of parents to be, long before the problems arise. This is the method used by many of the primitive races that I have studied. It does not involve parading sex problems but simply telling the story of biology to both grade and high school pupils, which now is being done very successfully. An adequate nutritional program will indicate in detail both the nature of the defects produced by faulty foods, in each of the individuals themselves and in their offspring. The needed better foods for both are indicated, It is significant that the proper foods have been found available in all the countries where primitive races have succeeded, very often however, certain foods, recognized as necessary, were carried long distances" (p. 524).

We urge the members of this Committee to give the same attention to the nutritional aspects of mental illness and mental retardation as is now being given to psychiatric oriented therapy.

Mr. MILLER. The National Health Federation is opposed to the pending bills on Mental Health and Mental Retardation unless they are amended.

Mr. Chairman, we are fearful about the failure in these bills to define and limit definitely and precisely the terms, "mental health, mental illness, and mental retardation."

As a basis for this concern, I draw your attention to the following statements from those who are acknowledged as experts in the field of mental health and mental illness. Apparently from a reading of the definitions of symptoms of mental illness and emotional disturbance by some experts who might be recognized by the Department of Health, Education, and Welfare in the administration of this law, every living person might be considered by the authorities as being mentally ill. This would, of course, include those who are treating the mentally ill and those who are passing the laws.

We will submit in our written statement a proposed amendment that would make it a felony for any person administering this law, to attempt to change a person's belief in, concept of, or respect for God. The need for this amendment will be substantiated by our sec-

ond group of quotes from the book "The Psychiatric Study of Jesus."

I have included in my statement, and in the material that you have before you, is a reprint from a health education journal written by Marion Firor, M. D., chief psychiatrist, health education and health services branch of the Los Angeles city schools. This is from the January 1957 issue. The title of the article is "Recognition of Symptoms in Emotionally Disturbed Children."

I am not going to take this committee's time to read the entire pamphlet. The thing that disturbs me is that this is a picture of mental illness casefinding at a local level, a community level. It is to educate teachers on how they are going to be able to recognize symptoms when they just begin to show so that they can be treated, or so that they can be prevented in time. Early diagnosis and treatment is the argument that makes so much good sense in the proposed legislation. However, the symptoms cover everyone.

At the bottom of the first column the author states:

Included are the following suggestions for the teacher to use in observing emotional disturbance:

1. Good ability but not producing.
2. Reading problems.
3. Short attention span.
4. Nervous mannerisms.
5. Hyperactivity.
6. Withdrawal tendencies.
7. Aggressiveness.
8. Stuttering.
9. Crying spells.
10. Tiredness.

It is difficult for me to believe that there are very many children who are not at one time or another covered by one or all of those disturbances.

Then, to spell this out more clearly for the teacher, he states:

Following are several illustrative but incomplete categories of pupils who show evidence of emotional disturbance:

1. The hyperactive, aggressive, "acting-out" child who is the bane of existence in the classroom—the child who can't sit still, can't shut up long enough, pushes here and crowds there, swats, pays no attention, is distractible, short-spanned, and short of control in everything he does.

I might state here Mr. Chairman, parenthetically, that I was a schoolteacher at one time and some of my outstanding students in later life fit this pattern when they were young.

Next he says:

2. The withdrawn child who sits with a faraway look, quiet, shy, living more within himself and his own world then with his peers—the child who doesn't hear when he's spoken to—the child who appears unhappy.

Now here again in reading the biographies of some of our greatest men I find this describes their youth. Certainly Edison would have very aptly fit into this category. He was considered an odd, withdrawn child.

Teachers are now being told to watch for these symptoms and not leave students alone as has been the custom in the past but to jump in the middle of it and immediately refer this person for help. This is case-finding at the community level.

Continuing:

3. The child of very unhappy appearance, who seems depressed, not just withdrawn and quiet, who seems nervous, insecure, defeated, abject.
4. The child who seems fearful, nervous, who bites his nails—the child who would tell of bad nights and fearsome dreams.
5. The child who has a chip-on-his-shoulder attitude—

This could apply to some Congressmen.

the child who is surly, defiant, quick to take offense—the child who views the teacher, other pupils, and all around him as against him.
6. The child who doesn't play or socialize with other children.

Then as though he has not covered everybody in the school by now he adds this:

The child who doesn't appear to be upset or feel neglected—the child who just doesn't care.
7. The child who by and large gets along reasonably well, but erupts explosively, volcanically, whose temper outbursts are out of all proportion to the stimulus provoking the reaction.
8. The child who seems awkward and may have trouble reading, writing, or talking.

Notice that he has not listed any pupil age limit. This is written for all teachers. It does not matter when a child may have trouble reading, writing or talking.

9. More overt and apt to come to the teacher's attention is the child who is lying and/or stealing.

Now I believe that in 9, 10, 11, and 12 that he is down to the proper function of a schoolteacher. This is what traditionally schoolteachers used to watch for.

Lying and stealing obviously endanger the health and safety of somebody else in the classroom.

10. The child whose sex curiosity and interest have spilled over in the classroom or playground with stories, words, or open activity.
11. The deliberately destructive chidl—the depredator—the fire-setting, mauling, beating, knifing child.
12. The child who is having serious difficulty in learning.
The child who has trouble reading or who writes backward, or who has trouble talking. Is he feebleminded or is he schizophrenic? Has he an emotional block?

By taking this to the comunity level, we are becoming a Nation of watchers. This would make every schoolteacher instead of a disciplined, professional educator, an amateur—if semi-professional, psychiatrist.

Now frankly, Mr. Chairman, I believe that when we start talking about mental illness that we should have a clear and limited definition of exactly what mentally illness is. I find that those that are administering the law have made their definition so broad that they have included everyone, absolutely everyone.

You expressed, Mr. Chairman, a feeling that our first concern should be with personnel and second with those facilities in which the personnel would be working. I agree with you. I have included some excerpts from a book entitled "The Phychiatric Study of Jesus," Beacon Press, Boston, Mass. Dr. Winfred Overholser, M.D., past president of the American Psychiatric Association, wrote the forward to the book "The Psychiatric Study of Jesus."

The book quotes leading psychiatrists who, Overholser claims, "agree on one point, namely that Jesus suffered some form of 'paranoia.'"

They disagree with each other and the author only as to the extent that Jesus was mentally ill.

Overholser explains on page 12:

Paranoia gradually came to include a variety of clinical groups characterized by ideas of persecution and grandeur, in varying proportions. Some of these groups exhibited almost entirely a distortion and misinterpretation of actual facts. A religious coloring of the delusions is far from uncommon.

Overholser on page 10 states that following "higher criticism" of the Bible, which—

was basically hostile to established belief * * * it was inevitable that in the quest for motives some consideration should be given to the possibility that the beliefs of Jesus might be explained as those of a mentally abnormal person, perhaps even of one clearly deranged.

On page 40 we find:

Dr. William Hirsh makes a diagnosis of Jesus, namely, paranoia. Everything that we know about him conforms so perfectly to the clinical picture of a paranoia that it is hardly conceivable that people can question the accuracy of the diagnosis.

Hirsch traces the development of the delusion in this way—

and these were the symptoms the schoolteachers were told to watch for.

We find a boy with unusual mental talents who is, nevertheless, predisposed to psychic disturbances, and within whom delusions gradually form.

This next statement is a classic—

He spends his whole leisure in the study of the Holy Scriptures, the reading of which certainly contributed to his mental illness. When at the age of 30 he first made public appearance, his paranoia was completely established—

and again, page 40:

shock was provided for Christ by another paranoid, no other than John the Baptist.

I would assume that to this author every follower of Jesus would be a paranoid.

Page 39:

The driving of the moneychangers out of the temple, de Loosten describes as a shocking act of violence.

Besides visual hallucinations, De Loosten thinks that it is highly probable that Jesus suffered from voices which seemed to him to come out of his own body.

Another thing that alarms me, Mr. Chairman, about this broad interpretation of mental illness is the fact that I have a tremendous respect for the power and for the knowledge that has been developed in this field which makes it possible to alter permanently human behavior without one's consent. We now have the power and the technical knowledge, to take a person with one attitude and one set of convictions and beliefs and change those beliefs and convictions permanently.

In view of this I would like to draw your attention to Dr. Chisholm. I will quote from him at length in my written statement. He is considered the dean of psychiatrists, who stated that "the reinterpretation and eventual eradication of the concept of right and wrong which has been the basis of child training and the substitution of intelligent

and rational thinking for faith in the certainties of the old people, these are the belated objectives of practically all effective psychotherapy."

Thank you, Mr. Chairman.

Mr. ROBERTS. Thank you, Mr. Miller.

Would you be inclined to support the bill if the failure which you allege—to define definitely and precisely the terms "mental health," "mental illness," and "mental retardation"—was to be rectified?

Mr. MILLER. Mr. Chairman, if it is defined to include the wide definition that I have indicated, then naturally I would oppose it. I believe that traditionally civilizations have risen to their highest level when the emphasis was upon the home. I think that the family unit is the basis of any great civilization that has ever been raised.

I feel that one proper function of Government is to keep one person from meddling in the private life and business of another person. I think that the old saying, "Mind your own business," still goes.

Mr. ROBERTS. I agree but I still think that Justice Holmes was right when he said that freedom does not include the right to yell "Fire" in a crowded theater.

Mr. MILLER. Precisely.

Mr. ROBERTS. I think that we have a situation which has been pointed out by practically every witness we have had in the last 3 days we have been in these hearings which indicates that the type of program that we have at the present time is simply not doing the job; that we are just merely providing in the case of mental health, the people who are affected with mental disease, that we are in too many cases simply providing them with more room, and that the attempt in H.R. 3688 is to bring this problem home, so to speak, instead of carting these people off under court orders to a remote, isolated institution where they are forever and forever stigmatized.

While many of these institutions, the ones I know anything about, with limited funds do provide us I think as well as they can under the circumstances, we hope to take that sort of a situation and focus the attention of the local community on the problem and to have an awareness of it that we have not had with this other system. It seems to me that I certainly agree that we do not want to take away anyone's freedom but that we are attempting here to let the people help themselves instead of relying on court orders and commitments and putting people in jail.

I do not know of any better way than that to take freedom from people and incarcerate them in jail until they can be sent to another institution. It seems to me that the ideal situation would be that these people could be restored to some kind of wonderful treatment and not have to go to any kind of an institution.

Many of these cases can be handled in the home. I think some of these cases can be with visits, regular visits to either a mental health clinic or in the case of children that they will not be taken away from parents and will still be able to get some help right in their own local communities.

I understand that we must certainly respect the individual's right to whatever faith he wants to exercise. I do not have the fear that we will meet interference with that approach that you seem to have.

Mr. MILLER. Mr. Chairman, I could not agree with you more on your first point; that is, the criticism of our present treatment. Our criti-

cism of the pending legislation does not mean that we defend the present treatment of the mentally ill. I consider it deplorable. We feel that the commitment procedure in many, many States, if not all, is in violation of the constitutional protection which was fought for by our forefathers.

Every person is entitled to a day in court except a person once accused of being mentally ill, and then under the guise of being kind to them we, in many States, refuse them the right to even be present at their own trial. I am not defending our present treatment of the mentally ill, nor is the National Health Federation. I think you will find we are very critical of the present treatment, but we do not believe that we should just jump from the frying pan into the fire and spend money simply because the present system is wrong.

Historically, I remember when they used to call and use these institutions as insane asylums. Then under the false guise that we were being kind we said, this puts a stigma on people. We took away the words "insane asylums" and called them "mental hospitals." I would like to explore this with you for just a minute.

I think institutions for the insane are a proper function of the State whereas treatment for mental illness gets over into this tremendous broadness of the definition that includes everyone. This makes us fearful. An insane person is an obvious hazard to the health or safety of somebody else, so they have to be put away. With due process of law, if a man is a man who cannot control himself in such a way that he does not endanger somebody else, then certainly he has to be put away. I think frankly that we would go forward if we called them insane asylums again.

I do not think we have in any way taken the stigma off anyone by calling them mental hospitals. We have broadened the number of branded people without a protective classification between those that are harmful and not harmful. For example, a withdrawn child that stutters now has the same general stigma as an alcoholic, dope addict, or violently insane murderer. They are all mentally ill.

I am disturbed that we are told by giving HEW so many millions of dollars we are returning this problem to the local level. The people who will be chosen to administer this at the State level are the people who have these attitudes about the broadness of mental illness.

I can see taking a child who molests another child and confining him or giving him psychiatric treatment, but I cannot see taking this down to the person who stutters or to the person who might bite their fingernails or to the person who might come to school with tears streaming down their cheek and make these part of a total case-finding clinic under the guise we are taking this closer to the community.

I think that the families and communities that have these mental retardation problems and the mental illness problems know about them. The most efficient way by far to keep problem solving at a local level is to refrain from taxing the money from citizens, running it through Washington, and having it returned to the community under the control of some of the men who hold the ideas like Dr. Crisholm.

Mr. ROBERTS. I understand, I think, the basis of your fear. However, I do not think there is anything in these bills that would take it out of the control of the parent or the legal guardian of a child

as to the attendance of this child at some mentally retarded institution. I do not see that the Secretary of Health, Education, and Welfare would have any power to go into a State and say through some agent of his that x number of children from y school must go to this mentally retarded clinic.

These clinics are to be under the control of the local people, and the admission as I see it would be voluntary. I do not know of any provision in here that would give the Secretary of Health, Education, and Welfare this power. There may be a strange construction somewhere that I have missed, and if you point it out to me I would be glad to have it.

Mr. MILLER. I believe when we consider this mental health and mental retardation legislation we have to consider it all together. It includes that which has passed and that which is presently pending.

Now I think we are considering today the bill H.R. 2567. This is by Mr. Dent.

Mr. ROBERTS. Well, it is one of the bills that is in the record. However, I think most people recognize that the main attempt to this subcommittee will be to use that as a vehicle of the bills H.R. 3688 and H.R. 3689.

Mr. MILLER. That was my understanding, Mr. Roberts. However, H.R. 2567 was listed as one of the bills to be considered before the Committee at this time.

Mr. ROBERTS. That is right. The hearing considered all the bills before the House.

Mr. MILLER. On page 3 of this bill, H.R. 2567, on line 10, it says: "Establish State mental health agencies with well defined authority to," and then it lists, "assume overall responsibility for services to the mentally ill and mentally retarded." I refer to (e) under this also.

Mr. ROBERTS. I understand that bill which, as you say, is one of the bills we are considering, we still go back to the States. I think that the members of the State legislatures in these various States are going to be very generous of any plan that would appear to have the power to enlist these children to any person, State, or Federal authority. Except in those cases where there might be some indication of violence or where some overt act had been committed such as you have in juvenile court, that would be the only instance in my opinion where there would be any direct court authority or where the parental discipline and control would be displaced. I mean either a parent or person who stands in position of a parent.

I appreciate your pointing that out and I can assure you you have been very careful about giving anyone, certainly not a school, teacher in a school, power to say that child is going to go to these clinics. We still have a pretty good bit of control in the local field on that.

Mr. MILLER. Mr. Chairman, would there be any objection to clearly spelling out, much the same as the founders did in the Bill of Rights, that the local authorities may do no act without the consent and knowledge of the parent?

Mr. ROBERTS. I think if you would offer us language in that field we would certainly be willing to consider it. It may be that the bills are sufficient as written; if not, we would certainly look very carefully at that situation.

Mr. MILLER. Let us assume there is no intention to do wrong. I have seen teachers, young girls and boys come straight from college and they are filled with a desire to do more than just teach a skill. I can visualize something like this.

A teacher might come into a classroom right after having heard or read this particular list of mental illness symptoms. A child comes into the class with tears running down his face. Immediately the teacher recognizes this is one of the symptoms she should watch for. Now this child is so disturbed because of something that has happened at home that he cannot concentrate on his work so the teacher, instead of realizing that she has 30 other students, suddenly says, "Well, this is my primary calling." So she "refers." She sends a note to the counselor and says, "We have to work on this one fast. I have a mentally ill or potentially mentally ill person and we cannot let this thing go."

The child is sent to the school guidance center and the counselor there, who is not a psychiatrist, let us say, asks him what the trouble is. Well, the first two words the child says with gritted teeth, is "my dad" and then he breaks out crying again. Immediately this counselor realizes that this is something that he has been told to refer on up to the child guidance clinic, the community clinic.

Now the question that arises is, What are these people going to do when the father is the individual who supposedly caused the problem in the first place? Would there not be a tendency, unless it is specifically forbidden, for them to say, "Maybe we better take care of this child without his parents consent because it is obvious we have an Oedipus complex here"? So I can see, unless it is specifically forbidden at the Federal level, referring this child down to a psychiatrist for "treatment."

Now I am deeply disturbed to find out what some of these psychiatrists believe, especially Chisholm. He says, "We have a concept of morality and this is the basic problem, and the way that you get rid of mentally ill people is to get them to realize there is no such thing as sin, there is no such thing as evil."

This child who simply had his parent spank him before he left to go to school because he did not get a school assignment is now at the hands of a psychiatrist without this parent's knowledge or consent. This psychiatrist begins to explain to this child his behavior in terms of Freudian principles. One of the basic Freudian principles is the Oedipus complex which teaches a child that the motivating thing in life is that every boy has a natural animosity to his father and an unnatural attraction to his mother and vice versa for a girl.

Mr. O'BRIEN. May I ask a question at this point, Mr. Chairman.

Mr. ROBERTS. Yes.

Mr. O'BRIEN. With reference to the article that you read, I dare say that some of the symptoms you mentioned might apply to one or more of my grandchildren, especially the aggressive ones.

I find nothing in that article that suggested that the child who comes in with tears in his eyes 1 day or who is a pest another day is practically on the threshold of a mental institution. The article itself goes on to say that if these things are unrealistic, if they are inflexible, if they are persevering, then the teacher should talk with the child and if that fails then she should consult the parents and see if perhaps the child should not have some professional help.

Now if we read the full article, I would think that any good teacher, if there was this habitual attitude that you mentioned, would, if she was a good teacher, do something about it. I do not mean to clap the child into a mental institution, but certainly answer the questions.

I think that the article in question was a rather good article if you read it all. I do not think many teachers, at least the ones I know, are going to apply for a court order to put a child in a mental hospital because he stutters and cries 1 day or even raises the devil more often than the other kids.

I would like to ask this question, Mr. Chairman, if I may.

How old is the National Health Federation?

Mr. MILLER. The National Health Federation was organized 8 years ago.

Mr. O'BRIEN. Eight years ago. Did the National Health Federation take any position on the Alaska mental health bill?

Mr. MILLER. I have not read the hearings. I was not in the Washington office at that time and I cannot answer that. To my knowledge, no.

Mr. O'BRIEN. Did not take any position?

Mr. MILLER. To my knowledge, no.

I might state that I recently received a directive from our president, Mr. Fred Hart, to look into this because one of our members has asked questions about it and he said that it was my duty to find out what the present status of this Alaska mental health bill was so that we could factually report it to these people that are asking us what the present status is.

Mr. O'BRIEN. Yes, I hope that there will be a more factual report than the type of attacks that we had on it when it was before Congress. I realize it is not before us today. It was a pretty good demonstration of getting far afield from the matter before us when we in the Congress were charged with a plot to set up a million-acre concentration camp in Alaska and send anybody up there who might be emotionally disturbed in the classroom or out of it, which was a bald-faced lie accepted by I think several million people. We barely passed the bill.

Now the people who attack along those lines, and I assume they may have been some of the people who have written to you for a report, refused to accept repeated statements that the million acres had nothing whatsoever to do with the location of the mental health facilities, that it was only a tax base for a territory which had no land of its own.

I think that every time we get a mental health bill at a Federal level we are in for trouble. I notice in the testimony that your attack is almost entirely upon mental health legislation, period, and not this particular bill, because if you want to improve conditions certainly this bill is going to improve them.

We are not trying to change here committal provisions by the several States, but if they are bad, as you say, is it not much worse to use those committal provisions to send a patient to a mental Siberia than to give him treatment in his hometown? We cannot correct what is being done at the State level, I do not think. We are not attempting to change it here. All we are trying to do is improve the atmosphere in which these people are treated.

Mr. MILLER. You made several comments, I do not know how to answer each of them. I am not aware of any action at all that the federation took on the Alaska mental health bill.

Do I understand, sir, this was before your subcommittee?

Mr. O'BRIEN. Yes, it was. And the Finn twins were the principal lobbyists against the bill? The Finn twins tried to arrest the President's brother, as I recall.

Mr. MILLER. Are you aware, sir, of any representation that was made against the bill by any previous member or lobbyist of the National Health Federation?

Mr. O'BRIEN. No, that is why I asked the question.

Mr. MILLER. Because I was just asked to make a brief on this bill. We probably have not made a determination on it. I do not think at the time that it came up we had a sufficient staff to even consider it as part of our legislative activity.

Mr. O'BRIEN. That is probably true, but I may say that a great many organizations that opposed it obviously did not have a sufficient staff.

Mr. MILLER. I will be very glad, sir, to give you a copy of my analysis of the Alaska mental health bill when I make it. I do not believe that we should be fearful of an endeavor to approach these problems. This is not what I hope that my testimony indicates.

Mr. ROBERTS. I think it is one thing to oppose legislation and it is another thing to offer some alternative. I do not think that we can simply say in many cases where a problem is as vast as this that we can afford to do nothing because what we might do might possibly have some features of it that are not entirely what you would hope for. After all, we have been told that this affects about 17 million of our citizens, that it is costing the country billions of dollars.

In the rejections for military service, I believe, in World War II, I saw some figures that were rejected on mental grounds that would have been enough to constitute 175 million. It seems to me that it would come with much better grace if you do not approve this approach that you would offer an approach that the Federation might approve.

Mr. MILLER. This criticism is, I think, well directed and I accept it in the spirit in which you have given it. It is much easier to throw darts at balloons than to blow them up.

Mr. ROBERTS. We have to blow up a lot of balloons.

Mr. MILLER. We have taken the view in this particular legislation that the federation at the present time is not large enough to defeat the legislation. We do hope to amend it in such a way that it puts the responsibility and control back with the parent and family where it belongs.

In the way of a constructive suggestion we propose that we study health instead of sickness. Unless Congress is aware that there are countries without mental illness or mental retardation problems, we soon regard the mental health problem to the point where it becomes a pretty hopelessly morbid study. We should take a fraction of the money that is proposed to be spent on treating this problem and appoint a commission to go into a country where they have no mental illness, and give this study the same amount of publicity that we are giving to the problem now. This would be my constructive suggestion, Mr. Chairman.

Now there is a country in the world where they have no mental illness. This was brought to America's attention by Art Linkletter on "People Are Funny."

Mr. O'BRIEN. Where is that?

Mr. MILLER. Hunza, H-u-n-z-a. It is in Pakistan.

A tremendous amount of English research has been done on this country because they found out not only were those people free of physical sickness but they had none of the mental ailments that were affecting so-called civilized countries. They are isolated. For centuries they had little access to our modern contaminants, whether it be air pollution, water pollution, foods, ideas, or what have you. They live to be fantastically old. Many of them are over a hundred, and are vital people. I mean they are not crippled, senile, and sitting around in rest homes.

The original researcher that went into this country found such a fabulous state of good health that he reported it. This report, instead of receiving the 10-inch headlines that we give in this country to the sick and to the morbid things, was buried.

Recently American teams were sent over. Dr. Banik was picked to investigate this country and to report back on Art Linkletter's program what he found. I think he was an eye doctor. He came back and reported that they had unbelievably marvelous health. He and Renee Taylor wrote a book which I will be glad to furnish to all the members of the committee. I would like to propose constructively that where there is a country like this that we spend our time and money in and learning from these primitive people whatever secret they have. We should send our finest scientists, and spend $20 or $30 million if necessary to find out why they have no mental illness, why they have practically no dental decay, why there is not a jail in a country of 30,000 people, and why they have no juvenile delinquency. This is Shangri-La, and actually I understand that the story of Shangri-La was written about this conutry.

Now we do have constructive suggestions to make. We would be delighted to offer as a substitute bill that we take all the millions that are going to be spent for this pending legislation and send a team to Hunza to find out how we can have every young man that's called up for military service physically and mentally fit.

Mr. ROBERTS. I think that bill would get about as far as our request for a trip to Hunza would.

Mr. O'BRIEN. I notice you mentioned the fine teeth they have there. Would you suggest that pending our investigation there we stop filling teeth here or improving our methods of treating them.

Mr. MILLER. Dr. Winston Price met that very problem and wrote a book called "Nutrition and Physical Degeneration." As one of the finest dentists in Cleveland, he made a fortune at patching up teeth. He finally thought that he was like a man who was plastering up a wall while letting somebody go ahead of him poking holes in it. He thought this was a rather foolish thing. He said to himself, if I can get ahead of that man who is making the holes in the wall, I will be applying my intelligence in a much better way. So he and his wife, who was a very able scientist, left their practice. In direct answer to what you ask, they stopped immediately filling teeth, they went around the world and visited every primitive area where they had heard rumors of health like I told you. In these primitive areas these people do not have the illness we have in our so-called civilization. He published a book which I will make available to the members of this committee.

Now frankly, sir, the answer to your question is, "Yes." I think some of our scientists ought to immediately stop watching and treating the sick and go into a country where they are building finer thoroughbreds and find out how. I do not think we should spend another tax dime for patching up holes in the wall. With Federal funds we ought to get ahead of the man or condition that is making the holes. Isn't this the intelligent way to approach the problem? I think this is what the people in your district expected you to do when they sent you to Congress and paid your salary, take time to find out about these things and do this for the country as a whole.

Mr. O'BRIEN. Perhaps I might be a better judge of what my people in my district had in mind when they sent me to Congress and paid my salary, but I am very sure of one thing: If I were to report back to them tomorrow that I was supporting this bill in turn for a visit to the beautiful Utopia that you mentioned, they would have a new boy here.

Mr. MILLER. Mr. O'Brien, I did not recommend that you go. If you will check back in the record, I recommended that we send a qualified group of scientists, people who can evaluate this, send them in there to find out if the story is true to start with.

Art Linkletter gave national publicity to it, yet nothing was ever done by the Government. It seems to me that if we have the possibility of a country that could put 100 out of 100 of their boys when they became of military age into the military service because they all have a full set of teeth, they are mentally sound, they are good, strong men, they are not delinquent, they do not have a jail record, I frankly think your constituents would be delighted if you drew that to their attention.

Mr. O'BRIEN. I recall Mr. Linkletter was down here not too long ago in connection with the polio drive, I believe it was. I do not recall that he recommended at that time that we stop contributing to that fund and study why they did not have polio in this mythical kingdom.

Mr. MILLER. Well, I am not defending Art Linkletter's application of the knowledge that was available to him, but I believe frankly that we should find out why they have no polio in Hunza.

Mr. ROBERTS. Gentlemen, I would like this to be pursued on some rainy afternoon. I have to help this very fine gentleman, Mr. Fitzpatrick, meet a train schedule.

Mr. MILLER. Thank you very much, Mr. Chairman.

Mr. ROBERTS. Mr. Fitzpatrick, I have a note from Mr. Nelsen who had to leave because of another commitment. He wanted to be here during the time you testified. There are certain communications which he left with the Chair with reference to your testimony which we will put in the record.

I understand you are up against a 5 o'clock train schedule. We will try to get you down there on time.

You may proceed with your statement, Mr. Fitzpatrick.

Mr. FITZPATRICK. I might say preliminarily to my statement that I am pleased to be before this committee. I know something of you, Mr. Chairman, from my friends in Alabama. I am particularly pleased to be before you. Of course I can't help saying that I like the name O'Brien, similarly. And a neighbor of mine is Mr. Nelsen.

STATEMENT OF DR. GUNNAR DYDWAD, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION FOR RETARDED CHILDREN, NEW YORK CITY, AND VINCENT J. FITZPATRICK, CHAIRMAN, GOVERNMENTAL AFFAIRS COMMITTEE

Mr. FITZPATRICK. On behalf of its more than 1,000 member associations throughout the country, the National Association for Retarded Children wishes to go on record in strong support of H.R. 3689, the Mental Retardation Facilities Construction Act of 1963, introduced February 11, 1963, by Representative Harris for the purpose of assisting States in combating mental retardation through construction of research centers and facilities for the mentally retarded.

Since its inception, the National Association for Retarded Children has emphasized the need to develop and strengthen research in the area of mental retardation. In spite of the fact that at that time, in the early 1950's, there was everywhere in the country a crying need for services and facilities for the care, treatment, training, and education of the mentally retarded, the leadership of the national association recognized that, looking at the problem from a long-range viewpoint, an active program of research on causes and treatment could not be delayed.

Therefore, in 1953, the National Association for Retarded Children established a scientific Research Advisory Board, which became the first broad interdisciplinary mental retardation research body in the United States.

It was recognized that the immediate major concern was to stimulate interest in the problem of mental retardation on the part of leaders in the scientific community. Closely related was the task of assessing past and existing research efforts and of blueprinting mental retardation research needs.

The National Association for Retarded Children, with assistance from private foundations and Federal agencies, requested the Scientific Research Advisory Board to initiate a 3-year study. It was conducted by Doctors Masland, Sarason, and Gladwin during the years 1955 to 1957, and the results were published in 1958 in the volume "Mental Subnormality," which has since became a landmark in this field.

Following the publication of this 3-year study, the National Association for Retarded Children established the NARC Research Fund, and in line with the needs pointed out by the study, the fund concentrated on the establishment of research professorships in a variety of university centers.

I have sketched out this history, Mr. Chairman, not only to indicate our longstanding interest in the area of research, but also to emphasize that a stage of development has now been reached where we must move on to more comprehensive efforts involving larger, multidisciplinary research teams as well as more adequate laboratory and clinical facilities.

It is for this reason that we consider as particularly timely the provision of title I of H.R. 3689 pertaining to grants for construction of centers for research on mental retardation and related aspects of human development. Once again we hope Congress can take action which will break new paths in this so long neglected field.

The past several years have seen exciting new scientific developments in the field of mental retardation. A few years ago, talk of a preventive program in mental retardation would have been considered visionary. Today, preventive practices in mental retardation are firmly established—the question is how far our growing knowledge will take us and how fast a rate of progress we can achieve.

At this very time, with funds of the U.S. Children's Bureau, an extensive program of testing newborn babies for phenylketonuria (PKU) is in process in a large number of States. In Massachusetts, where the State health department has gained the full cooperation of all private and public hospitals, during the course of the past several months eight infants have been detected as suffering from PKU and by prompt application of the diet which effectively curbs this dread disease, these eight infants have been saved from serious mental retardation.

It is of particular satisfaction to us that one of the grants which supported Dr. Robert Guthrie in the development of this new screening test came from the Research Fund of the National Association for Retarded Children. Dr. Guthrie is presently engaged in exploring how the principle used in this new test may be used to develop other tests to detect other types of metabolic disorders which also lead to severe mental retardation.

Equally remarkable has been the discovery of deviations in the chromosome structure of persons afflicted with Downs syndrome (Mongolism), another serious form of mental retardation. However, as yet, the new information merely affords us a better understanding of the causes of this affliction but there is good reason for hope that eventually we will find leads which will make prevention possible as specifically as is already the case with regard to PKU.

Other important new scientific discoveries have been in the area of the peculiar ways of learning characteristic of mental retardates and of the disturbances in their perceptual processes.

These striking advances underline that we no longer can be contented with support of the individual research scientist. The magnitude of the problem of retardation and the range of related research efforts it requires demand establishment of research centers so that maximum benefit may be secured by the interplay of the biological and social sciences.

Thus, Mr. Chairman, the program of Federal grants this bill foresees is indeed the next essential step. Much as we hope to gain the interest and cooperation of many of our State and private institutions of higher learning, and other research centers, they obviously will need financial aid to establish in this new field of inquiry that kind of appropriately designed, staffed, and equipped research facility deemed essential.

I might say, parenthetically, that I was very much heartened that the report of the President's Panel on Mental Retardation recommended that high priority should be given to developing research centers on mental retardation, not only at strategically located universities but also at institutions for the retarded.

As president of the board of trustees of the Hamburg State School and Hospital, a Pennsylvania State institution for the retarded, I very much welcome this reference to institutions. It is my hope that

this subcommittee agrees that the language of section 721, title I, of H.R. 3689 includes among possible recipients of grants selected institutions for the retarded that have developed an effective research program under the direction of competent scientific investigators. If we want to create better, more effective institutions, if we want to change them from mere storage houses to centers of treatment and prevention and rehabilitation, then we must make it possible for these institutions to attract outstanding professional personnel. Incorporating research facilities into our institutions will have that result.

Likewise, we are grateful, Mr. Chairman, that title I includes social and behavorial research along with biological research and medical studies. The President's Panel on Mental Retardation has presented ample evidence as to what extent mental retardation is linked to nonmedical causes and to what extent we need to establish, on a scientific basis, new approaches to the education and vocational and social adjustment of the retarded. The availability of Federal grants will be particularly welcome in these fields where we have far fewer established research centers than in the biological sciences.

Gratified as we are at the prospect of mental retardation research centers, funds for this purpose will be of little avail unless sufficient appropriations under existing statutory authority to the various agencies of the Department of Health, Education, and Welfare are available to help in manning these centers in the various States. Indeed, the question may well be raised whether title I of the bill under discussion here would not have been vastly more effective if it would have provided not just for construction grants but also for core staff, much as H.R. 3688 provides for this in the grant to community mental health centers. I want to thank you, Mr. Chairman, for your comment.

In summary, then, we feel that title I with its relatively small grant program of $30 million, spread over a 5-year period, will pay substantial dividends in accelerating the probing of a vast area in mental retardation where we have as yet only the most meager clues as to causes or methods of detection and prevention.

President Kennedy in his message to Congress of February 5, 1963, highlighted the tremendous economic burden which mental retardation imposes on the Nation. Considering the high cost of maintaining the severely retarded individual over his lifetime, it is indeed quite feasible to say that if, for each year the title I program is in effect, 100 new cases of severe retardation can be prevented, Mr. Chairman—just two cases for each of the 50 States—you will have recouped your investment.

TITLE II—GRANTS FOR CONSTRUCTION OF FACILITIES FOR THE MENTALLY RETARDED

Many of the institutions where retarded children and adults receive care are obsolete, having been constructed in an era when there was insufficient knowledge of proper methods of care, education, training, and treatment of these individuals.

For the severely and moderately retarded who reside in the community, the situation is even more serious because in most parts of our country there is an almost total lack of facilities, let alone adequate ones.

The National Association for Retarded Children is grateful that title II of H.R. 3689 makes broad provision for grants supporting construction of needed facilities for the mentally retarded. It is to be hoped that the actual appropriation under this bill will be substantial enough to permit a large number, if not all of the States, to avail themselves of this badly needed assistance.

We welcome in particular that in section 204(a), item 7, provision is made for minimum standards (to be fixed at the discretion of the State) for the maintenance and operation of facilities receiving Federal aid under this title, and we hope that this shall be interpreted to include standards for staffing.

We also welcome, in section 203(c) the provision that the Federal Hospital Council shall prescribe by regulation for facilities of different classes and in different types of locations, general standards of construction and equipment. This provision should remedy the source of many complaints that under the Hill-Burton Act administration, many mental retardation facilities were strait-jacketed by insistence on Federal regulatory requirements that did not fit the needs of the mentally retarded, no matter how appropriately they were when first issued.

Here, as in other areas, it must be emphasized and reemphasized that the needs of the mentally retarded differ in many and substantial ways from the needs of the mentally ill. Federal and State planning and regulations must reflect this difference.

One can no longer permit mentally retarded children and adults to be cared for under programs once designed for the mentally ill but by no means appropriate for the mentally retarded. It is fortunate indeed that H.R. 3689 recognizes that expertness in the field of mental illness does not necessarily include expertness in mental retardation.

We would also like to express our appreciation that this bill provides for consumer representation, that is, inclusion of parents of retarded children on both the Federal Hospital Council (section 212(a)) and the proposed State advisory councils (section 204(a)). Certainly the great achievement of hundreds of associations for retarded children across the country in demonstrating effective new methods of training and treatment of the mentally retarded suggests that their advice and counsel be sought.

A good feature of title II of H.R. 3689 is the provision for combining specified portions of allotments of one or more States with another State to make possible construction of a facility these States can use jointly. For our less populated States, this feature will be most useful in implementing needed, small, specialized services (section 202(b)).

While in general our association is wholeheartedly in support of this bill, there are two parts to which we have to raise specific objections:

Section 211(b) lists "custodial care" as one of the purposes for which funds under this bill would be available. The National Association for Retarded Children does not believe that the relatively limited amount of money to be made available through H.R. 3689 should be used for custodial care. While we realize that in many of our States we can expect only a rather slow discontinuation of this

type of care in favor of dynamic programs of training and treatment, Federal funds certainly should not be used to enable States to continue to build outdated, ineffective, oversized, congregate buildings. Accordingly, we urge that this subcommittee strike out the words "custodial care" on line 18, page 20 of the bill, and insert "residential" or "day care".

We also wish to register our disagreement with section 202(c). It provides for the transfer of funds set aside under H.R. 3689 for the construction of mental retardation facilities so they may be used for community mental health centers under certain conditions. Since section 204(a) requires designation of a single State agency as the sole agency for the administration of both the mental retadation and mental health centers, that agency could use all funds for mental health rather than for mental retardation centers. The limited consideration given in the past to the mentally retarded in States with community mental health service programs should be cited in support of our recommendation. Accordingly, we urge a change on page 7, line 10, to strike out "simultaneous certification" and insert in its stead "a showing satisfactory," thus requiring that the State agency report to the satisfaction of the Secretary of Health, Education and Welfare, that indeed, after reasonable efforts, no acceptable mental retardation projects were identified. We request a similar change in section 102(c) in H.R. 3688.

Aside from these two points, however, we feel that title II of H.R. 3689 will, if enacted, make a distinct contribution to the field of mental retardation.

We strongly endorse this bill, and commend it to this distinguished committee as another important milestone in our fight to conquer one of the Nation's major health problems.

Thank you, Mr. Roberts.

Mr. ROBERTS. Thank you very much.

I am not speaking for Mr. O'Brien, I am speaking personally, but I think this is one of the clearest, best statements we have had in the 3-day hearing.

It has been my feeling, I think you know from some of the questions I have asked, that in some respects it seems to me that there is a little bit of a tendency to downgrade the mental retardation feature of this problem, and it is certainly my feeling that I do not want to see that take place. I say that with all due respect to the other people who expressed opinions about staffing propositions, the changes that you mention so that funds could not be transferred; that is, the mental health could not come out of these funds and leave the mental retarded centers do the best they can. That certainly does not appeal to me. I appreciate very much your stand on those two important features of the bill.

Mr. FITZPATRICK. Thank you very much, Mr. Chairman.

Mr. ROBERTS. I hope you make the train.

Mr. O'BRIEN. I will just say "amen" so you can make it.

Mr. FITZPATRICK. Thank you.

Mr. ROBERTS. Dr. Arthur H. Brayfield, American Psychological Association, 1333 16th Street NW., Washington, D.C.

It is a pleasure to welcome you to the hearing.

STATEMENT OF ARTHUR H. BRAYFIELD, AMERICAN PSYCHOLOGICAL ASSOCIATION

Dr. BRAYFIELD. Mr. Chairman and Mr. O'Brien, my name is Dr. Arthur H. Brayfield. I am executive officer of the American Psychological Association which has its central headquarters in Washington, D.C. I am not from Hunza, I am not from Alaska, but I think I might otherwise qualify as an expert witness on behalf of this legislation, my four children are aggressive and hostile.

I am speaking on behalf of the association, a national organization with a membership of 21,000 psychologists. I am grateful for the opportunity to speak in support of the general outlines of the legislation to which these hearings are addressed.

In our view, the Congress is now considering what may well be the most important health legislation since the Mental Health Act of 1946.

The President's special and historic message to the Congress relative to mental illness and mental retardation was a landmark document in providing a broadened conception of the problems and proposed programs that embrace public and private, and Federal, State, and community responsibilities and resources.

Parenthetically, I might add that I am so impressed with the basic and fundamental nature of the President's message that I am carrying it in a forthcoming issue in its entirety in the American Psychologist, a scientific and professional journal that goes to our entire membership.

The legislation upon which you are holding these hearings, and I think we should emphasize this, culminates several decades of constructive action by the Congress and a remarkable record of progress, much of it stimulated by the imaginative programs of the National Institute of Mental Health under the leadership of Dr. Robert Felix. It represents a logical and realistic step forward.

It is perhaps appropriate to specify the interest of psychologists in legislation which has as its objective the enhancement of the health, welfare and effective functioning of the American people. The psychologist is especially involved in relevant research, teaching and the provision of services to people through the organized agencies of society such as the schools, community mental health centers, hospitals, institutions for the retarded, and many different rehabilitation agencies.

Psychologists, for example, are principal investigators in almost 50 percent of the research being carried out under the research program of the National Institute of Mental Health. Of the psychologists trained under the auspices of the traineeship grant program of NIMH during 1947–59, over 90 percent are working in public agencies or universities where they can and do contribute directly to research, service and the training of mental health specialists. Further, since only about 5 percent of all psychologists engage in private practice, it is obvious that the community mental health centers here proposed will rely heavily upon this important source of manpower.

Thus psychologists are strongly identified with the purposes to be served by this legislation and do indeed have an informed interest in it. We welcome the opportunity to join our colleagues in the mental health professions and interested citizen groups in support of this legislation. I wish now to make the following observations and suggestions regarding it.

It makes good sense to present separate measures for programs concerned, respectively, with mental disorders and mental retardation. Despite the interest and programs of several government agencies, there has been a tendency for work on mental retardation to be overlooked in our concern with the more dramatic problems of mental disorder and behavioral disturbance. I do recognize that there are operational difficulties at the local level in separating these two programs but we strongly support the conception of separation.

The proposed legislation moves the mental health problem out of its isolation in State hospital settings and into the mainstream of life in the community where it originates. This is a bold conception and one which we applaud. It would be our hope that the emerging community programs will be as varied as possible in their character, location, staffing, sponsorship, and methods of operation.

The behavioral disturbances which are the concern of this legislation are perhaps uniquely different from many kinds of illness or disability. They are enmeshed in the total family, community, and social life—in parental and family practices and pressures, in education, employment, recreation, and religion. Genetic, physiological, and biochemical factors also play their role to a greater or lesser degree in many forms of emotional disturbance. But the concept of mental disorder as the private illness of a person is no longer adequate.

These considerations lead me to recommend that not all community mental health centers be hospital based. I express the hope that leeway will be provided to enable communities to experiment with diverse patterns of mental health care including arrangements with community clinics, schools, and particularly universities as well as with general hospitals.

There is a lesson to be learned here from our experience with the big mental hospital set apart from the community. Just as we now recognize that this development, significant at the time of its inception, actually worked to dampen needed innovation, we should seek to avoid the dreary prospect of a repetition of this experience by inadvertently providing a new, though advanced, straight-jacket for the future.

On another policy matter, we suggest that a significant proportion of these potential new resources be made available to children and youth. Some concentration upon the prevention, early detection, and treatment of behavior disturbances among the rising generation commends itself as an effective strategy. It is perhaps at this point that major long-range economies will be effected.

Further, and importantly, we urge that legislation in this area of human concern provide for both training and research in connection with the proposed centers. There are practical reasons for this recommendation. The most effective service agencies are likely to be those that are kept fresh and alive through continuing and daily contact with training and research. Further, it is a common observation that competent personnel are more likely to be attracted to those settings which provide these types of staff stimulation. This can be a critical factor in rural and/or remote regions of the country. It is our recommendation that at least 10 percent of construction and operating funds be provided for training and research appropriate to the operation of community health centers.

The proposed mental retardation legislation has been hailed by one of my colleagues as possibly the beginning of a new "bill of rights" for children by providing for every child the opportunity to learn to his fullest capacity. Since a major share of the handicapping condition known as mental retardation is a matter of social and cultural deficit, it is hoped that subsequent administrative interpretations of this legislation will sustain an emphasis upon research related to human development and the provision of education as well as diagnosis and treatment for the many victims of inadequate environmental stimulation and inadequate opportunity to learn from infancy on.

Finally, I should like to comment on aspects common to both areas of legislation.

The manpower requirements for these programs are formidable. New ways of utilizing the competence and skill of psychiatrists, psychologists, and other highly trained personnel must be found. The administrative provisions in the proposed programs must be such that the invention of new patterns of organization and operation are encouraged. We should not freeze existing arrangements into practice.

New kinds of mental health personnel must be identified and given appropriate professional suport. For example, in Nashville, Tenn., an NIMH grant supports a program in which retired men and women qualify in meeting a shortage of social caseworkers. At NIMH, here in Washington, Dr. Margaret Rioch has worked with selected housewives to demonstrate that they can be trained to provide psychotherapy service to disturbed adults. Under another NIMH grant, Peabody College has developed two residential schools for emotionally disturbed children staffed entirely by carefully selected elementary school teachers assisted by a professional consultant team. We make the point that the plans developed for service programs under this legislation must be willing to break with precedent if the manpower requirements are to be met.

I should like to note here also that the programs which emerge from the adoption of this legislation should be available to all persons on the basis of need alone. I am confident that the Congress and the administration will ensure that the programs which develop within the States will provide comprehensive and integrated services irrespective of economic, geographic, or social status. In this regard, we would suggest that the Congress consider the provision of incentives for the development of programs to be located in rural and smaller urban areas. Some means must be found to encourage the widespread diffusion of mental health resources so that all the people may be served.

In the review of project proposals, as provided for in this legislation, we would urge that there be brought to bear the competencies of the full range of scientists, professional people, and administrators engaged in research, training, and service in these areas of concern. The Joint Commission and the President's Panel on Retardation have pointed the way to genuine and effective collaborative effort in behalf of the millions of citizens affected most directly by the provisions of this legislation.

The Congress has moved with wisdom and compassion in these matters. We are on the threshold of another great advance.

Thank you for the opportunity to appear in support of legislation in these areas of common concern and to present these general comments.

Mr. ROBERTS. Thank you, Dr. Brayfield.

I notice that you mention Nashville. Is that your home?

Dr. BRAYFIELD. Two generations back, sir. So I have some feeling of identification with Nashville but I do not know that situation specifically.

Mr. ROBERTS. I was of the opinion that you probably were familiar with the new effort that has been made there. Do they call it Cloverbrook? Is that the name?

Dr. BRAYFIELD. Yes.

Mr. ROBERTS. I understand there is a great deal of interest in that particular community.

Dr. BRAYFIELD. That is probably one of the two or three outstanding demonstration projects in the country in the general field of mental retardation and also of emotional disturbance. They have given very real leadership to the Nation through their work there.

Mr. ROBERTS. We had a statement yesterday from the Governor of Tennessee, Frank Clement, which apparently Tennessee is quite sold on this new concept and new approach. As a matter of fact, I recall that our own witnesses with one or two exceptions indicate that this legislation is being well received in the various States. We have already had expressions from more than 22 Governors who seem to be ready to get going.

I want to thank you very much, Doctor, for your statement. I want to say that I agree certainly with you that we have the same thinking about the consideration of this problem of the two bills. I think that is good. I think this approach that we are taking is the proper one, and I am glad that you agree with it.

I also appreciate the fact that you apparently do not want to see the mental retardation problem receive any less emphasis than does the mental health.

Dr. BRAYFIELD. That problem is simply not as dramatic as the other problem. To the people involved it is a deep concern, obviously.

Mr. ROBERTS. I certainly thank you for your statement.

Mr. O'Brien.

Mr. O'BRIEN. I agree with the chairman, I am grateful to you for your statement and I have a feeling that if it puts sufficient emphasis on the retarded children that we are going to provoke a much broader stream of community help and participation because there is a natural sympathy of all parents for children who are retarded. I think that unless we put as much emphasis on that program that we are not going to get the maximum of community support that we anticipate.

I am very grateful to you for your statement.

Dr. BRAYFIELD. Let me just say that I am very much impressed with the thought that the Congress has given this problem through its legislative activities in 1946, the creation of the Joint Commission and the work it is engaged in today. It is most gratifying.

Mr. ROBERTS. Thank you.

This will conclude the hearings on the two bills, H.R. 3688 and H.R. 3689 and related bills.

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The subcommittee has received many statements, telegrams, and letters and if possible, I would like to have them printed at this point in the record.

STATEMENT OF THE AMERICAN PARENTS COMMITTEE, INC., BY MARGARET K. TAYLOR, EXECUTIVE DIRECTOR

I am Margaret K. Taylor, executive director of the American Parents Committee, Inc., a nonprofit, nonpartisan, public service organization.

Since its formation in 1947 the American Parents Committee has worked exclusively for legislation in behalf of America's children. Through the office of the Chairman, Mr. George J. Hecht, who is also the published of Parents' magazine, and the Washington office, it keeps abreast of a wide range of legislative proposals affecting children. The Board of Directors and National Council, composed of one hundred fifteen outstanding leaders of national, State and local child welfare organizations across the country, determine by majority vote the position of the Committee on legislative proposals.

The American Parents Committee shares with you a concern about all situations in which the prospects for normal development of any of our children are imperiled, and a particular concern for those children for whom preventive measures are now already too late. For this reason we have placed high on our list of legislative goals for 1963 "an expanded program on Mental Retardation as recommended by the President's Panel on Mental Retardation." We commend to you the excellent report just issued under the title "A Proposed Program for National Action to Combat Mental Retardation."

It is clear that we must have coordinated action on a number of fronts, within and outside the Federal Government, to achieve the various objectives set forth by the Panel. While bricks and mortar do not make a program, without them programs everywhere are seriously hampered. The bill sponsored by Representative Oren Harris (H.R. 3689) providing as it does for the construction of facilities for research and services for the mentally retarded, constitutes an important basic step in upgrading existing programs and making possible new ones for this disadvantaged group.

Those familiar with the fields of knowledge basic to the study of mental retardation know that many sciences must interdigitate, in order to shed light on the causes of this condition and on the combinations of environmental conditions, stimuli, experieces, and treatments which will enable each mentally retarded child to make the maximum possible progress. Today, even with all our modern instruments of communication, the face-to-face contact between scientists still affords the best opportunity for the communication or verification of nascent ideas from which new discoveries emerge. Some important work relevant to mental retardation is done in laboratories by men who never see or talk to a mentally retarded child, but much needed research requires that mentally retarded persons be available as subjects. To foster such research, therefore, it is necessary to provide the physical facilities in which scientists with various disciplinary backgrounds find it convenient to work and communicate with one another and also to establish contact with retarded subjects; at the same time we must make sure that these same mentally retarded children and adults are themselves provided with the most favorable environment for their own growth and development, even as they are being observed and studied.

Such research and clinical facilities especially designed to foster this kind of work are almost non-existent in this country today. While we can applaud the persevereance and devotion of those investigators who may manage to produce results under unfavorable conditions, we must recognize that it is the mentally retarded who are paying the price of the inefficiencies and delays which inevitably ensue.

Likewise, the services needed by the mentally retarded are varied. Around the country parents have been organizing programs for their children, housing them where they could, in church basements, in abandoned school buildings, on sufferance in settlement houses out of hours, and in war surplus sheds. These children deserve more at our hands. Surely an attractive and appropriate building is the most tangible and obvious evidence that a community and a nation does care. Yet the grants-in-aid available under the hospital and medical facilities construction program, of which your Committee has such just reason to be proud, cannot properly be diverted to day care centers, group homes,

imaginatively conceived programs of residential care, sheltered work or activity centers and the like.

Moreover, in view of the continuing need and demand for hospital, nursing home, and clinic facilities for the general population, it is clear that special facilities for the mentally retarded will not receive the needed support and participation from the Federal Government unless Congress makes clear its intent that funds be specifically allocated to be used for precisely such purposes.

We believe that H.R. 3689 is well drafted to stimulate construction of physical facilities for research, service, and training of personnel, in this neglected field. We recommend its early passage, not only as a sign of Congressional belief in the dignity and rights of the mentally retarded, but also a point of departure from which planning at the State and community level can proceed without further delay.

Thank you, Mr. Chairman, for giving me this opportunity to present our views to you and your Committee.

SULLIVAN, MCMILLAN, HANFT & HASTINGS,
Duluth, 2, Minn., March 21, 1963.

HON. ANCHER NELSEN,
House of Representatives,
House Office Building,
Washington, D.C.

DEAR MR. NELSEN: I am writing you as president of the Duluth Mental Hygiene Clinic, a nonprofit corporation, which provides community mental health services to residents of this area. Recently I was informed that you are a member of the Health Subcommittee of the Interstate and Foreign Commerce Committee which will hold hearings on March 26 through March 28 on the Federal Community Mental Health Centers Act of 1963 (S. 755), in which we of the Duluth Mental Hygiene Clinic are very much interested.

For your information, the Duluth Mental Hygiene Clinic has been serving residents of this area since 1938. After the adoption of the Minnesota Community Mental Health Program in 1957, the services of the clinic could be and were materially expanded. At that time, Dr. John Haavik, formerly in the private practice of psychiatry in the City of Duluth, was employed as medical director of the clinic. Since 1957, demand for services of the clinic has increased steadily. The clinic now serves the southerly half of St. Louis County, Carlton County, and Cook County, as well as the City of Duluth. Recent increases in demand for services furnished by the clinic has made it necessary for us to employ an additional full-time psychiatrist plus supplementary staff personnel. As a result, the present quarters of the clinic are entirely inadequate.

In an attempt to resolve the space problem, we have explored a multitude of possibilities and have reached the conclusion that the best solution to the problem lies in the construction of a new clinic building. We have, among other things, investigated the possibility of obtaining Hill-Burton funds for this construction program but have been advised that by virtue of a peculiar provision in the Hill-Burton Act, we are not eligible to receive, as a diagnostic and treatment center, Hill-Burton funds for this project. Our problem apparently is not unique. We are informed that the ineligibility for funds applies to all mental health clinics in the nation which are organized and operated as private non-profit corporations. The ineligibility apparently stems from the fact that although mental health clinics fall within the definition of diagnostic and treatment centers under the Hill-Burton Act, Subsec. (d) of Sec. 291v. U.S.C., relating to applications for Federal funds in connection with the construction of diagnostic or treatment centers provides:

> "(d) Notwithstanding subsection (a) of this section no application for a diagnostic or treatment center shall be approved under such subsection unless the applicant is (1) a state, political subdivision, or public agency, or (2) a corporation or association which owns and operates a non-profit hospital (as defined in Section 291(i)(g))."

In order to make Hill-Burton funds available to mental health clinics throughout the nation organized on the same basis as the Duluth Mental Hygiene Clinic, we suggested some time ago that this subsection be amended by adding thereto a third category to read somewhat as follows:

> "or (3) a non-profit corporation or association which administers a community mental health service program and which is eligible under the law

of the State in which such services are provided to receive assistance or grants from such State in support of such program."

This suggestion was apparently presented by the Minnesota delegation to the Surgeon General's Conference on state hospital construction held in Washington on January 7. It is an interesting fact that at this conference, the Ohio delegation presented a similar proposal. In this connection, I am enclosing for your information a copy of a letter which I received from Dr. Helen L. Knudsen, Director, Division Hospital Services, Minnesota Department of Health.

You will note that in the last paragraph of her letter, Dr. Knudsen asked that members of our board meet with members of the St. Luke's Hospital Board and others concerning the feasibility of planning for sufficient space in a contemplated addition to St. Luke's to house the Duluth Mental Hygiene Clinic and the Duluth Rehabilitation Center. At that meeting, which I attended, the entire situation was discussed. I believe it was apparent from this discussion that such a plan was not feasible in view of the space requirements of the hospital and the limited space available. At this meeting, I asked the representative of the United States Public Health Service whether the Duluth Mental Hygiene Clinic would not be eligible for funds for the construction of a new clinic building under the rehabilitation center provisions of the Hill-Burton Act. Although he indicated that we might be eligible under this section, he pointed out certain problems in connection therewith but indicated, however, that no funds were presently available under this section.

The problem of the Duluth Mental Hygiene Clinic is becoming more acute as each month passes. We have run into one difficulty after another. We are, therefore, vitally interested in the Community Health Centers Act of 1963, although we recognize that funds under this act will not be available until the fiscal year ending June 30, 1965, which may be too late in our case. We are also vitally interested in an amendment to the Hill-Burton Act which would make us eligible for funds as a diagnostic or treatment center under that act. We would sincerely appreciate any assistance you can give us in resolving this problem. As I have indicated, a satisfactory solution must be found within the very near future if the services which we render to the people of northeastern Minnesota are not to be jeopardized.

As you may or may not know, the Duluth Mental Hygiene Clinic receives grants in aid from the State of Minnesota under the Minnesota Community Mental Health Program. In connection therewith, we are required to submit annually to the Commissioner of Public Welfare a program of our activities. I am enclosing for your information a copy of the current program.

I might add that, in addition to the functions we now perform, we have been requested by a responsible welfare agency in Duluth to undertake the establishment of a new phase of the mental health program, i.e., a social and recreational program for discharged mental patients. We have been told that this program would probably necessitate our employing two additional staff members. This, of course, would necessitate additional space.

Sincerely yours,

P. M. HANFT.

STATE OF MINNESOTA,
DEPARTMENT OF HEALTH,
Minneapolis, February 20, 1963.

Re: Proposed Duluth Mental Hygiene Clinic, Duluth, Minn.
Mr. PHILLIP HANFT,
Attorney, Duluth, Minn.

DEAR MR. HANFT: Your correspondence of January 3, 1963, was brought to the attention of Dr. Ralph E. Dwork, the Health Officer of Ohio, who also served as Chairman of the Legislative Committee of the Conference of the Surgeon General with the State Hospital Construction (Hill-Burton) Authorities held in Washington on January 7–9, 1963. It is interesting that Ohio and Minnesota had submitted similar items relative to mental health center eligibility. The final recommendation from the Conference reads as follows: "That the Surgeon General recommend to the Secretary of the Department of Health, Education, and Welfare that the administration support an amendment to the Hospital and Medical Facilities Survey and Construction Act to allow as an eligible applicant for assistance under the diagnostic and treatment category "A non-profit corporation or association which receives direct financial assistance other than fee

for service from any governmental unit for the operation of a mental health center or clinic."

You called us last week regarding the possibility of including the proposed Duluth Mental Hygiene Clinic under the Rehabilitation Facilities category and we have contacted the Kansas City Office of the U.S. Public Health Service and learned that although there has been no such Hill-Burton project in Iowa, the Minnehaha Guidance Center in Sioux Falls, S. Dak., received Hill-Burton funds under the Rehabilitation category of the Hill-Burton program.

A copy of the program for this Center which has just been received from Kansas City as well as a copy of the cover letter is attached herewith. In our opinion, this is a vocationally oriented rehabilitation center which includes mental health services.

On Tuesday morning, February 26, Mr. E. C. Slagle of our staff and Mr. William Shuler, Architect of the Kansas City Office, U.S. Public Health Service, will be in Duluth to visit St. Luke's Hospital in connection with its proposal for replacing the oldest part of the existing hospital under the Accelerated Public Works Program. We would like to arrange for a meeting at St. Luke's Hospital at 10:00 A.M. with representatives of St. Luke's Board as well as the Boards of the Mental Hygiene Clinic, the Rehabilitation Center and Dr. Fischer to discuss the feasibility of planning for sufficient space in St. Luke's Hospital to provide for the housing of both centers. Obviously the availability of A.P.W. funds depends upon additional appropriations. However, it appears that St. Luke's priority for funds would be strengthened substantially by incorporating these services into a single structure which would avoid duplication of facilities and personnel and substantially strengthen the services.

Sincerely yours,

HELEN L. KNUDSEN, M.D.,
Director, Division of Hospital Services.

STATEMENT OF CHARLES H. FRAZIER, MEMBER OF THE BOARD OF DIRECTORS OF THE NATIONAL ASSOCIATION FOR MENTAL HEALTH

My name is Charles H. Frazier. I am director of development for the Philadelphia Gas Works, a division of the United Gas Improvement Co., and a resident of Philadelphia. I am here today to testify as a member of the Board of Directors of the National Association for Mental Health in behalf of its 800 chapters and divisions and its enrolled membership and volunteer corps of more than a million. I am also chairman of the board and past president of Pennsylvania Mental Health, Inc., the State division of the National Association for Mental Health.

My organization—the National Association for Mental Health—has been in existence since 1909—first as the National Committee for Mental Hygiene, and then, since 1950, under its present title.

The representatives of the National Association for Mental Health have been here in the Capitol many times before to testify on various mental health measures In 1946, we came to Congressional hearings to urge enactment of the National Mental Health Act. And almost every year since then, we have come back again to testify on appropriations measures for the National Institute of Mental Health.

For many of the people who are here to testify today, and perhaps even for some of the Members of Congress, mental health may be a matter of relatively recent interest. But our organization has been in this work for many decades. I make note of this, not to establish any prior claim or prerogative or position of authority, but rather to impart to you, some of the great satisfaction that we **we feel in the knowledge that such a measure as H.R. 3688** is now before the House for consideration and, we hope, for enactment.

Fifty-four years ago when the National Committee for Mental Hygiene was organized by Clifford Beers, there were few who knew about mental illness and the mentally ill. Then there were known only the lunatic asylums—the horrible places where you sent away the brother or mother or father who went out of his mind—and you sent that relative away because no one knew that anything could be done with him except to shut him away so that he would not be any trouble to society, nor any harm to himself.

This was how you handled insanity or lunacy then. A few psychologists and psychiatrists identified the different forms of abnormal behavior—but they were

practically the only ones who knew or even cared, except for the few hardy doctors and social workers and interested citizens who had visited the lunatic asylums, and there had seen the human wreckage, the miserable, starved, frozen, brutalized, terrorized things that were once human. And it was only these few people who saw, even in those broken things, the hand and the spirit of God, and the persistent image of a human being, twisted and misshapen and distorted though that image was.

It was these few people and some others who were drawn to the cause, who saw in the misshapen beings—not sub-humans possessed by demons, not witches, not the work of the devil—but human beings who had something wrong with them—something wrong that made them behave so differently, so peculiarly. There was great wisdom in these men and women—wisdom which led them to see the bizarre behavior as symptoms, and which led them to understand that these were symptoms of disordered functioning, just as the symptoms of physical illness were the evidences of disordered functioning. And with this insight and wisdom, they were able to see then, some 50 years ago, that science would continue to probe insanity, and to attempt to identify the different forms, and seek to learn the causes, and how to prevent them, how to treat the victims and how to cure them.

It was this wisdom and this vision that motivated first this handful and then hundreds of others and then thousands of others to work for improvement and change. Many years have passed since the first organized efforts began, and many changes have taken place—none easily, none quickly, none spontaneously. Government agencies and government officials worked on this. And with them the psychiatrists and social workers and psychologists and clergymen and other professional people. And along with them the service groups and fraternal organizations and their hundreds of thousands of members. And with them the business organizations and the trade unions. And in the center and in the lead, the mental health associations.

And as a result of all this work, some truly great advances have been made. Today, there is hardly a newspaper, hardly a radio program, hardly a magazine issue, hardly a television program that does not concern itself in a truly serious way and knowledgeable way with the mentally ill, and the branch of medicine which treats them, that is, psychiatry. Today, mental illness is no longer a dark and mysterious and secret subject. And today, we recognize the mentally ill as sick people, suffering from biological and psychological disorders —disorders which can be treated and corrected. Certainly, medical science does not have all the answers to mental illness, but it does have some of the answers. And more important than that, it knows that there are answers—that they can be found—and when found, they can be applied to the relief of the millions of sufferers from mental illness—a name which covers dozens of different individual disorders of the mind, each with its own causes—each requiring different and special treatment.

I have spoken of the many different forces which, working together, have achieved this change. And everyone deserves great credit. But if I were asked to identify the one single force which did most to implement this change and stimulate and catalyze many of the other forces which were thrown into action, I would say it was the National Mental Health Act of 1946 and the agency which it brought into being—the National Institute of Mental Health—and the services and programs of that agency.

In an unobtrusive way, that Act and that agency, provided grants, technical assistance, guidance to the states and communities and foundations and schools of training and centers of research, making it possible for them to develop sorely needed programs of training, programs of research, and community mental health services. I say, unobtrusively, because my organization, with contacts in literally every community of any size in the United States, has not encountered a single instance where this federal aid brought with it federal domination, federal interference, or federal control. Now, it may be that there have been such instances, but if there were, they certainly did not come to our attention.

The brunt of the work, and the great overriding burden of the expense, and the genius of inventiveness and creativity has without a doubt been borne by the states and the localities and the foundations, private organziations, schools and other local agencies and institutions. And there it will continue as it must, because that is where the major and primary responsibility and authority is and must remain. But we must also welcome the kind of aid which the federal government has given to facilitate and stimulate the development of great human

and material resources which there are in our states and communities toward the conquest of this problem of mental illness—a problem which the American Medical Association has called America's most pressing and complex health problem.

Our organization, therefore, endorses with enthusiasm the measure which is before us for consideration today, H.R. 3688.

This measure addresses itself entirely to the development of community mental health services, specifically the creation and staffing of community mental health centers.

Traditionally, the care and treatment of the mentally ill has been considered and handled as a custodial problem, and for that reason, the very great majority of the mentally ill have been housed in and cared for in state institutions. And were we living with the limited knowledge and narrow perspective of fifty years ago, we would still continue to think only in terms of making life more endurable for the insane wards of the state. But we are not living fifty years ago, and we know that we are confronted not with a custodial problem, but with a medical problem. We are not concerned alone with ways in which to relieve overcrowding and insanitary conditions, and of eliminating abandonment and neglect, of giving humane care to people in mental institutions. We are concerned with providing medical care for sick people under the very same conditions and with the very same medical consideration as obtains in the treatment of other sick people. Ten years ago, the idea of treating mentally sick people in the general hospital, or in other treatment centers in the community, or in the offices of private physicians—ten years ago this was considered daring and radical. But not anymore, not today.

Today, when you hear an ambulance bell clanging and see the ambulance rushing to the hospital, there is a good chance that that ambulance may be carrying a mentally sick person to the psychiatric emergency ward of a general hospital.

Last year, as many patients were admitted to the psychiatric wards of general hospitals as were admitted to the regular state mental hospitals, and a large proportion of those who came to the general hospitals were suffering from the various types of serious mental illnesses which in the past would have automatically been directed to a state institution.

Psychiatry has come a long long way in the past ten years. It has learned that the majority of mentally sick people do *not* need long-term hospitalization. It has learned that many can achieve quick recovery through short stays in a hospital, or even through out-patient care at a hospital, or by coming to the hospital during the day and going back home at night. All this has been made possible because of the psychiatric drugs, and because of new methods in group psychotherapy and other psychological treatment.

Psychiatry has also learned that separation and isolation of the patient from his relatives and friends, from his place of worship, from his normal human contacts in the community actually serve to intensify his illness and to make chronic patients out of patients who might be treated and discharged in a matter of days in a community setting.

The tragic story of the state custodial institutions has been too often told to warrant repetition in detail here. But if all the abandonment and neglect, all the indifference and apathy, all the understaffing and inadequacy of facilities—if all that were corrected by some miracle today—and it would truly take a miracle to do it—if all that were to happen, it would still not provide an ultimately satisfactory solution to the problem, nor an ultimately satisfactory answer to the needs of the mentally ill.

There is one thing that physical change can never do for these hospitals, and that is to remove from them the quality of separateness and difference. Their isolation and their distance, their very identification as custodial institutions of the past, their very separateness from the community and hence from the mainstream of medicine serve to intensify and to make chronic the conditions which they are supposed to relieve. This is not just physical alienation. This is spiritual and philosophical alienation—and even more important, it is medical alienation. So long as we continue to treat mental illness away from the community and away from community medical facilities, we will see the gigantic problem of mental illness intensify and grow worse.

There is one certain—and I mean certain way to cut down this tremendous problem quickly, to save large proportions of the billions of dollars it is now costing the Nation, to rescue large numbers of victims of mental illness, to bring

the whole problem permanently into line, and that is to bring the treatment of mental illness back into the community, for that is where it belongs.

There must begin, and there must begin immediately, a definite and decisive shift from the traditional, isolated custodial institution to the development of well-planned systems of comprehensive mental health services in the community. And we are very happy to see that H.R. 3688, companion bill to S. 755, provides a most practical, a most expedient way to do this. In H.R. 3688, we find the essential ingredients for such a development. We find the motivation, the plan and the wherewithal.

H.R. 3688 provides Federal assistance for the creation of community mental health centers which will either, by themselves or together with other mental health facilities in the community, provide comprehensive services for prevention, diagnosis, treatment and rehabilitation.

This may, at first glance, seem likely a truly radical concent. Certainly, it is new and different and radical when compared to our traditional practices in regard to mental illness: But in reality, it is nothing new at all because this is what we have been doing for decades with regard to the physically ill.

In practically every community of any size, there exists a comprehensive, coordinated, interlocking system of services providing a continuity of care for physical illnesses. In many instances, you can find in a general hospital—all of these—diagnosis, prevention, treatment, rehabilitation. And if you do not find all these within the walls of the general hospital, then you will find that the general hospital has worked out a relationship with other agencies and facilities so that there need be no gaps, no unfilled medical or surgical needs.

Well, this is exactly what H.R. 3688 is seeking to create in the realm of the physiatric disorders. And that is continuity of services for comprehensive psychiatric care.

Hence, the concept of a single facility which can, within its own structure, or in alliance with other facilities, provide every type of in-patient and out-patient service, for patients of all ages and suffering from every different type of mental disorders, in addition providing services for prevention and rehabilitations, is a new one only as it applies to psychiatry. In effect, H.R. 3688 is attempting to bring the treatment of the mentally ill up to date and in line with the established methods for treating the physically ill.

H.R. 3688 proposes that these community mental health centers might be set up around existing facilities in general hospitals. This is an eminently practical and wise proposal because it eliminates duplication and overlapping, and permits maximum utilization of the medical staff and other services which already exist for the other patients for whom the hospital was originally constructed. There are already a number of places where centers of this kind have already been established. One is the Mayo Clinic in Rochester. Others are the Mt. Sinai Hospital in New York, the Montefiore Hospital in New York, and the El Paso, Texas County Hospital.

Relationship to a general hospital, while important is not essential in the concept of a community mental health center which provides comprehensive services. There are already in existence a number of such centers which provide all these services, and without connection with any other institution. Among these are the new Fort Logan Community Mental Health Center, near Denver, the Better Mental Health Center in Providence, Rhode Island, and the San Mateo Mental Health Center in California.

Without exception, these centers—all of them report remarkable success—with all kinds of patients, and those who make the reports continue to stress the fact that relatively small investments bring very good results with large numbers of patients.

No one can say whether there is one best answer to the treatment and rehabilitation of the mentally ill and the prevention of mental illness. But we do know that the mental health center, as it is now emerging is a very good answer, and even though the form may change through further trial and development, we believe that the essential principles will continue unchanged because these are time-tested principles—tested in other areas of medical practice and now firmly established.

There is implied recognition in H.R. 3688, both of the permanency of principle and the likely transience of the form. The bill does not establish a rigid formula. It does not insist that the entire range of services be enclosed within the walls of a single structure. It provides instead that these centers shall, either alone or in conjunction with other facilities owned or operated by

the applicant or affiliated organizations associated with the applicant, provide comprehensive mental health services. And it does not specify that those other facilities or those other affiliated organizations must be of a certain specific kind.

This is good. It provides a flexibility which permits local option. Each community can assess its own needs and resources and arrive at its own formula, one which suits it best. This encourages local enterprise and local responsibility, and assures local direction and control.

The measure makes only two things mandatory—and that is that the services provided by the center, either alone or together with other facilities, shall be comprehensive—and second, that they be part of a long-range plan.

The idea of comprehensive service is, as I have said, new in the field of mental health. What we have right now is a scattering of services, services which have grown up without investigation and plan. This is not something for which anyone need be criticized. For the past few decades, any one agency or organization which could do anything about bringing any kind of mental health service into begin, did so, and very often did it against great obstacles and resistances. During that period we were happy enough to see any kind of service emerging, even though it was only a token service, even though it was part of a patchwork, even though it was only part of a trial and error operation.

But the day for that is over. We now have the knowledge, the patterns, the models, and the resources to create comprehensive services—and to plan them in a way which will meet most of the needs of most of thhe mentally sick people, and not just an iota of the needs of just a fraction of the mentally ill.

Before a state can apply for federal funds either to construct or to staff these mental health centers, it must show that the particular center is part of a long range plan to provide adequate and comprehensive mental health services in a community.

I can say, without any fear of being challenged, that there is not a single community in the entire United States which today offers comprehensive and adequate mental health services to all or even most of the people in need of them. In those few instances where comprehensive services do exist, they are inadequate to care for more than a portion of people who need them. In 99.9% of the cases, they are neither comprehensive nor adequate.

If we do not go about the deliberate business of planning and projecting, then we will be condemning our communities, our neighbors, our families to a continuation of enforced sickness. The problem of mental illness can be cut down. Hundreds of thousands of mentally ill people can be treated and saved. Additional hundreds of thousands can be helped in the early stages of illness and so saved from more serious mental illness. But if this is to happen, then every state will need to work out, with all of its communities, a plan for comprehensive and adequate mental health services, and then it will need to go about putting this plan into action, through the community mental health center.

H.R. 3688 provides the motivation, the plan and the wherewithal. It would then be up to the states to act. Very wisely, H.R. 3688 places initiative and control of the entire process in the hands of the states and their communities. The Federal government provides grants up to 75% for construction and for staffing—the latter on a diminishing basis—and the state, through its designated agency makes use of this grant to implement a plan of comprehensive and adequate community mental health services.

That this kind of formula works to the great benefit of the states and communities has already been amply demonstrated. We know that the Hill-Burton formula of Federal grants for hospital construction has resulted in speedy development of additional general hospital services in communities throughout the country. With the stimulation provided by Federal grants, states and communities have moved ahead to fill up gaps, overcome inadequacies and to provide needed hospital services for their citizens.

In connection with mental health, we have seen how Federal grants to the States have resulted during these past 10 years in the development of community mental health services far beyond the Federal investment.

Through this process it has been demonstrated that community mental health services are vital. It is now time for the next step, and that is, to bring to a level of adequacy the services which have been shown to be necessary, but which exists now only in token form.

In other legislation, provision is made for grants to enable the States to plan these comprehensive mental health programs. It is urgent that H.R. 3688 be adopted to provide the wherewithal for the implementation of these plans.

From 1909, on, the National Committee for Mental Hygiene and then the National Association for Mental Health helped to initiate and to develop some of the most important programs in the fight against mental illness. Included in these developments are the psychiatric clinic movement; the mental hospital inspection program; first nation-wide training program for psychiatrists, psychiatric social workers and clinical psychologists—a program later taken over by the National Institute of Mental Health; the enactment of the first Federal mental health law—the Mental Health Act of 1946; the establishment of student counseling services in schools; sponsorship of the first comprehensive research program on schizophrenia and many others.

Throughout the years, our organization has carried on an intensive program of public education—to make the nation aware of the problem, to relieve fear and reduce prejudice, to keep hope alive, to stir sympathy and concern for the mentally ill, to stimulate interest in the state and communities, to mobilize community forces for necessary action to meet the needs of the mentally ill.

Each year, as I have said, we have appeared before committees of the Congress to testify on Federal mental health legislation. It has been most gratifying and most heartening to note the dedication and concern with which these committees have regarded the plight of the mentally ill. Many of the gains which have been made have come as a result of Federal legislative initiative and action. We urge now that this committee and that the entire House act favorable on H.R. 3688 so that we may truly move ahead into a new era in the fight against the nation's most pressing and complex health problem—mental illness.

STATEMENT OF THE PRESIDENT'S PROGRAM ON MENTAL ILLNESS, MADE BY A GROUP OF ORGANIZATIONS OF PARENTS AND RELATIVES OF MENTAL PATIENTS AT SEVERAL STATE HOSPITALS IN NEW YORK AND PRESENTED TO THE HOUSE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

In its historic final report to Congress, the Joint Commission on Mental Illness and Health accused society of "casting out" the mentally ill, of denying to these unfortunate Americans even a minimum of adequate treatment. The Commission attributed this failure in part to the fact that the mentally ill are unable to work together, and thus "lack the leverage" of pressure groups in promoting their own interest. Though doubtless unintended, the slap at relatives of these patients, who are capable of working together as pressure groups and have generally failed to do so effectively, is a deserved one. They are, however, beginning to do so.

As a group of organizations of parents and relatives of patients in several New York State hospitals, we would like to present to your committee and to Congress our position on the President's recent message to Congress concerning Mental Illness and Retardation.

First, we welcome most heartily the President's initiative in advancing a program for wider federal participation in the fight against mental illness. As the Joint Commission noted, this is essential and long overdue.

Second, we welcome as well the President's emphasis on the development of community mental health facilities as an effective means of combatting mental illness in a decade or two, and as the means of eventually eliminating the huge, isolated custodial institutions characteristic of past attitudes and current treatment of the mentally ill. Transference from these institutions to community general hospitals will both reflect and help bring to universal acceptance the concept that mental illness is a pathological condition no more disgraceful or blameworthy than physical illness.

All this, then, is to the good. We note, however, a rather strange omission in the President's plan, one which differentiates it in striking—and for us, tragic—fashion from the recommendations of the Joint Commission. We refer to the failure to provide NOW for federal subsidies to assist the states in improving the operations of existing state hospitals in order that they might begin at once to apply modern treatment methods on the scale required, and in order that they might extend more humane treatment to their helpless populations.

We call your attention to this declaration in the Commission's report:

"A national mental health program should recognize that major mental illness is the core problem and unfinished business of the mental health movement.

and the intensive treatment of patients with critical and prolonged mental breakdowns should have first call on fully trained members of the mental health profession.

The patients referred to, currently in state mental institutions, are included in the President's program only by way of token "Pilot" projects.

The Joint Commission report says further:

"Expenditures for public mental patient services should be doubled in the next five years—and tripled in the next ten. . . Only by this magnitude of expenditure can typical state hospitals be made in fact what they are in name only—hospitals for mental patients. . . It is self-evident that the states, for the most part, have defaulted on adequate care for mentally ill, and have consistently done so for a century. It is likewise evident that the states cannot afford the kind of money needed to catch up with modern standards of care. . . Only the Federal government has the financial resources needed to overcome the lag and to achieve a minimum standard of adequacy.

Accordingly, the Commission proposed that the VA hospitals to be taken as "financial models" for the operation of State hospitals. How far behind this model are New York hospitals can be gleaned from the fact that ward personnel in VA hospitals average one per patient; the formal ratio in New York hospitals is one for three patients (which translates into one for 11 patients on a three shift basis and allowing for weekends, vacations, illness, etc.), and in practice the ratio is even more unfavorable. The food budget in VA hospitals is $1.12 a day per patient; in New York State hospitals it is about 60 cents.

The Joint Commission thus suggested that Congress and the National Institute of Mental Health develop a federal subsidy program to encourage state governments to emulate the example of VA hospitals. The President's program omits this entirely as regards existing state hospitals, and our society remains in default of its responsibility to the patients in these hospitals.

The President said that merely pouring funds into outmoded institutional care would not be helpful. At the same time, however, he stated that "new medical, scientific and social tools and insights are now available," and with these it will be possible to restore all but a few hospitalized patients to useful lives. But why is it necessary to wait until the community programs is completed before undertaking these new intensive treatment methods in existing state hospitals? The Joint Commission states explicitly:

"Our study suggests a disparity between what we now do and what we could do if we did as much for most patients as we do for some; indeed, the majority of the mentally ill do not receive the benefits of present knowledge."

In his master plan for mental health, transmitted to the legislature early in 1962, Governor Rockefeller did envisage intensive treatment units in existing State hospitals, but his budgets have provided such treatment for only a few hundred of the 80,000 patients in these institutions. Apparently, finances are the obstacle to further extension. We believe the State can do more, and can be stimulated to do so with matching-fund subsidies from the Federal Government. Moreover, the Governor's master plan suggested that the nature of hospital living conditions helps to determine whether certain patients will be returned to normal lives. Again, neither the Governor's budgets nor the President's message provide the necessary means whereby this improvement in the conditions of life of State hospital patients can be realized.

In short, we feel that the program projected by the President in his message to Congress is deficient in that it continues to deny the "major mental patients"—those now in State hospitals—the benefits of present medical knowledge and modern standards of care. To overcome this deficiency, and to accept full responsibility for the mental patients in these hospitals, we respectfully urge your committee to include legislation now providing for an initial subsidy, on a matching basis, to States which undertake to develop intensive treatment methods and improvement of conditions in the State hospitals, as recommended in the Joint Commission report.

IRVING HEITNER,
Rockland Hospital Guild, Inc.
JAMES M. O'CALLAGHAN,
Rockland Hospital Guild Faith and Hope, Inc., Rockland State Hospital.
MORRIS GREENBERG,
Manhattan State Hospital Guild for Mentally Ill.
ROSE ROSEMAN,
Kids, Inc., Creedmore State Hospital.
MELVIN ELLENBOGEN,
Parents Council, Central Islip State Hospital.

STATEMENT OF GENE BIRKELAND, INDEPENDENT RESEARCH ANALYST

H.R. 3688 provides for the "construction of public and other nonprofit community mental health centers" (sec. 101) in accordance with regulations prescribed by the Secretary of HEW (sec. 103). Through the financial power wielded in sections 106 and 107 the Federal Government through its health czar actually maintains complete control of the clinics regardless of sections 110 and 104(6). The State or other administrative agency (such as one of the many foundations with clinics) is granted the right in those sections only of selecting the personnel and supplying janitor services for the buildings. All other administration must be in accordance with regulations made by the Secretary of HEW. Nowhere is there any provision for any group or individual to check on him. While retaining complete control through the power to withdraw funds, the only place where the Federal Government could not control the clinics is where they might be staffed, for example, with known Soviet agents, homosexuals, or whatever.

In order to insure Federal Government control, the bills provide that Federal funds pouring into the States (or portions thereof) shall not be less than 45 percent (sec. 104(c)) and for States this shall not be less than $100,000 per year (sec. 102(a)).

Additionally, State boundaries are broken down through the provisions of section 102(b) which allows for the transfer of funds from State to State through the collusion of the program's administrative officials.

There are many other adverse provisions in these bills with which its authors in HEW are well aware. It is a typical bill drawn by the "Welfare Staters" ensconced on taxpayers money in Government security. It would be well for Members of the House to refer to information on HEW and individuals in it, including the Assistant Secretary contained in Senate Finance Committee hearings on nominations of March 22, 23, 1961, pages 83–223.

There is absolutely no limitation placed on the amount of funds which may be appropriated by the HEW for this program and apparently the Congress is supplying a blank check to "provide adequate mental health services for mentally ill persons in a particular community or communities * * *" (sec. 103(b).

California, to promote the clinic program, quoted as their authority a cohort of Forstenzer's in New York, saying: "Primary prevention, according to Lemkau, includes not merely the physical protection of brain tissue, but also the preparation of the individual to withstand both predictable and unpredictable psychological stresses. Prevention in the organic area is the responsibility of the entire medical profession, and of public health workers in particular. The education and consultative services under this act (community clinics bill), on the other hand, have the goal. Primary prevention in the area of psychological disturbances that are precipitated by the exigencies of life, and this endeavor is synonymous with the promotion of mental health; for the growing preparedness of the individual from birth to maturity to withstand different stresses at different stages of life is what constitutes mental health."

I call to the attention of the Health and Safety Committee that while the House bills contain some definitions, they do not contain definitions of what constitutes mental health and mental illness. I call the committee's attention to the testimony of Dr. Thomas Szasz, New York psychiatrist, before the Senate Constitutional Rights Subcommittee in 1961, when he said there was no definition. Nor do these bills define the nature of a "comprehensive mental health program."

In practice and in writing this "comprehensive mental health program" constitutes a propaganda campaign to educate people in mental health principles through every medium of communication as well as through the public school system. These so-called principles incorporate political and social viewpoints designed to bring about a Socialist supranational government in control of U.S. foreign and domestic policies. The educational technique designed to bring about this political and social realignment is Pavlov's conditioned reflex which was designed to hold in thrall the peoples of Russia.

The mental health campaign was made a project of the advertising council a few years ago through the public policy committee of that group. That group is chairmanned by Paul G. Hoffman. Sitting on the board with him making the decision as to which campaigns to secure their more than $100 million yearly free advertising as public interest programs are several members of the World Federation for Mental Health. In 1954, the National Association for Mental Health, whose executive director was George Stevenson, also treasurer of the WFMH,

wrote that mental health had that year received more than 1 billion listener impressions through the always unidentified mental conditioning processes.

There is no need here to belabor the point that if this program were in any way a medical service, this would be socialized medicine. It is not medical and is predicated upon the same philosophy as so-called mental health practices in Soviet Russia. (See "Problems of Mental Health in the Soviet Uniin"; "Soviet Medicine in the Fight Against Mental Diseases"; "The Nature of Human Conflicts," A. R. Lauria, etc.

The community mental health clinic program was first developed in the State of New York shortly after Hyman Forstenzer left the Defense Department's I. & E. program and became assistant director of community mental hygiene services in New York. In the I. & E. program as the same time as Forstenzer (which was under the paper General Osborn of the Carnegie Foundation who is now on the board of the educational testing service which promotes psyhcological and academic testing instruments) was Julius Schreiber, psychiatrist and member of the National Association for Mental Health and World Federation for Mental Health; as well as numerous other fifth amendment pleaders and Mark Zborowski, convicted of perjury in denying espionage—Part 20: Interlocking Subversion in Government Departments; Part 5: Scope of Soviet Activity in the United States, SIS Committee.

It should be noted that Forstenzer has status and influence in both the American Association for Public Health, which promotes the clinic program, and the American Orthopsychiatric Association. He is now director in New York and as such participated in the so-called AMA National Congress on Mental Illness and Health in Chicago last fall.

After its introduction in New York in 1954, the community clinic program was then introduced into California where it was passed over vigorous opposition in 1957. It is now in New York, Indiana, California, Minnesota, New Jersey, Vermont, Connecticut, Wisconsin, Maine, South Carolina, Oregon, Utah, and Wyoming. The bills currently before the Congress are designed to implement this program and hasten its spread by purchasing State support.

It should be pointed out that recently New York was divided into mental health regions in order to facilitate the commitment to State hospitals of persons who enter the clinics and since a pattern is established, it is very likely that the entire country will be divided into such regions, on the order of the Federal judicial system, particularly through the 3,688 provisions for shuffling of funds.

It was in California that the philosophy behind the community clinic program was openly and widely published through the California Senate Interim Committee reports on community mental health centers and publications of the department of mental hygiene on community mental health services.

The biggest propaganda campaign has been conducted to convince public and legislators that insanity is a problem of staggering proportions. Actually, the word "insanity" is never used—the euphemistic term of "mental illness" has replaced it. To the lay mind, this means the same thing, but as Dr. C. Hardin Branch, now APA head, once said in 1952, "mental illness and insanity are not synonymous terms." Mental illness is a term so broad as to encompass anything which differs from the point of view of the diagnostician.

There are 542,000 individuals in mental prisons throughout the Nation. Many of these are not insane. Many are alcoholics, drug addicts, delinquents, seniles, etc. Many are merely nuisances to their families or neighbors because of their eccentricities. This number is a very minute fraction of our total population even if it were assumed that all of them were actually insane.

To bolster the point of view that mental illness is staggering in proportions, statistics of divorce, delinquency, alcoholism, addiction, psychosomatic ailments, etc., are cited as evidence. These problems have been prevalent in society since the beginning of time, but they have been aggravated in recent years by the removal of moral and religious restraints upon human activities. In their place has been substituted a humanistic philosophy which could only produce social chaos and anarchy. In other words, the situation has been carefully contrived in order that the solution might then be supplied. To quote Harry Overstreet as the Department of HEW once did: "Now, apparently, science is ready for a new method; that of uniting to conquer. What has been divided and subdivided for purposes of research is now being assembled for purposes of interpretation and of application to human affairs."

In 1955 the American Medical Association, although psychiatrists had a number of organizations totally their own—through psychiatric influences within the AMA—organized a mental health council which by 1961 had brought the

AMA to membership in the World Federation for Mental Health. The mental health council was under the direction then and continues to be under the direction of individuals prominent in the WFMH. It should be pointed out that the HEW's National Mental Health Advisory Council is also dominated by internationally minded doctors.

This same year, 1955, the AMA's Council on Mental Health, together with the APA (which to all purposes was actually the same thing) brought out of Congress through their powerful professional lobbyists, the establishment of a Joint Commission on Mental Illness and Health supported by tax funds. The task of this group was to establish a survey to convince the American public that mental illness was of staggering proportions and they were the only ones who could save us from disaster. The figures go to the advertising council for promotion of the idea that a minimum of 1 in 10 is mentally ill. The survey on which this statistic is based took place in 1936.

Is it an accident that the published statements coincide so clearly with the practice of mental health in the Soviet?

Joseph Wortis, psychiatric instructor at Bellevue for 20 years (and recently on the American Public Health Association's mental health section with Hyman Forstenzer; as well as a recipient of $25,677 in U.S. Public Health funds in 1961) in his appearance before the SIS Committee was shown as the author of a book descriptive of mental health in Russia. He described the prevailing point of view in Soviet psychiatry: "Prevention of mental disease consists primarily of the removal of the conditions which lead to mental illness in improving the conditions of work and of existence. * * *"

How little different is that from the goal of community clinics as described in California: "The sociological approach places emphasis upon the individual as a member of society or of the family, and upon the social and cultural determinants of mental illness and health. This approach stresses the importance of social factors both in the causation and in the rehabilitation of psychiatric disorders, which are here regarded as essentially symptomatic of a sick society. The sociological approach assumes that: (1) social and family conditions are not merely the results of individual psychobiological adaptive mechanisms but are, more importantly, prominent as etiologic factors in psychiatric disorders; (2) criteria for healthy and pathological patterns of social organization and for social action with respect to individual and communal mental health are applicable to the problem of mental illness; and (3) correctional measures applied to both social conditions and, through education, to individuals promote mental health" (second partial report, California Senate).

Frankwood E. Williams who was head of the National Committee for Mental Hygiene until George Stevenson took over (which is now the National Association for Mental Health, the so-called voluntary arm of the movement as opposed to the National Institute of Mental Health, the governmental arm, but which work in conjunction), admired Soviet psychiatry. He said: "Mental hygiene must have to do with keeping well people well, of so organizing life and the emotional development of the individual that the anxieties and fears that lead to defensive reactions on his part and which end in inefficiency, unhappiness and often illness and antisocial conduct, be minimized, so that he may be in a position to contribute of his best. * * * Is it possible that Russia is thinking in terms of 100 percent of the population, of mental hygiene in a positive instead of a negative sense?"

As the Congress knows, in March, 1962, this group presented a bill for their gigantic WPA project demanding a total sum of $3 billion.

Almost without exception witnesses appearing before various committees of Congress in support of this fantastic system of social control can be demonstrated to be participants in the international program designed to establish a supranational government.

Voluminous documentary evidence exists of this well-laid years' long scheme for those who are interested. Denial of its existence by its participants cannot expunge the record. The adoption of this system of national mental health clinics will provide a channel for the control of human thought which will eventually cause a reversion to the Dark Ages from which it is unlikely that we will emerge.

STATEMENT BY ROBERT REIFF, PH. D., DIRECTOR, NATIONAL INSTITUTE OF LABOR EDUCATION MENTAL HEALTH PROGRAM

For the past 4 years, the National Institute of Labor Education—an independent organization of universities and unions whose purpose is the development of workers education—has been conducting a study to conceptualize and organize a mental health program for labor organizations.

We have been working closely with the labor education and behavioral science departments of universities and with local union leadership in many communities to investigate the special mental health needs of industrial workers and their families, the manner in which these needs are now being met, and the measures necessary to strengthen programs of prevention, care, and rehabilitation.

What emerges clearly from our work is the pressing social need for a national action program to bring the benefits of modern psychiatry to millions of Americans who are presently denied them.

We, therefore, welcome and endorse the legislation before your committee and urge its speedy passage. More clearly than previous proposals, it embodies acceptance of the fact that mental illness, no less than physical illness, is a public health problem toward which society as a whole and the Federal Government in particular bears a full measure of responsibility.

We support, too, the manner in which the legislation proposes to employ Federal funds and machinery on behalf of improved services for the mentally ill. The plan for a nationwide system of comprehensive mental health centers is both scientifically sound and socially desirable. Sufficient evidence is on hand from the demonstration programs conducted in this country and elsewhere that such centers, embracing diversified forms of care from the emergency walk-in clinic to full inpatient treatment, are the most effective means of meeting the community's mental health needs. Other testimony has been presented on the validity of this approach. We should like to direct our remarks, therefore, to some aspects of the present situation which need to be known and taken into account if the proposed program for community based mental health services is to achieve its stated objective.

First of all, we believe that it is appropriate and important to predicate mental health legislation on the priority task of returning to the community the thousands of mentally ill now languishing under little more than custodial care in State institutions and sparing others the necessity for similar confinement. To fulfill this aim, however, we need to know just who are the people now crowding the State institutions and for whom the community program is being designed as an alternative form of treatment.

While in principle, it is true that the State hospital is available to the community in general; in practice, the population in State hospitals is not equally representative of all the segments of the community. On the contrary, it is overwhelmingly drawn from lower income groups. It is well known that patterns of medical care differ widely between the higher income members of our society and those with limited financial means, but the differentials existing in respect to the care and treatment of mental illness are especially marked. Every major study in recent years has produced additional evidence that people in the strata of society composed primarily of industrial workers and lower economic groups receive different diagnoses and treatment from those in the middle and upper brackets, even when they apparently suffer from the same illness. When they develop a mental illness, they are usually institutionalized, whereas outpatient treatment in the community is a predominant form of treatment for the middle and upper economic groups.

Consider the following:

In a relatively recent psychiatric treatment census conducted in the Borough of Manhattan in New York City—

(1) individuals were classified according to certain social and economic indexes as "upper," "middle," and "lower" strata and prevalence rates of psychiatric patients were computed for every 100,000 in the corresponding population group. When the place of treatment was studied, findings were that only 202 out of every 1,703 in the "upper" group were institutionalized as compared to 664 out of every 1,060 in the "lower" status group. Considering psychotic patients alone, where institutionalization rates would be expected to be more similar for all groups, it was found that 50 percent of "upper" group patients are treated on an outpatient, ambulatory basis, whereas 90 percent of the "lower" group psychotic patients are institutionalized.

Thus, we find that those courses of treatment which modern psychiatry holds as most desirable and effective have been restricted by and large to the economically favored section of the population—even in a community like New York City which is uniquely favored in the number of its treatment facilities and presumably should offer greater opportunities for working people to secure the necessary services without recourse to institutionalization.

The prevasiveness of institutionalization as the method of treatment prescribed for and applied to working-class people has also been dramatically documented by Hollingshead and Redlich—

> (2) in their now-classic study of treated cases of mental illness in New Haven. While treatment of psychotic patients on an outpatient basis is a relatively new development, outpatient treatment has been historically the treatment of choice for neurotic patients. Nevertheless, the New Haven study found that 32.8 percent of the neurotic patients in the lowest socioeconomic class who were receiving treatment for the first time were in State, military, or VA hospitals. Not a single neurotic patient in the upper classes was hospitalized.

The consistency of the relationship this study revealed between economic status and institutionalization for mental illness is startling; the percentage of all psychotic patients at each economic level who are treated in State hospitals rises step by step as the individual's socioeconomic position becomes progressively lower—from 33 percent in the two upper brackets to 70, 80, and 90 percent in the lowest.

The conclusion is inescapable that treatment in State institutions is related inversely to economic position. Since it is well known that these overcrowded and understaffed institutions have, for the most part, offered little more than custodial care, it becomes apparent that once a worker suffering from mental illness is hospitalized, his chances of return to family and job are meager. In one way, then, we might look upon the State mental hospitals as places of confinement where there is a pileup of the mentally ill of our society who have limited economic means—or, as Hollingshead and Redlich put it, the "dumping ground" for psychotic individuals in the lower economic brackets. In this sense, they are as anachronistic as the debtor prisons in which the economically needy were incarcerated years ago.

What we are confronted with, therefore, is a situation not merely of national neglect of the mentally ill—serious as that is—but differential use of existing resources in favor of the higher income families. This is an important fact to consider when new legislation is being framed, for it highlights certain conditions which must be built into a community mental health center program if it is to function as a realistic alternative to the public institutional program.

In looking into the reasons for this differential use of facilities, it becomes clear that it is not a matter of malice nor necessarily of bias. It arises primarily because the mentally ill individual in the lower socioeconomic groups cannot afford to pay for treatment services no matter what specific form they take. At the point at which he develops a mental illness, he becomes a public charge, and publicly financed psychiatric services are, with few exceptions, available only in State or VA hospitals.

If the planned community mental health centers are to serve those in need of such services, therefore, long-range and comprehensive methods of financing must be worked out. There are two aspects to the problem of adequate financing—one dealing with the resources needed to develop and operate the services, and another dealing with the utilization of these services. The bill's provision of Federal funds to aid in the construction and initial staffing of community mental health centers is a commendable step. However, we are concerned that the legislation does not furnish any plan for continuing permanent public support for such services. It is certainly questionable to say the least whether services on the scale necessary can be supported through either philanthropic funds or the payment of fees.

Since 1824, when the first State-supported mental institution was established in the United States, public funds have provided the major form of financing for psychiatric care programs. Now, when for the first time in history society can realize a gain from its social investment in such programs by converting them from custodial to preventative and rehabilitative purposes—is surely not

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