MENTAL HEALTH CENTERS CONSTRUCTION ACT EXTENSION

HEARINGS

BEFORE THE

SUBCOMMITTEE ON PUBLIC HEALTH AND WELFARE

OF THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

HOUSE OF REPRESENTATIVES

NINETIETH CONGRESS

FIRST SESSION

ON

H.R. 6431

A BILL TO AMEND THE PUBLIC HEALTH LAWS RELATING TO MENTAL HEALTH TO EXTEND, EXPAND, AND IMPROVE THEM, AND FOR OTHER PURPOSES

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MENTAL HEALTH CENTERS CONSTRUCTION ACT EXTENSION

TUESDAY, APRIL 4, 1967

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

The subcommittee met at 10 a.m., pusuant to notice, in room 2123, Rayburn House Office Building, Hon. John Jarman (chairman of the subcommittee) presiding.

Mr. JARMAN. The subcommittee will please be in order. The hearings today are on H.R. 6431, the Mental Health Amendments of 1967, introduced by Chairman Staggers at the request of the administration. This bill would extend the current program of grants for the construction and initial staffing of community mental health centers; would authorize research, training and demonstration project grants to be made to Federal institutions; and would authorize establishment of a contingency account for the Department of Health, Education and Welfare.

This committee has been active in the field of mental health legislation for over 20 years now, beginning with the initial legislation establishing the National Institute of Mental Health.

In 1955, this committee initiated the Mental Health Study Act of 1955 calling for the establishment of a program of research and study of our resources, methods and practices for diagnosing, treating, caring for, and rehabiltating the mentally ill.

A Joint Commission on Mental Illness and Health was established pursuant to this legislation and the Commission made its final report on December 30, 1960. The Commission recommended establishment of community mental health centers to provide care for the mentally ill close to their homes in a community setting.

The report of this Commission was studied by the executive branch and the Congress and in 1963, President Kennedy recommended to the Congress the enactment of legislation providing Federal matching grants for construction and initial staffing of community mental health centers. Hearings were promptly held on this legislation and legislation was enacted in October 1963 authorizing matching grants for construction of community mental health centers.

In 1965, President Johnson recommended the enactment of legislation providing matching grants for initial staffing of community mental health centers; and this legislation became law in 1965.

The authorization for matching grants for construction is due to expire June 30 this year, and the authorization for grants for initial

staffing is scheduled to expire June 30, 1968; therefore, prompt action on this legislation is required in order that orderly planning may continue.

(The bill, H.R. 6431, and department reports thereon, follow:)

[H.R. 6431, 90th Cong., 1st sess.]

A BILL To amend the public health laws relating to mental health to extend, expand, and improve them, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Mental Health Amendments of 1967".

GRANTS FOR CONSTRUCTION OF COMMUNITY MENTAL HEALTH CENTERS

SEC. 2. (a) Section 201 of the Community Mental Health Centers Act (42 U.S.C. 2681) is amended by striking out "and $65,000,000 for the fiscal year ending June 30 ,1967" and inserting in lieu thereof, "$65,000,000 for the fiscal year ending June 30, 1967, $50,000,000 for the fiscal year ending June 30, 1968, and such sums striking out "1967" and inserting in lieu thereof "1972".

(b) Section 207 of such Act is amended (1) by striking out "three", and (2) by striking out "1967" and inserting in lieu thereof "1972".

GRANTS FOR INITIAL STAFFING OF COMMUNITY MENTAL HEALTH CENTERS

SEC. 3. (a) Section 221(b) of the Community Mental Health Centers Act (42 U.S.C. 2688a(b)) is amended bp striking out "1968" each place it appears and inserting in lieu thereof "1972".

(b) The first sentence of section 224 of such Act is amended by striking out "and $30,000,000 for the fiscal year ending June 30, 1968" and inserting in lieu thereof "$30,000,000 for the fiscal year ending June 30, 1968, and such sums as may be necessary for the next four fiscal years". The second sentence of such section is amended by striking out "five" and inserting in lieu thereof "nine".

MISCELLANEOUS AMENDMENTS RELATING TO CONSTRUCTION OF COMMUNITY MENTAL HEALTH CENTERS

SEC. 4. (a) Section 401(e) of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (42 U.S.C. 2691) is amended by inserting "acquisition," after "new buildings,".

(b) Paragraph (7) of section 204 of such Act (42 U.S.C. 2684), is amended by inserting before the semicolon at the end thereof "and, effective July 1, 1969, provide for enforcement of such standards with respect to projects approved by the Secretary under this part after June 30, 1967".

PROJECT GRANTS TO FEDERAL INSTITUTIONS

SEC. 5. Effective July 1, 1968, title V of the Public Health Service Act is amended by adding after section 506 (42 U.S.C. 224) the following new section:

"GRANTS TO FEDERAL INSTITUTIONS

"SEC. 507. Appropriations to the Public Health Service available for research, training, or demonstration project grants pursuant to this Act shall also be available, on the same terms and conditions as apply to non-Federal institutions, for grants for the same purpose to hospitals of the Service, of the Veterans' Administration, or of the Bureau of Prisons, Department of Justice, and to Saint Elizabeths Hospital."

ESTABLISHMENT OF A CONTINGENCY ACCOUNT

SEC. 6. (a) In order to facilitate the more efficient and effective administration of the programs of the Department of Health, Education, and Welfare, there is hereby created in the Treasury of the United States a contingency account which shall be available to the Secretary of Health, Education, and Welfare without fiscal year limitation for use as provided in this section.

(b) There is authorized to be deposited in the contingency account established by subsection (a), to the extent authorized in annual appropriation Acts, the amount of any general fund appropriation to the Department for a fiscal year (beginning with appropriations for the fiscal year ending June 3, 1967) which, at the end of the period for which such appropriation is available for obligation, remains unobligated, but only to the extent such deposit, when added to the sum then in the account, will not increase such account to more than $50,000,000. The amount so deposited shall be based on estimates made at the time of the termination of availability of the appropriation, with subsequent adjustments (to be made no later than the close of the fiscal year following the year in which the deposit was made) being made to take account of errors in such estimates.

(c) The Secretary is authorized, to the extent provided in annual appropriation Acts, to draw upon the contingency account established by subsection (a) whenever he determines that such action is required to fulfill his responsibilities and that delay pending further appropriations by the Congress would be contrary to the public interest, but only if such withdrawal is required to carry out a purpose which the Secretary determines is significant and only if the need for such withdrawal could not reasonably have been anticipated at the time the Budget was submitted to the Congress. Funds withdrawn pursuant to such a determination may be transferred and merged with the appropriation or appropriations the Secretary determines to be appropriate. Each such determination shall be subject to the following limitations—

(1) no amount may be so used during any fiscal year for a purpose for which funds were requested in the Budget for such year but for which funds were not appropriated for such year;

(2) no amount may be so used for any activity or purpose which is not otherwise authorized by law;

(3) the amounts so used pursuant to any such determination for any fiscal year may not exceed $15,000,000; and

(4) no amount may be so used in any fiscal year for any purpose if amounts were so used during both of the two preceding fiscal years for the same purpose.

(d) The Secretary shall, at least ten days prior to the use of any funds pursuant to each determination under this section, notify the Appropriations Committees of the Congress of such determination; and on or before July 31, 1968, and on or before July 31 of each succeeding year, the Secretary shall transmit to the Congress a full report on operations with respect to the fund established by subsection (a) during the fiscal year ending on the June 30 preceding such July 31.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., April 5, 1967.

Hon. HARLEY O. STAGGERS,
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 March 14, 1967, for a report on H.R. 6431, a bill "To amend the public health laws relating to mental health to extend, expand, and improve them, and for other purposes."

The bill, to be cited as the "Mental Health Amendments of 1967," would extend or amend the provisions of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 in four respects:

(1) The authorization for grants for the construction of community mental health centers would be extended for five additional years—through fiscal 1972. For Fiscal 1968, $50 million would be authorized for this purpose, and for each of the remaining four fiscal years such sums as may be necessary.

(2) The authorization for grants for initial staffing of community mental health centers would be extended for four additional years—also through fiscal 1972. For fiscal 1968, $30 million would be authorized for this purpose (the amount now authorized for fiscal 1968) and for each of the remaining three fiscal years such sums as may be necessary.

(3) Section 401(e) of the Act would be amended to permit construction grant funds to be used for the acquisition of existing buildings as well as for the construction of new facilities.

(4) Section 204 of the Act would be amended to require that—effective July 1, 1969—State plans for the construction grant program shall provide for enforcement of State minimum standards for the operation of such mental health facilities.

In addition to these mental health amendments, the bill includes two other provisions of more general applicability:

(1) Section 5 of the bill would add a new section 507 to the Public Health Service Act which would provide continuing (and somewhat expanded) authority for certain Public Health Service project grants which have heretofore been permitted under provisions of annual appropriations acts. The new section would provide that appropriations to the Public Health Service for research, training, or demonstration project grants shall be available, on the same terms and conditions as apply to non-Federal institutions, for grants for the same purpose to hospitals of the Service, of the Veterans' Administration, or of the Bureau of Prisons, Department of Justice, and to Saint Elizabeths Hospital.

(2) Section 6 of the bill would establish in the Treasury of the United States a contingency account available to the Secretary of Health, Education, and Welfare to meet certain unforeseen needs relating to the program responsibilities of the Department. No new appropriations would be authorized for this purpose, since funds in the account would be accumulated through the transfer of unobligated general funds appropriated to the Department in annual appropriation acts. Both the accumulation of funds in the account and their expenditure to meet contingency needs would be subject to certain statutory limits and conditions, including a limitation to authorizations contained in annual appropriations acts. Full reports to Congress would be required.

The provisions of H.R. 6431 embody legislative recommendations contained in a draft bill submitted by this Department to the Congress on February 28, 1967, to implement the mental health recommendations contained in the President's Message on Education and Health. We strongly recommend early enactment of the bill.

We are advised by the Bureau of the Budget that enactment of this proposed legislation would be in accord with the program of the President.

Sincerely,

WILBUR J. COHEN, *Under Secretary.*

OFFICE OF THE ATTORNEY GENERAL,
Washington, D.C., April 5, 1567.

Hon. HARLEY O. STAGGERS,
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 Department of Justice on H.R. 6431, the "Menatl Health Amendments of 1967."

The Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, 77 Stat. 284, as amended, 42 U.S.C. 2661, authorizes the Secretary of Health, Education and Welfare to make grants to the States for construction of facilities for the mentally retarded and of community mental health centers. In addition, the Act authorizes grants for university-affiliated facilities for the mentally retarded and initial staffing grants for community mental health centers.

The "Mental Health Amendments of 1967" would extend the appropriation authorization for the Community Mental Health Centers program from 1967 until 1972. Similarly, the program of staffing grants for Community Mental Health Centers would be extended from 1968 until 1972. The definition of "construction" in section 401 of the Act (42 U.S.C. 2691) would be amended to include acquisition of existing buildings and the Community Mental Health Centers program would be amended to require that, after July 1, 1969, States enforce minimum maintenance and operations standards for centers constructed with grant funds. H.R. 6431 would also amend the Public Health Service Act, 58 Stat. 682, as amended, 42 U.S.C. 201 *et seq.*, to make research, training and demonstration project grants under that act available to various federal hospitals.

H.R. 6431 would establish in the Treasury a contingency account for the Department of Health, Education and Welfare, limited to a total of $50,000,000.

Unobligated appropriations of that Department would be deposited in the account and the Secretary of Health, Education and Welfare would be authorized to draw on the account whenever he determines: that such action is necessary to fulfill his responsibilities; that delay pending further appropriations would be contrary to the public interest; that the withdrawal is required to carry out a significant purpose; and that the need for such withdrawal could not reasonably have been anticipated at the time of the Budget submission. Individual withdrawals in excess of $15,000,000 in any one fiscal year would not be permitted, and no withdrawal could be made if Congress had refused to appropriate requested funds for the particular purpose or if withdrawals for the same purpose had been made in the two preceding years. Prior notice of withdrawals would be made to the Appropriations Committee and annual reports on the contingency account would be made to Congress.

The Department of Justice recommends enactment of this legislation.

The Bureau of the Budget has advised that there is no objection to the submission of this report from the standpoint of the President's program.

Sincerely,

RAMSEY CLARK, *Attorney General.*

VETERANS' ADMINISTRATION,
OFFICE OF THE ADMINISTRATOR OF VETERANS AFFAIRS,
Washington, D.C., April 6, 1967.

Hon. HARLEY O. STAGGERS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: We are pleased to furnish the following comments in response to your request for a report by the Veterans Administration on H.R. 6431, 90th Congress.

The stated purpose of the bill is "To amend the public health laws relating to mental health to extend, expand, and improve them, and for other purposes." Section 5 of the bill is of direct interest to the Veterans Administration and our comments refer to that section.

Section 5 would amend title V of the Public Health Service Act, effective July 1, 1968, by adding after section 506 the following new section:

"GRANTS TO FEDERAL INSTITUTIONS

"SEC. 507. Appropriations to the Public Health Service available for research, training, or demonstration project grants pursuant to this Act shall also be available, on the same terms and conditions as apply to non-Federal institutions, for grants for the same purpose to hospitals of the Service, of the Veterans' Administration, or of the Bureau of Prisons, Department of Justice, and to Saint Elizabeths Hospital."

We understand that this section was developed and proposed by the Department of Health, Education, and Welfare to overcome a problem that became apparent after passage of Public Law 89-239, enacted October 6, 1965. This law authorized through the new title IX of the Public Health Service Act grants to be made from the Public Health Service appropriations for establishment and operation of cooperative regional medical programs designed to aid in research and transmission of new knowledge and technology on heart disease, cancer, stroke, and related diseases from the Nation's medical centers to the community hospitals. The grant provisions in title IX include "public . . . institutions and agencies" but this has not been considered by the administering department as broad enough in this context to include Federal facilities such as VA hospitals.

It seems to us that to assure the effectiveness of the Regional Medical Program the same treatment should be accorded to Federal hospitals in providing grants for purposes directed to the health needs of the Nation as a whole as is afforded all other hospitals. The current exclusion of Federal hospitals works to the disadvantage of both the hospitals and various regions for it prevents an important segment of the national medical care system from fully and effectively participating in planning the regional programs at the formative stage. This is contrary to one of the major objectives of the Regional Medical Program, namely, to foster unified planning and utilization of regional resources.

Under the bill the Public Health Service grants could also be made directly to VA hospitals for research and related activities apart from the Regional Medi-

cal Program. Generally, the VA has not been able to participate directly in such grants under existing laws. The Public Health Service has been making grants to Medical Schools or Universities affiliated with the Veterans Administration which in turn use the funds to support projects conducted by VA researchers who are also affiliated with the school or university. Enactment of this legislation would permit VA hospitals to deal directly with the Public Health Service rather than having to rely upon the indirect arrangements now followed.

It is apparent to the Veterans Administration that cooperative efforts with HEW in research and related programs are mutually beneficial to both. In addition to the obvious benefits resulting from coordination and more effective assignment of talent, the projects should receive greater recognition when supported by the prestige of both the VA and the Department of Health, Education, and Welfare. It seems entirely proper that the Veterans Administration's program in the area should be assisted by Public Health Service grants since our research and training activities make a large and continuing contribution toward meeting the health needs of the Nation.

The importance of this proposal is emphasized by the recent action of the Congress in enacting Public Law 89-785 directly concerning the medical program of the Veterans Administration. Among other provisions, that law (38 U.S.C. 5054) authorized the Administrator to enter into agreements with medical schools, hospitals, research centers, and professional medical personnel for the free exchange of medical information and techniques. It also authorized grants to medical schools, hospitals, and research centers to support pilot programs for effectuating the arrangement for the exchange of medical information (38 U.S.C. 5055). Finally, this new law specifically directed that the Administrator and the Secretary of Health, Education, and Welfare "shall, to the maximum extent practicable, coordinate programs carried out under this subchapter and programs carried out under title IX of the Public Health Service Act."

For the reasons stated, I strongly recommend favorable consideration of H. R. 6431 by your Committee.

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,

W. J. DRIVER, *Administrator.*

Mr. JARMAN. We will start today's hearing with the statements of two of our colleagues, the Honorable Edward Patten, of New Jersey, and the Honorable Lee Hamilton, of Indiana. You may proceed as you wish, Mr. Patten.

STATEMENT OF HON. EDWARD J. PATTEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PATTEN. Mr. Chairman, and members of the House Interstate and Foreign Commerce Committee, on February 5, 1963, John F. Kennedy became the first President to send a message on mental health to the Congress. He pointed out the challenge: that mental illness and retardation are "of critical size and impact." We heeded that challenge and passed the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963—and improved it in 1965.

And in his message on education and health on February 28, of this year, President Johnson noted that "more community mental health centers are needed, and we must strengthen and expand existing services." This is another challenge we must meet and defeat.

There have been notable achievements under this historic program: As of February 1, 1967, 147 community mental health centers have received Federal grants of $54.3 million—$36.5 million in construction grants and $17.8 million in staffing awards.

In the State of New Jersey, Newark has received a Federal grant of $1,504,924 for a community mental health center.

Middlesex County, N. J., has applied for a Federal grant of $122,500 for the $350,000 Raritan Bay Community Mental Health Center in Perth Amboy. Other areas in the State have also applied and when I think of the valuable financial help this program will provide, it makes me particularly proud of the Congress that passed it.

For years it was obvious that community mental health centers should be provided, but it took the 88th Congress and its successor—the great 89th—to convert hope to victory—and then, accomplishment.

Federal construction grants ranging from one-third to two-thirds are provided.

And Federal grants are provided for staffing the centers—as high as 75 percent for the first 12 months, to 30 percent for the fifth stage.

When I was mayor of Perth Amboy, county clerk of Middlesex, and New Jersey secretary of state, I was greatly moved—and always will be—to see so many persons suffering from mental illness and retardation and not be treated effectively, either because of insufficient facilities, or obsolete and ineffective methods.

One of the most important features of the community mental health center concept is that patients are treated close to their homes, thereby improving their morale and spirit, for as all of us know, love is the best "medicine" of all. In fact, I was informed that some persons who suffer from some forms of mental illness work during the day and are treated at night at some centers.

Yes, significant progress has been made in these fields, but more—much more—must be made before we can honestly say that we have conquered mental illness and retardation.

So I strongly urge this committee to report the bill introduced by the able and respected chairman—the Honorable Harley O. Staggers—H.R. 6431 and continue the attack against mental illness and retardation.

By approving this bill, public health laws relating to mental health would not only be extended (5 years for construction and 4 years for staffing) and expanded, but improved.

One of the most important improvements, for instance, would enable existing buildings to be acquired, instead of building only new units. This would considerably reduce the time required to provide a center, as well as decreasing the cost.

Another improvement would establish a contingency account without a fiscal year limitation, increasing the efficiency and effectiveness of the programs.

The proposal also includes other improvements.

I voted for the 1963 act with deep happiness, because I knew it would help so many people and I voted for the 1965 amendments.

I am also looking forward to voting for the Mental Health Amendments of 1967.

Let us show the afflicted, our people, and even the free world our Nation leads, that compassion is not merely a word we speak—but a conviction we practice.

Mr. JARMAN. Are there any questions? If not, we thank you for your testimony, Mr. Patten.

Mr. PATTEN. Thank you for the opportunity, Mr. Chairman.

Mr. JARMAN. We will hear next from Mr. Hamilton.

STATEMENT OF HON. LEE H. HAMILTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF INDIANA

Mr. HAMILTON. Mr. Chairman, I am pleased to testify in support of H.R. 6431 before this distinguished Subcommittee on Public Health and Welfare which in recent years has led the Congress in historic legislative breakthroughs to assist in the treatment of mental disorders.

This committee is well aware of the enormous tragedy, personal and social, brought about by mental disorders.

Mental illness afflicts about one out of every 10 persons in this country. It is often a significant factor in criminal behavior, delinquency, suicides, alcoholism, narcotics addiction, divorce, and accidents. The overall cost of mental health has been estimated to exceed $5 billion. The personal tragedy that attends each instance of mental illness is the highest cost of all.

Americans spend more for chewing gum than for psychiatric research to get Americans out of mental hospitals. One out of every two hospital beds in the United States is occupied by mental patients. State mental hospitals are often overcrowded. There are more people in hospitals for mental illness than for polio, cancer, heart disease, tuberculosis, and all other diseases combined. Not a single community in this country provides an acceptable standard of service for mentally ill or retarded children.

The Mental Health Centers Act, authored by this committee, has begun to meet the challenge of mental health in a most heartening way by providing for mental health centers. As a result of the Mental Health Centers Act, a trend has been initiated in the treatment of mental illness to move away from the State hospitals and toward an emphasis on the community-directed mental health center. In 1965 almost two in every three patients were not hospitalized. They received either private office psychiatric care or were treated in one of the 2,000 mental health clinics in the United States.

The need for comprehensive community mental health centers is abundantly clear. The mental health center is a multiservice facility. It can provide easily accessible services for the early diagnosis and treatment of mental disorders, both on an inpatient and outpatient basis, and a resource for continued treatment for individuals returning to their home communities following periods of extended hospitalization. Services and training are made available to help restore a patient to his fullest mental, physical, social, and vocational abilities. Such mental health centers serve as a central focus for mental health services to the total community population.

The Indiana State Department of Mental Health strongly supports H.R. 6431, as does the Indiana State Mental Health Association.

I am persuaded that the enactment of H.R. 6431 can mean the difference between providing comprehensive care and service at the earliest practicable date to those afflicted with mental illness, and an indefinite delay in meeting these needs.

The State of Indiana, prompted by the Federal legislation, has now begun to move aggressively into a comprehensive community mental health program. By June 30, 1967, Indiana should have five approved mental health centers, and at least three more applications are planned to be submitted during fiscal year, 1968. The presently approved center projects will need help in procuring staffing funds in the future. It is

projected that Indiana will need to build and staff approximately 20 comprehensive mental health centers in the future to begin to meet the needs of its population.

Daily, I receive letters from Indiana's Ninth Congressional District which ask for advice on how to acquire mental health services for family members. The tragic fact is that at the present time I can only refer these people to the State hospitals where the waiting lists for admittance are discouragingly long. Public interest to provide facilities to combat mental illness and retardation in the Ninth District is high. Clark County Memoral Hospital has been approved for a construction grant of $530,000, and comprehensive community mental health centers are in the planning stages in Bedford and Columbus, Ind.

Important measures passed by the 95th Indiana General Assembly show Indiana's willingness to participate as a solid partner with the Federal Government in developing community programs to meet the needs of the mentally ill and retarded. One act provides a permanently dedicated source of funds to assist communities in matching Federal grants for the construction and operation of mental health centers. A portion of cigarette tax revenues will provide approximately $10 million in matching funds over the next 4 years. These funds will be available in the event that some committee find it impossible to provide adequate matching funds through local tax sources.

Another measure enacted by the Indiana General Assembly broadens the definition of community health centers for the mentally ill and retarded, gives counties permission to issue bonds as well as levy a 10-cent property tax to finance facilities, and provides that counties may support a center in a neighboring State that serves Indiana residents.

Indiana is beginning to meet the challenge of mental health. However, continued progress in Indiana's efforts to control mental illness and retardation is predicated on the continuation of Federal support. The passage of H.R. 6431 is essential to the success of Indiana's program.

Mr. JARMAN. Thank you for your presentation Mr. Hamilton.

Our next witness today will be the Under Secretary of the Department of Health, Education, and Welfare, Mr. Wilbur Cohen.

Mr. Cohen, we are pleased to welcome you and your associates here today, and you may proceed with your statement in your own fashion.

STATEMENT OF HON. WILBUR J. COHEN, UNDER SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY DR. WILLIAM H. STEWART, SURGEON GENERAL, PUBLIC HEALTH SERVICE; DR. STANLEY F. YOLLES, DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH; AND JAMES F. KELLY, ASSISTANT SECRETARY, COMPTROLLER

Mr. COHEN. Thank you, Mr. Chairman.

Accompanying me today is the Surgeon General of the Public Health Service, Mr. William Stewart; the Director of the National Institute of Mental Health, Dr. Stanley F. Yolles, on my right; and the Assistant Secretary, Comptroller of the Department, Mr. James Kelly.

My plan this morning, Mr. Chairman, would be to read my testimony, my prepared statement, and insert some materials in the record, and then at the conclusion of that, Dr. Yolles will make a brief chart presentation of the charts that are here which will attempt to illuminate some of the more important points. And at the conclusion of that, of course, all of us will be available for questioning.

Mr. JARMAN. That's fine. You may proceed.

Mr. COHEN. I am pleased to come before this subcommittee today to support H.R. 6431, the Mental Health Amendments of 1967 introduced by the distinguished chairman of the full committee, Mr. Staggers.

I should like to add, Mr. Chairman, that I wholeheartedly concur in the observation you made about the very significant contributions that this committee has made in the development of mental health legislation and mental health program over the last 20 years. We wouldn't be where we are today if a great deal of other legislation had not preceded this which came out of this committee.

H.R. 6431, recommended by President Johnson in his February 28 message on health and education in America, will carry forward landmark legislation recommended by this committee and enacted in 1963 and 1965.

Under this legislation the kind and quality of mental health services available to the people of the Nation is rapidly being transformed. The heart of the program is the concept of providing care to the mentally ill in the communities where they live—where they will have the support of family and friends.

That concept may seem perfectly logical and ordinary to the members of the committee. This, in itself, is a mark of the tremendous progress we have made in the mental health field.

The last half century in particular has seen a revolution in our attitudes toward the treatment of the mentally ill, and in our ability to deal meaningfully with mental illness.

Consider how great a distance we have traveled in a remarkably short time:

It is 113 years since Dorothea Dix succeeded in her fight to have Congress pass a bill appropriating 10 million acres of public land for the benefit of indigent insane, only to have President Pierce veto the bill.

It is 59 years since Clifford Beers, graduate of Yale and a former mental patient, really broke open the whole development in the field by writing book entitled "The Mind Which Found Itself," which really gave spirit and substance to what has become the mental health movement in America today.

Then, of course, the tranquilizing drugs, which greatly expanded the number of cases which could be managed outside of hospitals, have been available only since the early 1950's.

Today, by no means do we have guaranteed cures for mental illness. Indeed, the history of the treatment of mental illness has been all too full of overenthusiastic devotees of one "cure" or another. But we do have far better means of dealing with mental illness than ever before.

And it is a great tribute to the Congress that it has responded to the need to put our better knowledge to work providing services to the mentally ill as quickly as scientific developments have made it possible.

The "better way," that we now think is feasible, is treatment of the individual in the community. This is what was recommended by the Joint Commission on Mental Illness and Health in 1961, and this is what this committee and the Congress wrote into law in the 1963 enactment, which we now ask you to extend.

Responsibility for the care and treatment of the mentally ill has traditionally rested with the States and their communities. I hasten to say that this is wholly proper, and that we have no desire to supplant them in this responsibility. We do seek to help the States relieve themselves of what could otherwise be a crushing financial burden. State and local agencies in the United States now spend an estimated $3 billion each year as the direct cost of meeting their responsibilities in mental health.

I might add that various statements have been made of what would be needed if they were to do this on an adequate basis—in the neighborhood of $6 billion a year, or even $7 billion a year. This gives you an idea of the liability that States and local governments have at the present time. The total cost of mental illness in this country is far greater—including, I might say, $20 billion which is lost in tax funds by individuals who are not able to work, but who might otherwise be able to work if they were not mentally ill. In any case, all of these are huge, intolerable costs; direct costs to State and local governments of at least $30 billion over the next decade—and a total cost to our society of perhaps $200 billion in that period, if we continue to have the load of mental illness that we have at the present time.

The objective of the Federal program is to stimulate and assist the development of community facilities which we know can both reduce the necessity for institutional care and also reduce the length of time such care is required when it is necessary. The establishment of community facilities for the prevention and treatment of the mentally ill will allow the States and the localities to carry out their responsibilities in a more sensible and humane, and a far more economical, manner—and that is the goal of this important Federal legislation.

We have only begun a very large job. In the last 11 years, the population of State mental hospitals has been reduced by 19 percent. In the period between December 1963 and December 1966, alone, the population of these hospitals declined, from 504,000 to 426,000. I think that is a point worth stressing, when we have so many social problems that, in this area, there has been a decrease in the burden that the States and localities, and Nation as a whole, have had to bear. But many more could avoid long-term institutional treatment if community facilities were more widely available.

We estimate that one in every 10 Americans will become mentally ill at some time during his life. These people will require treatment; in many cases, serious illness, and the need for hospitalization, can be prevented if services are readily available to them in their own communities.

Increasingly, private insurers and Government programs have recognized the necessity to cover the costs of mental illness. And this

alone will be significant, because it will provide insurance funds to pay for the kinds of services that are being provided. The medicare program now provides hospital insurance coverage with certain deductibles and coinsurance for a total of 190 days of inpatient care in a psychiatric hospital during an individual's lifetime; and coverage under the voluntary, supplementary portion of more than $250 for outpatient psychiatric services. Title XIX of the Social Security Act, or popularly known as medicaid, also enacted in 1966, allows the States to receive Federal matching funds for services provided to the medically indigent elderly in mental institutions, particularly stressing trying to get them out of the mental institutions into community-based facilities. These legislative developments all constitute part of the same broad changes which have taken place, and which are still underway.

The Community Mental Health Centers Act of 1963 was enacted on the basis of dramatic evidence developed by the Joint Commission on Mental Health and Mental Illiness that those suffering from mental illness can be more appropriately, more intensively, and more successfully treated through local programs of mental health services using facilities in the patient's own neighborhood rather than through large-scale custodial programs such as those which existed in State hospitals in the past.

As you know, the Community Mental Health Centers Act, which you enacted in 1963, authorizes grants to assist in the construction of community mental health centers. It is, in general, patterned after the Hill-Burton program. Appropirations were authorized for fiscal years 1965, 1966, and 1967, which are to be allotted among the States on the basis of population, financial need, and the need for community mental health centers, with grants being made from these allotments to cover between one-third and two-thirds of the cost of construction of projects, depending upon the per capita income of the individual States. Priority in making the grants is accorded to centers which will provide comprehensive mental health services.

The amendments you enacted in 1965 authorized grants to meet part of the initial cost of professional and technical personnel of community mental health centers. The grants may cover the costs of these personnel for a period of slightly over 4 years, with the Federal share of these costs declining from 75 percent for the first 15 months to 30 percent for the last year of the period. Only centers providing essential elements of comprehensive mental health services are eligible for these grants.

This new approach enlists community resources to meet the total mental health needs of its people through an inclusive program of inpatient care, outpatient care, partial hospitalization, emergency service, and community consultation and education services. Each community mental health center develops its own plan to provide these services to the young and the old, the rich and the poor, the acutely ill, and those who may be saved from severe illness by early treatment.

The community mental health center is a local program of mental health services offering a broad spectrum of types of care to all of the population of a geographically designated area. It is not necessarily a single building or a type of building; the program may use

any combination of a variety of facilities—clinics, general hospitals, mental hospitals, remodeled space, or halfway houses.

The program of a community mental health center is designed primarily to provide an adequate range of services to meet the mental health needs of the community as a totality, irrespective of the type of building or facilities that are provided.

To provide all the services in a center which has none of them available, the center would need about 100 professional and technical personnel. The average center, however, already has some of the services, and needs about 50 professionals made up of psychiatrists, psychologists, social workers, nurses, rehabilitation and occupational therapists, and such technical personnel as technicians, dieticians, laboratory technicians, orderlies, et cetera.

At the conclusion of my testimony, Mr. Chairman, this report which Dr. Yolles, the Director of the National Institute of Mental Health, has made, will be appended. It gives you a full report on the program to date, including the number of centers that have been provided with grants, a full listing of all of those by States, and something about the goals and the ways that we went about developing this program. Dr. Yolles will later point out that so far to date we have funded 173 projects, 100 of them for construction, 47 for staffing, and 26 for both construction and staffing, and we hope by the end of this fiscal year to have funded 286. He will develop this further in his presentation.

The neighborhood community mental health centers being built and staffed with Federal assistance under the Community Mental Health Centers Act are providing care which will reduce both the severity and duration of disabilities resulting from mental illness. This goal is being achieved in communities across the Nation through an alliance of Federal, State, and local governments, professional groups, hospitals, and welfare agencies, both public and private. They are working more closely together than ever before on the basis of two principles: continuity of care for the patient, and partnership in responsibility on the part of all those who can help.

A center plan is inherently local; it must be designed by the community, which alone can assess its needs and resources. A center serving a large section of Harlem, for example, will have space and staff for treating narcotics addicts and special techniques for reaching disadvantaged people in emotional trouble. A center in western Kansas will face a number of different problems. There the problem is geographic accessibility of services, and establishing services on a scale which can be supported by a small and very scattered population. In a suburban California center, people may be able, in general, to pay for the services they need; but in a deprived Appalachian area, they may not. The centers may be located, as is one in Philadelphia, where a medical school has long prepared the way; or it may be located, as is one in Florida, where the local general hospital has never before had a psychiatric unit.

The point is this: there is not, and we do not intend that there shall be, a single, inflexible model for a community mental health center. Every one of these communities needs a center of its own design and making. This diversity makes the early success of the centers program, in my opinion, all the more impressive.

Indeed, diversity has been reflected in the type of applicants receiving grants for both construction and staffing support. For example, over half of the sponsoring agencies have been private, nonprofit groups. Also, well over one-third of the center grants have been made to rural areas, that is, cities or towns serving 50,000 persons or less.

As of March 27, 1967, more than $54.5 million in Federal funds had been obligated to assist the construction of 126 centers. State, local, and private matching funds of $109 million brought the total to $163.5 million—$17.8 million has been obligated for 73 staffing grants under the 1965 legislation; an additional $16.5 million is available for fiscal 1967 and we anticipate the approval of another 58 staffing grants by July 1 of this year. In all, more than 173 communities in 43 States have provided the initial enthusiasm and the community support to establish community mental health centers under the existing legislation.

The authority for the construction grant program expires June 30 of this year. The legislation before the subcommittee would extend the construction grant program through fiscal year 1972, with an authorization of $50 million for fiscal 1968, and such sums as Congress may appropriate for succeeding years. The authority for staffing grants, which expires at the end of fiscal 1968, would also be extended by H.R. 6431. The bill would continue the staffing grant program in its present form for an additional 4 years, through fiscal 1972, with the authorization remaining at $30 million for fiscal 1968, and for such as Congress may appropriate for succeeding years.

The bill also makes two changes in the substantive provisions relating to mental health construction. First, it amends section 401(e) of the act to allow the acquisition of buildings, as well as new construction. This amendment would give a further measure of flexibility to the program; in many cases, the program may be able to move forward more quickly and economically, and to provide services closer to the people who need them, if suitable existing facilities can be acquired, and adapted where necessary, for use as part of a community mental health center. New construction would not be required in every case; this amendment would widen the possibilities for local initiative in designing center programs, and would help assure that all available resources will be brought into play.

Second, H.R. 6431 amends section 204 of the Act to require State plans for construction of community mental health centers to include provisions for enforcement of minimum standards of operation of the centers. This means that the State must show that it has considered and adopted measures which will secure compliance with its own standards. This could involve regular inspection, licensure or financial restrictions. A choice of an effective approach would be up to the State itself.

Mr. Chairman, to achieve the goal of making essential community mental health services available to as many people in our country as possible as soon as possible, continued Federal concern and support is essential. Our goal is to provide these services in every part of our Nation; but our enthusiasm is tempered with realism. Speed and quantity alone, without the careful development and utilization of sound professional and administrative procedures are insufficient, and

ultimately self-defeating. Our request for continuation of these programs and our plans for further implementation are based upon such realizations. We mean to build a program in which numbers and novelty will not replace soundness of purpose and design. A community mental health center can only rise from firm foundations: from systematic priorities in the allocation of resources; from convincing evidence that service will in fact reach the people for whom they are intended; from a certainty that care will be comprehensive—that the continuum of human needs will be met by a continuum of responsive services.

Mr. Chairman, I am here today to ask the support of the committee in continuing this approach, and to urge early action on H.R. 6431. The first communities ready to establish a center program on the basis of sound planning have sought and received Federal assistance. Neighboring communities have been carefully laying their own plans. The States have been helping them lay this groundwork for comprehensive mental health programs. Some will be ready to apply for Federal funds next year, and I believe many more in the years which follow. We ask that they be given the same opportunity which more than 173 communities have now had—to take local responsibility for mental health care.

Amendments dealing with mental health take up the first four sections of the bill, Mr. Chairman, and I would now like to go on to section 5 of the bill, dealing with project grants to Federal institutions. Federal hospitals are a valuable resource for training, research, and demonstration projects. They offer a diverse array of patients and treatment settings.

Section 5 of H.R. 6431 authorizes research, training, and demonstration grants to Public Health Service hospitals, Veterans' Administration hospitals, and to St. Elizabeths Hospital.

Actually, this merely confirms in substantive terms in the statute a policy that has existed in a limited way through "point of order" language since 1960.

In that year, "point of order" language made St. Elizabeths Hospital eligible for research training, or demonstration grants.

In 1963, the hospitals of the Public Health Service were also made eligible, along with the medical facilities of the Bureau of Prisons in the Department of Justice.

The 1966 language in the appropriation act is as follows:

[Public Law 89-787]

SEC. 204. Appropriations to the Public Health Service available for research grants pursuant to the Public Health Service Act shall also be available, on the same terms and conditions as apply to non-Federal institutions, for research grants to hospitals of the Service, the Bureau of Prisons, Department of Justice and to Saint Elizabeths Hospital.

We are now asking that this policy—which has demonstrated its value—be made statutory and that hospitals of the Veterans' Administration be included among those Federal institutions eligible for the same kinds of grants. The language makes very clear that grants must be awarded under the same terms and conditions that apply to non-Federal institutions.

Our reasons for requesting this lie partly in our experience and partly in our recognition of the research, training, and demonstration potential offered by Federal hospitals.

Since the original "point of order" authority in 1960, a wide range of projects has been carried on in Federal hospitals, from studies of specific behavioral problems to experiments in new treatment methods and drugs. The diversity of patient population and treatment conditions make Federal hospitals no less valuable than non-Federal institutions for such study and research purposes.

In addition, the Federal hospitals have attracted physicians and scientists with valuable research, training, or demonstration ideas. They should be given the same opportunity to apply for grants that a physician or scientist in non-Federal institutions now has.

To put it another way, this section of the bill is an invitation to the physicians and scientists in our Federal hospitals to compete—on the same terms with their counterparts in non-Federal institutions—for Public Health Service research, training, and demonstration grants.

I would now like to turn to section 6 of H.R. 6431, which would authorize the establishment of a contingency account in the Treasury, giving the Secretary of Health, Education, and Welfare what we believe is needed flexibility to act promptly in extraordinary situations.

In an enterprise of such scope and complexity as the Department of Health, Education, and Welfare, it is inevitable that opportunities to accelerate the achievement of program objectives in these three areas, as well as new problem areas will arise during the course of a fiscal year. As much as we try, these breakthroughs and emerging problems cannot always be anticipated during the preparation of the President's annual budgetary plan. In certain instances, the need is met through requesting congressional enactment of a supplemental appropriation. On other occasions, the critical nature of the situation demands immediate action through a realinement of already available resources.

Let me give you some illustrations:

An emergency situation occurred in fiscal year 1964, when outbreaks of botulism poisoning from fishery products focused public attention on this longstanding public health problem. This incident was the first time a significant outbreak involving commercially processed foods had occurred. Investigations disclosed a new type of botulism of alarming severity (22 cases, 9 deaths). At the same time, prevention of the so-called type E botulism from smoked fish and other nationally distributed products was hampered by inadequate information concerning such matters as sources of the organism in food products.

You can well imagine that the Congressmen and Senators from those districts that were affected, as well as the businessmen, were really quite concerned about this situation, and asked us for immediate action. Because of the urgency of the problem, adjustments had to be made to provide funding for emergency research and training activities. A total of $315,000 was allocated within existing appropriations for the award of research contracts and purchase of necessary research equipment to develop necessary control measures. The availability, however, of a contingency fund would have made it unnecessary to reduce or discontinue other necessary health activities in order to carry out the emergency activity.

Another illustration: In March 1961, a chlorine-laden barge sank in the Mississippi River seven and a half miles below Natchez, Miss. To avert any possibility of endangering the public health, the President directed the Office of Emergency Planning to initiate and coordinate a broad-scale plan to insure safe removal of the barge and its cargo. Public Health Service was asked to assume responsibility for the public health and public information aspects of the project.

As part of this effort, the Division of Air Pollution rendered technical assistance by sending meteorological observers and chemists to the scene. Since no funds were available from the Office of Emergency Planning, $45,000 had to be diverted from other air pollution activities to support this emergency effort.

At any time there may be a breakthrough in any one of a number of targeted research and development programs in the whole field of health, education, and welfare. This could require the immediate availability of additional funds during the course of the fiscal year. If an effective German measles vaccine should be at the threshold, of development, we would certainly want to move as quickly as possible to move into the stage where there could be wide public use.

In the past, as in 1957, when there was a serious Asian flu epidemic in this country, the Division of Biologics Standards, National Institute of Health, worked for about 6 months assisting in the effort to get an effective vaccine on the market. This work, costing some $50,000, was done at the expense of the Division's regular activities related to the quality and safety of biological products coming within the jurisdiction of the Public Service.

In 1961, because of frequent polio outbreaks in local areas, large numbers of previously unvaccinated individuals were seeking polio vaccination. In such cases, however, it was usually too late for the Salk vaccine to be effective in combatting the epidemic. Accordingly, the Surgeon General's Advisory Committee on Poliomyelitis Control recommended that the Public Health Service maintain reserve stocks of oral poliomyelitis vaccine for use during epidemics. A supplemental appropriation of $1 million was required for the establishment of such an epidemic reserve.

We believe, particularly with the many new breakthroughs coming to our attention, that a new approach is required to cope with situations of this kind—an approach which affords the Secretary of Health, Education, and Welfare greater flexibility in the administration of a myriad of programs without at the same time infringing on the constitutional responsibilities of the Congress. The mechanics of our proposal, Mr. Chairman, are relatively simple.

A contingency account of indefinite duration would be created on the books of the Treasury with a monetary ceiling of not to exceed $50 million. Into this account would be deposited those amounts provided in any general fund appropriation of the Department which remain unused at the end of their period of availability. Prior to withdrawing money from this contingency account to supplement appropriated funds, the Secretary would be required to make a determination that—

Such action was necessary to fulfill his responsibilities;

Delay pending further appropriations by the Congress would be contrary to the public interest;

The withdrawal was required to carry out a significant purpose; and

The need for additional funds to purchase supplies or equipment, negotiate contracts or perform similar functions could not reasonably have been anticipated in the most recent President's Budget.

Numerous procedural safeguards have been incorporated to meet the needs and the opinions of the Congress. In addition to the provisions just mentioned, these include:

Congressional authorization of both the amount of deposits into and withdrawals permitted from the contingency account as part of the Department's annual appropriation act;

A prohibition against using funds from this account to conduct an activity for which funds were denied by the Congress in considering the appropriation bill for that year;

A requirement that the program to be financed must be otherwise authorized by law;

At least 10 days' prior notification to the Committees on Appropriations of any intended use of the contingency account; and

Submission of an annual report to the Congress on the operations of the account.

Thus within carefully prescribed limits, the Secretary of Health, Education, and Welfare would be able to react swiftly to important new findings gained from the Department's programs to extend the frontiers of man's knowledge. Support for large-scale clinical trials of a vaccine to protect pregnant women and their offspring from the ravages of German measles, and exploration of promising new leads in the quest for a fully implanted artificial heart are but two illustrations of how funds from the contingency account might conceivably be used.

Research does not represent the only area which may benefit from this proposal, however. Of equal importance is the opportunity to move quickly to cope with threats to the Nation's health or safety, broaden the dissemination of newly acquired knowledge, or deal with the impact of natural disasters.

This, then, Mr. Chairman, is the administration flexibility and operational efficiency which we seek to achieve through the establishment of a contingency account under the direction of the Secretary of Health, Education, and Welfare.

Thank you very much for giving me the opportunity to come before you to testify on these provisions of H.R. 6431. I know of your deep interest in mental health, and I urge that you report this bill favorably. If you have any questions, Dr. Stewart, Dr. Yolles, Mr. Kelly, and I will be happy to answer them.

(The report referred to by Mr. Cohen follows:)

COMMUNITY MENTAL HEALTH CENTERS PROGRAM STATUS REPORT

(By Director, National Institute of Mental Health, March 31, 1967)

PART I—GENERAL OVERVIEW

Twenty-one years ago, when the National Mental Health Act was passed, only very few workers in the field were concerned with the development of community mntal health services. Even to them, the goal of effective services near home seemed distant and remote, barely visible on the horizon. The limited community

mental health facilities of the day served primarily as transfer agents—between the shattered lives and homes of citizens and the back wards of custodial institutions. Across the country, the American's attitude toward mental illness was still heavy with centuries-old traditions of shame and fear.

The challenge was great and it could not be denied—a challenge embodied in those hundreds of thousands of mentally ill Americans, whose doom was being inexorably sealed in isolated hospitals across the country. Today, only three years after the passage of the historic Community Mental Health Centers Act, we can gauge the degree of our progress: Our Government has now supported the development of 173 community mental health centers, with funds totaling 73 million dollars to be devoted to the dual tasks of construction and staffing. By the end of Fiscal Year 1967 we will have supported 286 centers serving 47.2 million persons.

As of March 27, 1967:

Grants made:

Construction only	100
Staffing only	47
Construction and staffing	26
Total number of centers funded	173

Funds Obligated:

Construction:

FY 1965: 33.6 million or 94% of 35 million.

FY 1966: 21 million or 42% of 50 million. Applications pending: approximately 28 million or 56% of 50 million.

FY 1967: 300,000 obligated or 0.6% of 50 million.

Staffing:

FY 1966: 15.2 million or 80% of 19 million (new grants) (4 month availability).

FY 1967: 2.6 million or 14% of 19 million (new grants). Applications pending: 19.5 million or 102.6% of 19 million.

Funds obligated at all levels (Federal, State, Local) $209 million. Averaging as follows: Construction cost per center 1.2 million; 1st year operating cost $776 thousand; Rate of Federal participation 50%.

Currently, 28 million persons have community mental health centers available to them, or have centers slated for construction and/or staffing in their communities. Each center serves an average population group of 165,000.

These centers—the symbols of a new era in mental health care—serve 45 States and Territories. They have sprung from the creative collaboration of mental health professionals, and political and civic leaders at the Federal, State and local level. And, they have evolved from a solid base: a broad range of public and private agencies—hospitals, clinics, medical schools—many of them combining their efforts to develop a single comprehensive center.

Procedures for implementation are functioning well—as NIMH staff members join with professionals and volunteers in States and communities across the Nation, taking those necessary technical steps that lead, ultimately, to the construction of individual centers. State plans are being reviewed as they are developed and submitted—a prerequisite for the formal submission of proposals for specific centers within the State. In this way, inventories of existing community resources and surveys of current needs are made to mesh with projected goals.

There are those who, sharing our own zeal, would have wanted us to speed ahead at a faster pace—who would like to see new community mental health centers offering services in every American community now. Today. In the face of our country's need, they share our own impatience.

This ideal cannot be faulted, and we will not be satisfied until the entire American community is served. But our enthusiasm must be tempered with realism. Attempts at speed without the careful development and utilization of sound professional and administrative procedures are unrealistic; and, quantity without quality is self-defeating.

Ours is an innovative program—involving new concepts in architecture, in manpower, in services—and such programs require time to build: time between the appropriation of funds and the psychological readiness of communities and States to act; between the readiness to act and the development and submission of tangible plans and proposals; and between the approval of a program and

its actual operation. History teaches us that all new programs—if they are to be successful—must follow a similar course of careful planning and development.

Even more important is our insistence on quality—our conviction that there is no substitute for excellence where the health and welfare of our citizens are concerned. Implied here is no lack of concern for human needs, but rather the sure knowledge that we serve these needs best if, as scientists, we adhere to high standards. We mean to build a program in which numbers and novelty will not replace soundness of purpose and design. A community mental health center can only rise from firm foundations: from systematic priorities in the allocation of resources; from convincing evidence that services will in fact reach the people for whom they are intended; from a certainty that care will be comprehensive—that the continuum of human needs will be met by a continuum of responsive services.

I want to share with you our conviction that our progress cannot be gauged solely by bricks and mortar. Those of us close to the centers construction task are aware that this new program is far more than one of construction alone—that its impact cannot be measured solely in physical terms. The fact is that we have inspired here a revolution in mental health activities across the country.

Old and unrewarding attitudes toward mental health needs are changing, and they are being restructured in communities and States across the Nation. No longer is mental health seen as the privilege of the few who can afford private care—with the sickest and neediest of our fellow men shunted away in distant hospitals, removed from the conscience and concern of the community. All Americans—the indigent along with the wealthy, the laborer and blue collar worker along with the professionals—are beginning to be seen as the community of effort that forms the centers program. A community mental health center can succeed only if it is accepted by the citizens of the community in which it is located.

Long entrenched patterns of passivity are changing. Communities have become involved in planning for the mental health of their own residents—with new services appearing at the local level; and, the States—29 of which have now passed Community Mental Health Services Acts—have begun to advance the organization and distribution of their own mental health resources.

Patterns in the financing of mental health services have been revolutionized. In some States Federal money is being matched with State money exclusively; in others with State and local money; in still others with private funds. As recommended by the National Governors' Conference, the NIMH—working with the Council of State Governments—is encouraging the development of the broadest possible base for the financing of community mental health programs.

MEASURES OF PROGRESS

It is important at this point to assess the shape as well as the degree of our efforts. We must evaluate the extent to which we are meeting the criteria of quality we set for ourselves and for the millions of citizens who are the potential beneficiaries of this contemparary approach.

The program requires, for example, that each community mental health center make its services not only available, but readily accessible to all. How have the results of our efforts matched this objective?

It was clear from the outset that communities seeking support for mental health programs would ultimately represent a sweeping cross section of the total American community. Initiative has come from depressed areas and from regions of great wealth; from one-industry towns to cities built on a broad industrial base; from areas containing some of the strongest medical centers in the country to those which have until now attracted few or no professionals in the mental health field.

The image of the mental health center as serving populations concentrated only in the metropolis is hardly valid. The developing centers are marked by a broad regional diversity: a third are in cities of a half-million persons or more; another third in cities of fifty to five hundred thousand; and a final third in communities of fifty thousand residents or fewer. Mental health services will thus reach big city dwellers, suburbanities, and rural residents alike. In fact, nearly 150 predominantly rural counties are included in the population areas served by centers now being formed; residents of many areas will now have mental health professionals in their midst for the first time.

What about the range of services provided?

On this score, too, the program requirements were clear. Each center, they prescribed, must assure continuity of care—encompassing five basic treatment services: inpatient services for those who may require short-term hospitalization; partial hospitalization—during the day or over-night; out-patient treatment for patients who might make appointments as they would routinely with their family physicians; emergency services, available around the clock; and consultation and education programs.

How have we fared?

The center programs, I am pleased to report, are evolving as they were intended to—with a spectrum of services by mental health workers who seek to equal the range of needs brought by citizens in search of help. A number of the centers now under way sprang from agencies already providing nearly the entire span of essential services. But the program has also given sharp rise to many new and improved services in communities across the country:

.New inpatient services will be available in 40 percent of the centers funded, and in an additional 32 percent, they will be enlarged—either through new physical facilities, increased staff, or both.

.Over half of the centers currently under way will provide partial hospitalization facilities in areas where no such capacity existed before.

.New inpatient services will be available in 40 percent of the centers funded, ters, and an additional 40 percent will improve and expand existing therapeutic approaches used on an outpatient basis—including individual and group psychotherapy, family therapy, and drug treatment.

.Half of the centers will offer new emergency services, and a third more will increase them beyond their present levels; many plan to publicize emergency facilities widely within the community in order to assure their increased use.

Forty percent of today's centers will offer new consultative services, and another 40 percent will broaden existing ones—reaching out to schools, churches, court and juvenile authorities, and welfare agencies.

The community mental health centers program was a bold confrontation of the almost universal problem of fragmentation of services—in which the interests of professional agencies reigned supreme over the needs of the patient and his family. The program placed the patient at its hub, and citizens and professionals alike responded. Already, the community mental health center has served as a model for other programs—from neighborhood centers to community delinquency programs—in which comprehensive and continuous services must replace fragmented and overlapping ones.

MEETING SPECIAL NEEDS

These data do not imply a rigid uniformity among the centers. Far from it. There is no single model, for no two American communities are alike. Each center has its individual characteristics—reflecting the needs and the resources of the area it serves. The range portrays the face of America, and the ingenuity and adaptive ability of its citizens. Some centers, for example, will reach out to crowded metropolitan areas, while others will spread their services across thinly populated mountains and plains. In Texas, Dallas will have a full span of mental health services used in the city's large general hospital. In Louisiana, in contrast, two agencies have devised a plan to serve the people of the bayou country through individual clinical units ranging over four counties; and in Kansas, two agencies have combined to provide comprehensive services to residents of a rural area spanning over 20 counties.

PATTERNS OF FINANCING

The diversity of the center programs is further reflected in funding patterns used across the country. In some States, Federal money is being matched with State money exclusively; in others with State and local money; in still others with private funds. We are encouraging the broadest possible base for the financing of community mental health centers, and some communities have pioneered new funding programs among several counties or regions, and across State lines.

As a result of the Community Mental Health Centers Program, many States have sought to involve their communities directly in the provision of mental health services. The most common mechanism has been a State-implemented

Community Mental Health Services Act. Since the passage of the first such act in New York thirteen years ago, twenty-eight States have followed suit. These laws have provided for decentralization in the administration of community services, cost sharing by the State and localities, and the maintenance of local choice and initiative; State funds have typically been provided on a matching basis.

Within the last year, several States have considered and passed community mental health services legislation. Perhaps the boldest approach to date has been the recently developed act in Pennsylvania. The Pennsylvania act ensures that the localities of the Commonwealth provide a wide range of mental health services, and pledges State support of 90 percent of eligible costs.

It is a source of satisfaction for us to note that community mental health center financing efforts have often grown from the deepest roots of the communities—from the citizenry itself. The Lane County Community Menatl Health Center in Eugene, Oregon, for example, is largely the result of community sponsorship; seventeen county agencies are affiliated with the center, which will serve residents in an area reaching from the Pacific Ocean to the summit of the Cascade Mountains, as well as the 12,000 students at the University of Oregon in Eugene. In Pittsburgh, a grant from the Appalachian Regional Commission will help in the realization of a center to serve an area of 160,000 residents—primarily from low-income, urban areas. At Daytona Beach, Florida, the Volusia County Mental Health Center is the result of a unique community drive to guarantee adequate mental mealth services. The local Mental Health Association initiated a campaign to raise money toward construction of the center, and the largest corporation in the country contributed the services of its public relations department to promote the drive. Civic groups and hundreds of individuals participated—physicians, bankers, lawyers, housewives; one resident contributed the income from an orange grove to the project; the clergy sponsored a Mental Health Sabbath. Most important, the total effort brought all the interests within the county together for the first time in its history.

Part II—Selected Examples of Centers

1. *Extension of high quality care to new population groups.*—Temple University, Philadelphia, Pennsylvania:

Staffing grant

Fiscal year 1966:	
Federal share	$420,240
Total operating cost for 1st 12 months	921,240

The Temple University Community Mental Health Center is an example of how a University Department of Psychiatry can develop a Community Mental Health Center which will expand services to its surrounding population area and provide high quality care to a population that has a high incidence of social problems and socioeconomic deprivation. This facility will serve an area in Northeast Philadelphia.

This is predominantly a slum area with a high percentage of negroes (63.5% in 1960). It is also an area of social decay and multiple problems, e.g., 60 percent unemployment for youth of 15 to 21 who are not students. One-fourth of the families are at the poverty level, i.e., less than $3,000 per annum income.

The Temple University Medical Center is in the center of this area and is readily accessible to its population. It has previously offered diagnostic services to people in the area at an estimated level of 350 patients per year, but very few of these patients received subsequent interviews or treatment. Furthermore, the inpatient service was limited to private and teaching cases. Stimulated in part by the Community Mental Health Centers Program, the Psychiatry Department has just entered a new phase of rapid expansion.

A unique feature of the Temple Community Mental Health Center's program which will ultimately serve to improve the delivery of mental health services to the poor is a built-in evaluation system that is designed to provide constant feedback to the administration and assure continuity of patient care. The service program will provide the utilization data; the evaluation unit will do the follow-up studies, and the Center will draw upon the full resources of the Medical School for survey research and sociocultural data. A variety of resources will thus be brought together into a sophisticated operations research

program that should contribute to a greater understanding of the mental health problems of the poor.

This Center has also worked out specific arrangements for members of their staff to share responsibility for the inpatient unit of the large State hospital in the area, so that the Center can assist in the aftercare of patients returning from the State hospital.

Temple University Community Mental Health Center is thus an excellent example of how the Community Mental Health Center program has encouraged the development of a project which will marshall personnel resources, research capacities, and the service capabilities of a large medical center to more effectively provide high quality mental health care to the poor.

2. *Interstate cooperation.*—Bristol Memorial Hospital, Bristol, Tenn.:

Construction grant

FY 1965:

Federal share (64.5 percent)	$576,907
Total project cost	888,429

A mental health center program including essential mental health services will serve 190,000 people from two states, Virginia and Tennessee.

The development of this project necessitated a change in the state construction plans for both States and modification of the program to suit the two state catchment areas.

The applicant is the Bristol Memorial Hospital, a 215-bed voluntary nonprofit hospital located in Bristol, Tennessee. This project will serve two States and three counties, two of which are in Tennessee and one in Virginia. The participants in developing the project are this hospital and the Bristol Mental Health Clinic in Virginia.

There is a history of excellent cooperation between Tennessee and Virginia in Bristol. The state line practically divides the State Hospital property which is located in Tennessee and the clinic property, even though adjacent, will be physically located in Virginia.

3. *Rural Services Coverage.*—Memorial Mental Health and Mental Retardation Center, Bismarck, North Dakota:

Staffing grant

Fiscal year 1966:

Federal grant	$51,249
Total operating cost for 1st 12 months	354,558

Southeast Mental Health and Retardation Service Center, Fargo, North Dakota:

Staffing grant

Fiscal year 1966:

Federal grant	$74,745
Total operating cost 1st year	396,961

St. Michael's Hospital, Grand Forks, North Dakota:

Construction grant

Fiscal year 1965:

Federal share (59 percent)	$46,465
Project cost	78,755

Staffing grant

Fiscal year 1966:

Federal share	$85,936
Total operating cost for 1st 12 months	192,594

Among the sparsely populated States, North Dakota is showing the way to the development of a vigorous and progressive community mental health program.

North Dakota has established three centers and two others will probably be functioning within the next year. The three established centers—at Bismarck, Fargo and Grand Forks—have received four Federal grants totaling $258,395, to date. Bismarck and Fargo have each received staffing grants while Grand Forks has received both a staffing and a construction grant. A proposed fourth center, at Minot, is expected to submit a staffing grant application in April 1967.

When all four centers are operational, three-fourths of the State's population will be within an hour's drive of a community mental health center.

Despite its rural nature (there is no city with more than 47,000 people; 90 percent of the towns have less than 5,000 people; and the total State population is less than 700,000). North Dakota has not experienced undue difficulty to date in recruiting qualified professional personnel to staff its mental health facilities.

This is attributable in part to the unusual popular support the community mental health centers have received there. In 1965, the State passed a community mental health services act which, for the first time in North Dakota's history, permits the counties to levy taxes to establish and support mental health and retardation services. Recently, four counties approved overwhelmingly a ¾-mill levy to support the Grand Forks community mental health center. A similar levy has been approved by the voters who will be served in the Minot center.

Thus, a combination of private resources, Federal aid and vigorous citizen action has enabled North Dakota to implement a successful and dynamic community mental health program.

4. *Mental health services to children.*—Bernalillo Community Mental Health Center, Albuquerque, New Mexico:

Construction grant

Fiscal year 1965: Federal share	$209,852
Fiscal year 1966: Federal share (50 percent)	294,770
Total project cost	1,009,244

Staffing grant

Fiscal year 1966:	
Federal grant	$104,115
Total operating cost for 1st 12 months	313,820

This center proposes to provide mental health and mental retardation services to a population of 160,000 in a designated area of Albuquerque and Bernalillo County. Plans were formulated after an intensive community survey by the Community Council and were enthusiastically supported locally.

Service area includes the widest possible range of socioeconomic characteristics, both sparsely settled rural and densely populated urban districts, and substantial numbers of Spanish-Americans, Negroes and Indians. The large proportion of young people under 19 years of age creates a special need for children and adolescent services.

Construction funds will help provide a facility which will provide full range of comprehensive services under one roof. The staffing grant will support a core staff to plan, develop and operate the first phase of the center program. For children there will be an intensive day treatment program as well as outpatient and consultation services. Specialized inpatient facilities for children (and adolescents) also will be provided. These are in addition to other services for both children and adults.

5. *Specialized Services for Drug Addiction, Alcoholism and Suicide Prevention.*—Meadowbrook Hospital—The Nassau County General Hospital, East Meadow, New York:

Staffing Grant

Fiscal year 1966:	
Federal grant	$196,525
Total operating cost for 1st 12 months	2,030,802

This is a private non-profit psychiatric center which is part of a general hospital serving a catchment area of 147,854 consisting primarily of a low-middle class population in a growing suburban community. It is developing a set of specialized services, based on existing facilities, in the area of drug addiction and suicide. The center will render these special services by:

1. Admitting addicts to the inpatient service.
2. Developing an intake and evaluation clinic.
3. Initiating home visits.
4. Developing a partial hospitalization program for drug addicts and alcoholics.
5. Expanding their suicide prevention service to a 24-hour a day answering service.

6. Developing an activity program utilizing voluntary county, community and state resources.

The Federal assistance will be used to assist with operating costs of the entire center, but with particular emphasis on the special programs for drug addiction and suicide prevention.

6. *Multiple Source Financing.*—The Brookdale Hospital Center, New York City:

Construction Grant

Fiscal year 1966:	
Federal share (33⅓%)	$1,134,000
Project cost	3,402,400

Staffing Grant

Fiscal year 1966:	
Federal grant	$531,641
Total operating cost for 1st 12 months	818,555

Support of this Community Mental Health Center was funded from several sources. The total construction cost was $3,611,674 and the Federal share was $1,134,000. The applicant supplied two-thirds of the total cost or $2,407,782, of which $1,900,000 was mortgage money and $507,782 was provided directly by the applicant.

The Federal staffing grant was $531,641. The non-Federal money was $257,619, for a total operating cost of $811,260. The non-Federal share was from the following sources: patient payments $13,660, philanthrophy $31,296, prepaid payments and insurance $50,000, NYC Community Mental Health Board (State and City) $162,663.

The Center will provide all essential services.

This project is a comprehensive community mental health center serving a population of 130,000 of middle class white population and a larger area including public housing projects in which Negroes, Puerto Ricans, and Cubans predominate.

PART III—STATISTICAL DESCRIPTION OF CENTERS FUNDED

To date we have funded 173 Centers: 100 Centers have received only a construction grant, 47 Centers have received only a staffing grant, and 26 Centers have received both a construction and a staffing grant.

The first important questions are how much these Centers cost and how they have been financed. Data are reported as "averages" if the median and the mean are esseitially identical. Where they differ, the number used is identified. The average cost of new construction funded is just over one million dollars. Of this amount, the Federal Government contributes 45 percent, the State contributes 5 percent,[1] and local sources contribute 50 percent. Local sources of funds include mortgages, pledges, cash and bond issues. The range of cost is between $75,000 and over $2,000,000. About 20 percent of the construction grants have been given for large projects costing over $2,000,000 to build, another 20 percent cost between one and two million, and the remaining 60 percent cost less than $1,000,000.

The average Federal share of staffing grants funded is $280,000. By law during the first year this amount must be matched by an amount equal to 25 percent of the total budgeted for new professional services. Matching funds have averaged $93,000 per Center.

Data are also available on the source of operating funds for the Centers to which staffing grants have been made. Seventy-three Centers have a mean operating budget of $780,000 per Center. Of this money 45 percent is Federal in origin, 27 percent comes from the State, 10 percent is from county and local sources, 4 percent is from private philanthropy, and 14 percent is expected to come from fee payments including third party private insurance payments.

The next question of interest concerns the types of applicant institutions that applied for Centers grants. The largest group of applicants were general hospitals, either public or private non-profit. The second largest group were mental health clinics or mental health centers. Some of these applicants

[1] This figure is a median. The mean is almost 10 percent because some Centers received over $1,500,000 each in State funds.

were entirely new organizations, others were cooperating groups of already existing facilities which incorporated to become Centers. Other types of applicants included mental hospitals and university teaching hospitals.

Considering the applicants from another vantage point, approximately 40 percent were public facilities or agencies, and 60 percent were private non-profit groups of one type or another.

More than 70 percent of the Centers funded are planned as cooperative ventures involving two or more agencies, each of which contributes space and personnel for elements of the Center program. Examples of such cooperating agencies are: a non-profit general hospital providing inpatient service and a county health department providing outpatient service; or a private mental hospital providing inpatient and partial hospitalization service, while a child guidance clinic provides consultative and outpatient services. There are even some Centers which have as many as 5 cooperating agencies.

Each Center has associated with it a defined population group—a catchment area. The Center has the responsibility to provide all mental health services to the residents of the catchment area. The average number of people in Centers catchment areas is 165,000.

We find that 30 percent of funded Centers are in cities of 500,000 people or more, 35 percent are in cities of 50,000 to 500,000, and 35 percent are in cities or towns of 50,000 people or fewer. Thirty-five percent of Centers serve a rural county.

These figures serve to demonstrate that the Federal program has been able to assist in the development of Centers in communities of all kinds. There are applicants from depressed areas and from wealthy areas; from one-industry towns, and from cities with a broadly diversified industrial bases. There are applications from some of the strongest medical centers in the country, and from some of the areas which historically have had the most difficulty in attracting and holding professional personnel.

The most important features of the Mental Health Center program are the services which will be provided and the people who will provide them. New inpatient services will be provided in 40 percent of Centers funded. Such new services will offer milieu therapy and group individual therapy as well as the somatic therapies. In another 32 percent the applicant already provided some inpatient service but planned to upgrade and expand this service either by providing new physical facilities or by providing new and increased staff.

Among the applicants for construction funds, many had no inpatient beds available to them at all, a number had over 50, and the remainder were distributed evenly between five or less and 40 or more. The number of beds proposed in the new construction ranged from zero in a few rural centers which planned to hospitalize patients on medical wards to over 100 in a few of the larger centers. The average number of planned beds was 24 to serve an average of 165,000 people. Thus the average proposed bed: population ratio is 14.5 beds: 100,000 people.

New outpatient services will be offered by 45 percent of applicants, and an additional 40 percent of the applicants will upgrade and expand existing services.

Fifty-five percent of the applicants will provide new partial hospitalization services, and an additional 15 percent of applicants will increase the size and scope of their partial hospitalization efforts. Partial hospitalization represents a relatively new service even for those applicants who already have some service in operation. The development of this service represents one of the substantial contributions of the Community Mental Health Center program. Consultative assistance by NIMH central and regional office personnel has proved to be of value to applicants in helping them develop plans for this service. Plans for partial hospitalization include services which will care for all patients including the very ill. Such services will provide back-up for inpatient services to deal with the occasional patient who needs 24-hour care for a few days at some point in his course of treatment. Other partial hospitalization programs will tie in more closely with inpatient services, and patients will very often be treated first as inpatients, then as day or night patients as they travel the road to recovery and return to the community.

New emergency services will be provided by 50% of applicants, and 30 percent of applicants will increase their emergency services beyond what is

already available. In a few rural centers the emergency service will consist of a general hospital emergency room with a nurse on duty and a physician on call. In a larger town there may be an intern on duty and a psychiatrist on call. In an urban center a psychiatric resident will be available 24 hours a day. New personnel will be hired and further training will be provided to personnel already available. Additionally, many centers plan to publicize their emergency services more heavily within the community so that better use can be made of them.

Forty percent of applicants will offer new consultative services, and another 40 percent will upgrade and increase existing consultative services. Existing services are for the most part informal and do not account for a large proportion of professional time or budget. The centers are planning to develop formal consultative relationships with other community agencies. Most frequently consultative relationships are with schools, churches (clergymen's groups), court and juvenile authorities, welfare agencies, and Alcoholics Anonymous and other groups concerned primarily with alcoholics.

The emphasis on consultation in the Centers represents one of the important innovations of the Community Mental Health Center program. This emphasis grows out of the broader NIMH philosophy regarding provision of services. We encourage existing service resources to deal with human problems wherever possible, rather than referring people for treatment to a mental health professional. We are committed to a public health model of provision of services. In mental health such a model implies that treatment by professionals should be a last resort, to be sought only when indigenous efforts at managing a human problem fail. To that end we encourage the use of mental health professionals, not only as direct treatment agents, but as consultants to those who are directly concerned with human problems.

The development of the five named essential services takes priority over the development of other services in the Community Mental Health Center program. For this reason many centers have concentrated their immediate efforts on developing these services, while planning to provide at a later time the five additional services characteristic of a comprehensive center. These five additional services are diagnosis, precare and aftercare, rehabilitation, training, and research and education. Separate diagnostic services are planned in those centers which are sufficiently well staffed to justify a separate service. In smaller centers diagnosis is currently carried out by staff members as part of their initial evaluation of patients within the framework of existing services.

Precare and aftercare services are also carried out within the framework of existing outpatient and inpatient services. In large, well-staffed centers, precare and aftercare have been developed as separate services, as a result of efforts to establish channels for early case referral and efforts to assure that the patient discharged from inpatient status can maintain his optimal level of functioning in the community.

Rehabilitative services are being developed to meet the specific needs of center patients for occupational retraining. Many centers have established liaison with State Vocational Rehabilitation Services, and rehabilitation counselors are available for consultation to centers on a part-time basis. Again, the larger more comprehensive centers are staffing their own full-time rehabilitative services.

Almost all the centers recognize that the center is a training resource as well as a service resource. Several States have explicitly considered this in developing their plans and have attempted to place centers close to sources of potential trainees. Plans for training in all mental health disciplines are being developed. These include psychiatric residency and community psychiatry training programs, psychology internship programs, social worker placement programs, psychiatric nurses' training, and training for occupational therapists, activity therapists, and various aides and other subprofessionals.

Research and evaluation services are seen by all centers as desirable.

The staffing patterns for the centers give a further perspective on the magnitude of the proposed effort. We report the data as full-time equivalents (FTE's), rather than as numbers of personnel, since many centers make extensive use of part-time professional staff. The average center uses between five and six psychiatrists. The range is from one to 32. The average center uses between four and five FTE psychologists. The range is from one to 29.

The average number of social workers planned for is between 11 and 13, and the range is from one to 62. For registered nurses the projected average is

between 14 and 16, and the range is from one to 80. These data serve to illustrate the great range of efforts. The smaller rural centers have a staffing pattern of two or three professionals, and the larger metropolitan centers plan have well over 150 professionals. The professionals are of course supported by non-professionals in all cases. Our data on non-professionals are less exact, but we estimate that each professional is supported by approximately two non-professional workers.

PART IV—GOALS AND PROSPECTS

The outlook, then, is a positive and promising one—reflecting substantial progress in the Community Mental Health Center program itself, and in the allied programs of the NIMH converging on that effort. This statement would be incomplete, however, without an acknowledgment of the problems we must yet face.

We must continue our efforts to fill the enormous reservoir of manpower demanded by the Community Mental Health Center program, without which our highest purposes will be frustrated.

Through careful research, we must continue to pursue the kinds of creative approaches to the treatment of the mentally ill that alone can give true meaning to the establishment of comprehensive services.

We must encourage close collaboration among the many professional disciplines working in the interests of the Nation's health, molding them into the kinds of compassionate staff that best serve the patient's interests.

We must assure that existing patterns in the financing of mental health services are maintained and strengthened in the States and communities across the Nation.

Despite our progress, we must be constantly aware that the Nation's need is still great—that nearly half a million Americans continue to reside in mental hospitals, and that a third of our citizens are significantly impaired at some time in their lives by symptoms of mental illness. We have made only a modest start in meeting the mental health needs of the American people; the great bulk of our population remains to be served through the 2,000 centers planned by 1980.

Difficult tasks and obstacles are still clearly before us, yet I have every reason to believe that we will succeed. This conviction arises out of the confidence and strength we feel as partners with communities throughout the Nation. Ours is a cooperative venture embracing various segments of society. Across the country we have stimulated a wave of rising hopes. We shall continue in our efforts to satisfy those hopes—and thereby advance the well-being and productivity of our people.

APPENDIX

Centers funded by State and locality as of Mar. 1, 1967

State, city and name of center	Construction grants	Staffing grants	Combined total
Alabama:			
Florence: Muscle Shoals Comprehensive Mental Health Annex to Eliza Coffee Memorial Hospital	$1,000,000		$1,000,000
Alaska			
Arizona:			
Phoenix:			
St. Luke's Hospital	305,000		305,000
Jane Wayland Child Center, Inc	65,000		65,000
Saint Joseph's Hospital	574,351		574,351
Camelback Hospital		296,655	296,655
Arkansas:			
Little Rock:			
Greater Little Rock Comprehensive Community Mental Health Center	633,333		633,333
Do		300,000	300,000
Pine Bluff: Jefferson County Family Child Guidance Center		103,888	103,888
Jonesboro: Jonesboro Community Mental Health Center	862,223		862,223

Centers funded by State and locality as of Mar. 1, 1967—Continued

State, city and name of center	Construction grants	Staffing grants	Combined total
California:			
San Rafael: Marin Hospital	455,644	122,575	568,219
Olive View: Olive View Hospital	791,627	170,767	962,394
Burlingame: Peninsula Hospital	589,823		589,823
Los Angeles: Resthaven Psychiatric Unit	632,928		632,928
Santa Barbara: County of Santa Barbara	108,915		108,915
San Jose: (Santa Clara County) Central Center	[1] 270,000	258,511	[1] 528,511
Sunnyvale: (Santa Clara County) El Camino Center	[1] 67,000	162,317	[1] 229,317
Los Gatos: (Santa Clara County) West Valley Center	[1] 67,000	162,317	[1] 229,317
Unspecified: (Santa Clara County) North County Center		97,186	97,186
Totals for all 4 Santa Clara County centers	[2] 378,853	[2] 680,331	[2] 1,059,184
San Jose: San Jose CMHC		109,804	109,804
Santa Monica: CMHC of St. John's Hospital		331,013	331,013
Pacoima: Golden State CMHC		305,679	305,679
Los Angeles:			
Central City CMHC		262,455	262,455
Gateways Hospital	226,177		226,177
Bakersfield: Kern View Hospital		135,612	135,612
Ventura: Simi-Conejo MHC		124,652	124,652
Sacramento: Sutter Memorial Hospital	140,922		140,922
Reedley: Kings View Hospital		152,587	152,587
Ventura: North Coast Regional Mental Health Center	444,745	127,315	572,060
Santa Barbara: Santa Barbara Cottage Hospital	166,737		166,737
Obispo: San Luis Obispo Community Mental Health Center	112,118		112,118
Okland: Fred Finch Home	513,232		513,232
Sacramento: Sutter Memorial Hospital	140,922		140,922
Colorado:			
Adams City: Adams County Community Mental Health Center	94,763		94,763
Boulder: Mental Health and Mental Retardation Center of Boulder County	147,59		147,590
Denver: Community Mental Health Center of Denver General Hospital	576,774	140,350	717,124
Englewood: Arapahoe Mental Health Center, Inc		61,504	61,504
Lakewood: Jefferson County Mental Health Center, Inc		65,413	65,413
Connecticut:			
Bridgeport: Bridgeport Community Mental Health Center	985,664		985,664
New Haven: Connecticut Mental Health Center		311,113	311,113
Total	985,644	311,113	1,296,777
Delaware:			
New Castle: Mental Health Center of Southern New Castle County	200,000	72,573	272,573
District of Columbia:			
Howard University CMHC—Area B		385,884	385,884
Area C CMHC		393,787	393,787
Total		779,671	779,671
Florida:			
Bradenton: MHC of Manatee Memorial Hospital	331,500		331,500
Orlando:			
Orange Memorial Hospital Association, Inc	640,161		640,161
Winter Haven: Winter Haven Hospital	467,338		467,338
Daytona Beach:			
Halifax District Hospital	245,256		245,256
Guidance Center, Inc	170,803		170,803
Panama City: Memorial Hospital of Bay County	269,750		269,750
Pensacola: Escambia County Guidance Clinic, Inc	185,900		185,900
Tampa: St. Joseph's Hospital	396,000		396,000
Miami: Variety Childrens Hospital		492,476	492,476
Total	2,706,708	492,476	3,199,184
Georgia:			
Athens: Community Mental Health Center of Athens General Hospital	614,962		614,962
Macon: Community Mental Health Center of the Macon Hospital	430,000		430,000
Total	1,044,962		1,044,962

[1] Estimated.
[2] Actual.

Centers funded by State and locality as of Mar. 1, 1967—Continued

State, city and name of center	Construction grants	Staffing grants	Combined total
Hawaii:			
Honolulu:			
The Queens Hospital	194,056		194,056
The Maui Mental Health Center		23,997	23,997
Total	194,056	23,997	218,053
Illinois:			
Chicago: Presbyterian—St. Luke's Hospital	955,674		955,674
Rock Island: CMHC of Rock Island—Mercer Counties	646,209		646,209
Total	1,601,883		1,601,883
Indiana: Indianapolis: Marion County General Hospital	545,163		545,163
Iowa: Dubuque: St. Joseph's Mercy Hospital of Dubuque	1,237,779		1,237,779
Kansas:			
Newton: Prairie View MHC	200,924	58,688	259,612
Hays: High Plains Mental Health Clinic		100,566	100,566
Total	200,924	159,254	360,178
Kentucky:			
Madisonville: Hopkins County—Madisonville Mental Health Center	223,090		223,090
Lexington:			
Comprehensive Care Center—Region 10A		134,595	134,595
Comprehensive Care Center—Region 10B		198,702	198,702
Paducah: Lourdes Hospital and Mental Health Center	518,810		518,810
Total	741,900	333,297	1,075,197
Louisiana:			
Raceland: Terrebone Mental Health Center	255,200		255,200
New Orleans:			
Tulane University	496,403		496,403
Touro Infirmary Community Mental Health Center		124,740	124,740
De Paul Hospital		113,314	113,314
Total	751,603	238,054	989,657
Maine:			
Lewiston: Child and Family MHC	91,060		91,060
Portland: Maine Medical Center	315,700		315,700
Total	406,76		406,760
Maryland:			
Cheverly: Prince Georges General Hospital	290,931		290,931
Silver Spring: Holy Cross Hospital	249,881		249,881
Baltimore: Inner City CMHC		217,432	217,432
Total	540,812	217,432	758,244
Massachusetts:			
Concord:			
Emerson Hospital	158,792		158,792
Community Agencies Center	108,810		108,810
Fall River: MHC of Fall River	568,290		568,290
Lowell: Lowell MHC		510,080	510,080
Boston: Massachusetts MHC		33,241	33,241
Greenfield: Franklin County Public Hospital	319,691		319,691
Total	1,155,583	543,321	1,698,904
Michigan:			
Grand Rapids: Grand Rapids Child Guidance Clinic	162,720		162,720
Battle Creek: Battle Creek Sanitarium and Benevolent Association	400,000		400,000
Port Huron: Port Huron Hospital	292,620		292,620
St. Joseph: St. Joseph Benton Harbor Memorial Hospital Association	350,000		350,000
Kalamazoo: Borgess Hospital	800,000		800,000
Lansing: The Sisters of Mercy St. Lawrence Hospital Comprehensive MHC	700,000	552,370	1,252,370
Alpena: Alpena Area MHC		130,271	130,271
Pontiac: Pontiac State Hospital		259,309	259,309
Marquette: Marquette Area Community Mental Health Center		90,380	90,380
Total	2,705,340	1,032,330	3,737,670

Centers funded by State and locality as of Mar. 1, 1967—Continued

State, city and name of center	Construction grants	Staffing grants	Combined total
Minnesota:			
Minneapolis: St. Barnabas and Swedish Hospitals	827,969		827,969
St. Cloud: St. Cloud Hospital	424,000		424,400
Total	1,252,369		1,352,369
Mississippi			
Missouri:			
Columbia: Mid-Missouri Mental Health Center	1,012,006	466,585	1,478,591
St. Louis: Malcolm Bliss Mental Health Center		419,418	419,418
Kansas City: Western Missouri Mental Health Center		494,779	494,779
Joplin: Ozark Psychiatric Foundation	51,667		51,667
Total	1,063,673	1,380,782	2,444,455
Montana			
Nebraska			
Nevada			
New Hampshire:			
Hanover: Mary Hitchcock Memorial Hospital	285,318		285,318
New Jersey:			
Newark: Community Mental Health Center of Newark, N.J	1,540,924		1,540,924
New Mexico:			
Albuquerque: Vista Larga Center	504,622	104,115	608,737
New York:			
New York:			
Metropolitan Hospital CMHC	$1,350,000	$598,000	$1,948,265
Maimonides Hospital CMHC	600,000	920,931	1,520,931
Brookdale Hospital Center		531,641	531,641
Sound View—Throgs Neck CMHC		1,223,707	1,223,707
Rochester:			
The Rochester General Hospital	301,826		301,826
Convalescent Hospital for Children	292,653	184,930	477,580
Woodbury: Nassau Center for Emotionally Disturbed Children	333,000		333,000
East Meadow: Meadowbrook Hospital		196,525	196,525
Total	2,877,479	2,655,734	5,533,213
North Carolina:			
Burlington: Alamance County MHC	126,000		126,000
Cullowhee: Western Carolina College	134,247		134,247
Fayetteville: Cape Fear Valley Hospital	815,220		815,220
Total	1,075,467		1,975,467
North Dakota:			
Grand Forks: St. Michael's Hospital	46,465	85,936	132,401
Bismarck: Memorial Mental Health and Mental Retardation Center		51,249	51,249
Fargo: Southeast Mental Health and Mental Retardation Center		74,745	74,745
Total	46,465	211,930	258,395
Ohio:			
Youngstown: Child and Adult Mental Health Center, Inc	450,895		450,895
Dayton: Good Samaritan Hospital	389,166		389,166
Cincinnati: Child Guidance Home—Jewish Hospital Central Community Mental Health Center	315,908		315,908
Zanesville: Muskingum County Mental Health Center	162,669	200,758	363,427
Columbus: Mount Carmel Community Mental Health Center	437,678	211,044	648,722
Dover: Union Hospital Mental Health Center	481,229		481,229
Akron: Portage Path Community Mental Health Center	370,713		370,713
Total	2,608,258	411,802	3,020,060
Oklahoma:			
Norman: Central State—Griffin Memorial Hospital	531,000	449,652	980,652
Oklahoma City: St. Anthony's Hospital	675,790		675,790
Total	1,206,790	449,652	1,656,442

Centers funded by State and locality as of Mar. 1, 1967—Continued

State, city and name of center	Construction grants	Staffing grants	Combined total
Oregon:			
Eugene: Sacred Heart General Hospital	315,796		315,796
Salem: Willamette Valley Community Mental Health Center		164,382	164,382
Total	315,796	164,382	480,178
Pennsylvania:			
Pittsburgh:			
Western Psychiatric Institute and Clinic	687,930		687,930
St. Francis General Hospital and Rehabilitation Institute		502,473	502,473
Philadelphia:			
Hall Mercer Hospital Community Mental Health Center	749,744	237,933	987,677
The Nazareth Hospital	233,839		233,839
Temple University Health Sciences Center		420,240	420,240
Philadelphia Psychiatric Center		491,659	491,659
Hahnemann Medical College and Hospital (includes supplemental grant)		765,887	765,887
Sayre: Robert Packer Hospital Mental Health Center	64,307		64,307
Stroudsburg: General Hospital of Monroe County	93,170		93,170
Butler: Mental Health Guidance Clinic of Bulter County	211,464		211,464
Johnstown: Conemaugh Valley Memorial Hospital	56,854		56,854
Fredrickstown: Centerville Clinics, Inc	183,208		183,208
Total	2,280,516	2,418,192	4,698,708
Rhode Island: Newport: Newport Hospital	291,392		291,392
South Carolina:			
Greenville: Greenville General Hospital System	966,666		966,666
Anderson: Anderson-Oconee-Pickens Mental Health Center	120,000		120,000
Charlestown: Charlestown Area Community Services Center	245,440		245,440
Total	1,332,106		1,332,106
South Dakota			
Tennessee:			
Knoxville: Mental Health Center of Knoxville	354,750		354,750
Oak Ridge: Mental Health Center of Anderson and Roane Counties, Inc.	387,547		387,547
Bristol: Bristol Memorial Hospital	576,907		576,907
Total	1,319,204		1,319,204
Texas:			
Amarillo: Amarillo Hospital District		328,480	328,480
Dallas: Presbyterian Hospital of Dallas	600,000		600,000
Plainview: Hale County Hospital Authority, (Plainview Hospital)	268,800		268,800
Houston: St. Joseph's Hospital Mental Health Center	342,160	718,826	1,060,986
El Paso: El Paso Center		134,248	134,248
Total	1,210,960	1,181,554	2,392,514
Utah: Provo: Central Utah Community Mental Health Center	189,911	122,644	312,555
Vermont:			
Newport: Northeast Kingdom Mental Health Service Center	55,000	63,422	118,422
Bennington: United Counseling Service of Bennington County Inc	51,750		51,750
Total	106,750	63,442	170,172
West Virginia:			
Huntington: Cabell County Comprehensive Mental Health Center	376,793		376,793
Elkins: Appalachian Community Mental Health Center		210,161	210,161
Wisconsin:			
Green Bay: Brown County Hospital and Community Mental Health Center	664,800		664,800
Milwaukee: Milwaukee County Mental Health Center Services I, II, III, IV, V, VI	1,136,000		1,136,000

Centers funded by State and locality as of Mar. 1, 1967—Continued

State, City and name of center	Construction grants	Staffing grants	Combined total
Wyoming: Sheridan: Northern Wyoming Mental Health Center		83,063	83,063
Puerto Rico			
Mayaguez: Mayaguez Medican Center	1,539,869	45,391	1,585,260
Santurce: Caguas Community Mental Health Center		51,516	51,516
Santurce: Arecibo Community Mental Health Center		62,135	62,135
Total	1,539,869	159,042	1,698,911
American Samoa			
Guam			
Virgin Islands			

Mr. COHEN. I would like now to permit Dr. Yolles to present the brief chart presentation on the mental health centers program.

Dr. YOLLES. Mr. Chairman, I would like to start by pointing out the status of patients in our mental hospitals around the country.

There are 289 mental hospitals in the country today. We have a very happy situation to report, in that over the past 11 years there has been a decreasing rate of patients resident in the mental hospitals at the close of each year. The numbers have been coming down in the hospitals, and this in the face of a very slowly rising rate of admissions to the hospitals. (See fig. 1, below.)

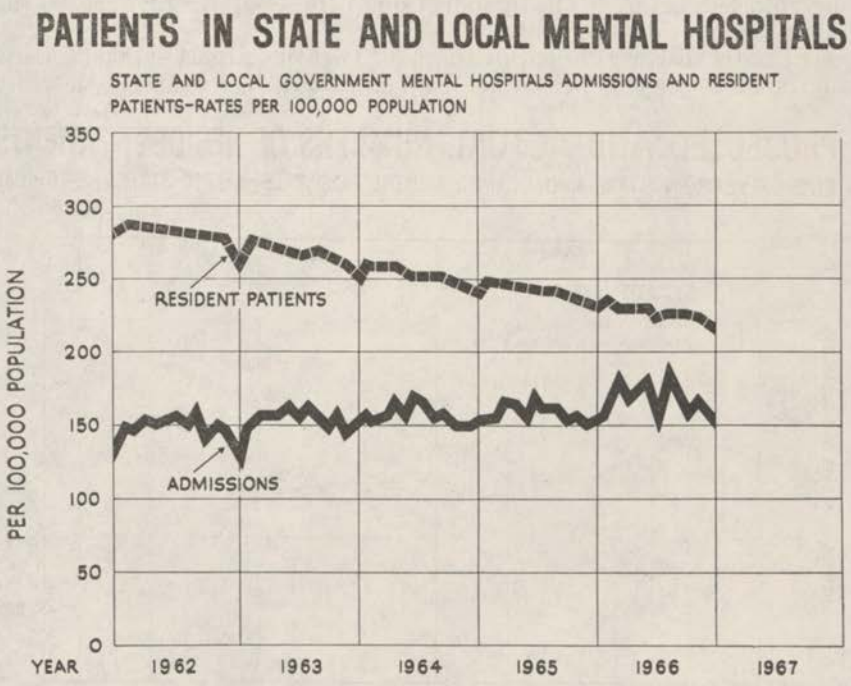

FIGURE 1.

There are more admissions per year, but in the face of increasing admissions, there is still a declining rate of resident patients at the end of the year.

Mr. BROWN. It is 226 per 100,000?

Dr. YOLLES. It is about 226 now.

Mr. ROGERS. In the hospitals?

Dr. YOLLES. Yes, in State and county hospitals in the United States.

Mr. ROGERS. 226 per 100,000?

Dr. YOLLES. Yes. Here are the actual numbers. This table (fig. 2) is in terms of numbers, rather than rates. From 1946 to 1955—and preceding that, you will note that there was an increasing rate of patients remaining in mental hospitals. Now this is a continuation of that rate projected to the present time.

If that rate had continued, we would have 702,000 patients in mental hospitals in the United States today. In 1955 a break in that upward trend occurred, due to a number of factors. Perhaps the principal factor involved was the introduction of the psychoactive drugs, but there are other factors. The actual numbers of patients remaining in hospitals at the end of 1955 started to come down.

You will note that the rate of decrease is much more rapid in the last few years. This is the result of the introduction of inpatient services in general hospitals, and the introduction of more community mental health approaches. We have over 1,000 general hospitals in the United States today that now accept mental patients who did not accept them before. The introduction of those services has caused the decrease in resident patients.

For this year, we are happy to report that the largest single decrease in the 11- or 12-year period involved an average per year rate decrease

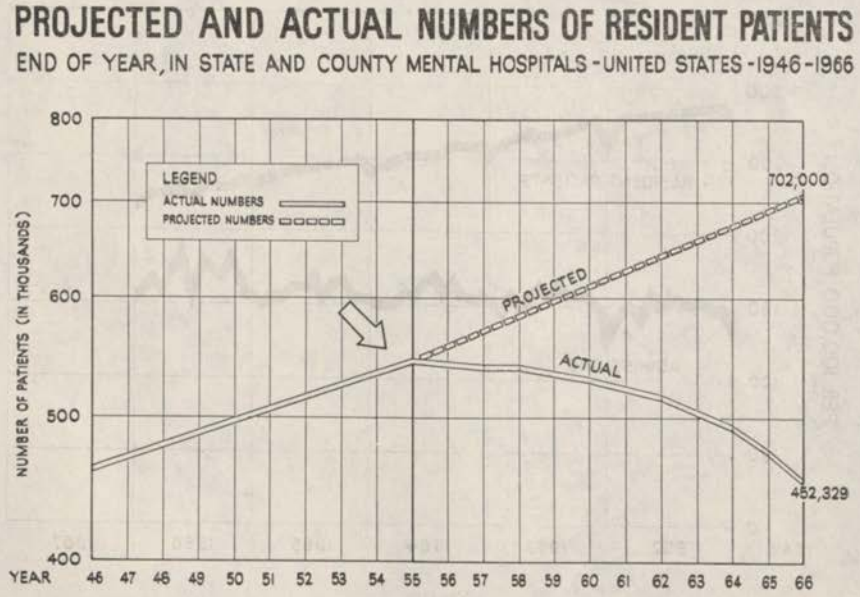

FIGURE 2.

of 4.9 percent, and a decrease between the 2 corresponding months of December 1965 and 1966 of 7.2 percent. This is a very significant decrease.

Mr. ROGERS. What year was the turning point?

Dr. YOLLES. 1955.

Mr. ROGERS. Thank you.

Dr. YOLLES. There is one other point. There has been a decrease from the projected number of 702,000 patients to 452,000. In terms of dollars to the State and local governments, this amounts to $4.4 billion of expenditures, both for cumulative cost of care of the patients over these years, as well as the capital improvements, that would have been built to take care of them. Those funds were used for other purposes during these years, and not used for mental hospitals.

I would like now to present three examples of community mental health centers that have been funded under this program. The first of these is purely a construction grant, the second purely a staffing grant, and the last is a combination of both.

This construction grant was awarded to the Swedish-Saint Barnabas Community Mental Health Center. (See fig. 3.) Actually the joint applicants were the Saint Barnabas Hospital and the Swedish Hospital in Minneapolis, across the street from each other. These two hospitals joined to provide community mental health services. They closed off the street and plan to construct the community mental health center between them, uniting the two hospitals.

This new structure will provide to central Minneapolis, which has a population of 200,000, all of these services which were not available to this population before except in fragmented or partial form. They will provide outpatient, inpatient, day and night or transitional services, consultation and education services to schools, courts, welfare departments, and other agencies as well.

In addition, the St. Barnabas hospital and the Swedish hospital will provide emergency services to this total community and by contractual arrangement with private physicians, some patients will be given outpatient care. Further, through a backup arrangement, to be sure that they can serve all of the people in the community when demand is heavy, there is a backup service with the county general hospital to provide outpatient and inpatient services.

The Federal share on this project was $828,000. The total, including local and private financing, was $1,700,000. This project was approved June 27, 1966, and the ground-breaking ceremony was July 10, 1966.

The second example is of a pure staffing grant. This is the Tacoma Mental Health Center in Tacoma, Wash. (See fig. 4.) Prior to the award of this grant, there were some five agencies delivering mental health services within the city and counties surrounding Tacoma, Wash. None of these provided a total service. No total service was available to the city of Tacoma.

By joining together these five agencies to set up the Tacoma Mental Health Center, a total program of services was devised. This is what Mr. Cohen referred to as a program of services with these agencies joining together to provide total services to the city of Tacoma, with a population of 153,000.

SWEDISH-ST. BARNABAS COMMUNITY MENTAL HEALTH CENTER
MINNEAPOLIS, MINNESOTA

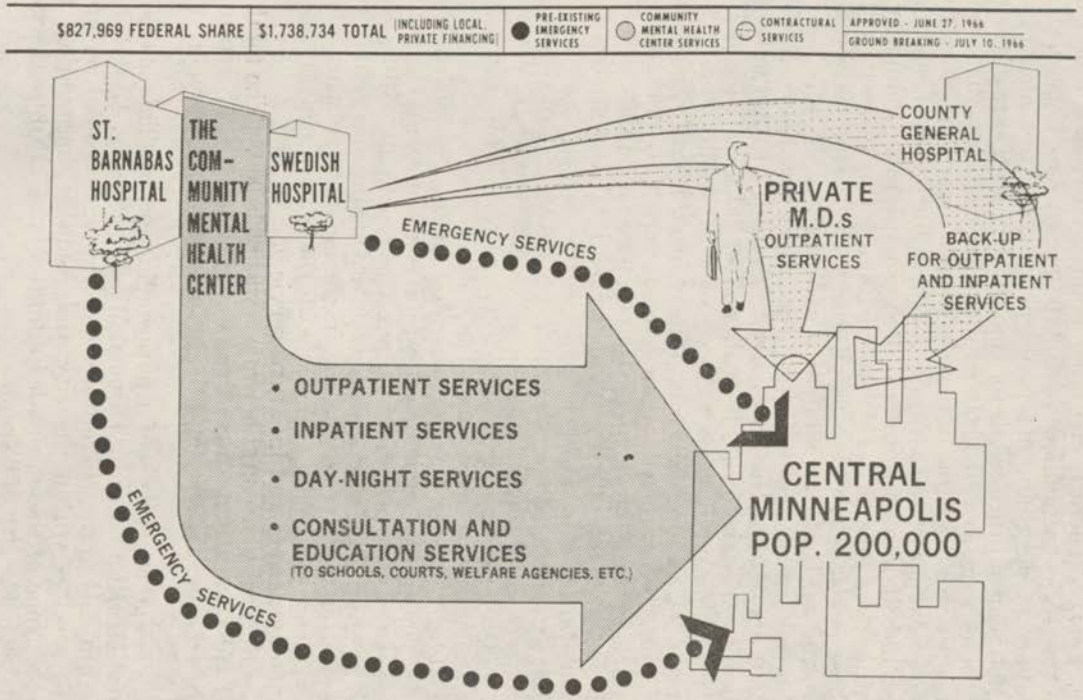

FIGURE 3.

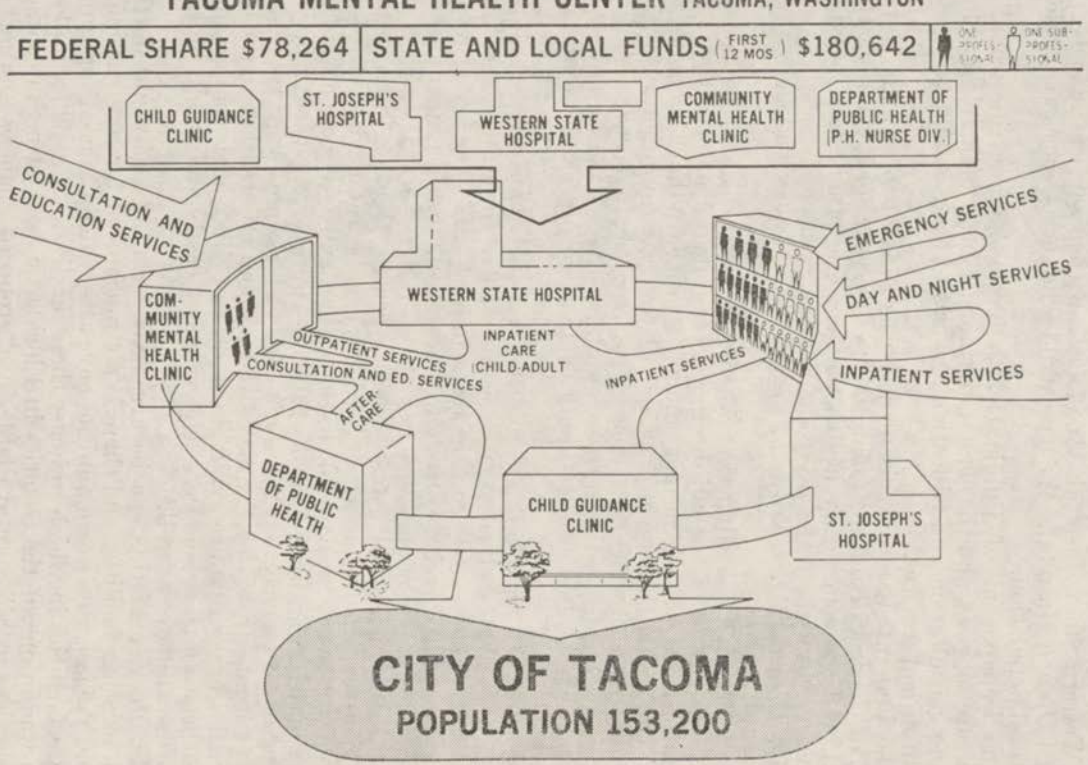
TACOMA MENTAL HEALTH CENTER TACOMA, WASHINGTON
FEDERAL SHARE $78,264
STATE AND LOCAL FUNDS (FIRST 12 MOS.) $180,642
ONE PROFESSIONAL
ONE SUB-PROFESSIONAL
CHILD GUIDANCE CLINIC
ST. JOSEPH'S HOSPITAL
WESTERN STATE HOSPITAL
COMMUNITY MENTAL HEALTH CLINIC
DEPARTMENT OF PUBLIC HEALTH (P.H. NURSE DIV.)
CONSULTATION AND EDUCATION SERVICES
EMERGENCY SERVICES
DAY AND NIGHT SERVICES
INPATIENT SERVICES
COM-MUNITY MENTAL HEALTH CLINIC
WESTERN STATE HOSPITAL
OUTPATIENT SERVICES
CONSULTATION AND ED. SERVICES
INPATIENT CARE (CHILD-ADULT
INPATIENT SERVICES
AFTER-CARE
DEPARTMENT OF PUBLIC HEALTH
CHILD GUIDANCE CLINIC
ST. JOSEPH'S HOSPITAL
CITY OF TACOMA
POPULATION 153,200

FIGURE 4.

Dr. YOLLES. The staffing grant provided funds for the initial partial support of professional and technical personnel for emergency services, day and night services, inpatient services, as well as consultation and educational services. The totality of services provided by the stimulus of this grant was far greater. We have inpatient care being rendered to this total population, as well as for children and adults by the Western State Hospital. We have inpatient services rendered by the St. Joseph Hospital. We have child guidance services available to the total population.

The Department of Public Health has cooperated in providing aftercare services, and the community mental health clinic is now providing consultation and education services to the community, as well as outpatient services.

The Federal share on this project was $78,000 to provide 75 percent of the cost of initial staffing in the first year for St. Joseph Hospital, and the community health center. The others have provided their services without the aid of the Federal grant.

Mr. ROGERS. Mr. Chairman, may I ask a question there for a moment?

It is my understanding that when we passed this bill the concept was to put it all in one building, a community mental health center; to put all five services in one center. It appears that this is not the way you are administering the act. I thought the intention was to require that the services, all five services, be given in one area. I don't know how far it is between these hospitals. Does a person have to go across town? How do they know where to go for which service, and so forth?

Dr. YOLLES. The original intention was to have a single building which would have all of the services as well as for a number of individual services to join together to form a center. The act also calls for agreement by contract to show that the center will render all services to the individual.

The center itself will have a basic or central location in terms of a headquarters operation where patients can be referred. All of the units must be easily accessible to the patient and fairly close together. They may be in different parts of town. However, a patient who is in an inpatient service, and the stage of his illness now suggests that he be in outpatient service, can be moved without any redtape to the outpatient services that are available because of this contractual arrangement between these services. He can move easily and freely, and his records can move as well.

Mr. ROGERS. If this can be arranged, then, anyone could do this with existing facilities and there is not much need for construction.

Dr. YOLLES. Some communities have a very definite need for appropriate facilities in which to house these services. A good example of this was in one of the counties in Florida, in your own State, where no services at all were available in a group of counties—no mental health services at all. The hospital had no inpatient psychiatric services. They have asked for and are receiving a construction grant to construct an inpatient psychiatric service. In addition, however, they have joined with other agencies in other communities to provide a totality of services over and above the inpatient services, which may be the only part constructed.

Mr. ROGERS. All right. Thank you.

Mr. COHEN. Might I add—because Mr. Rogers raised quite a fundamental question, and that is why I dealt with it in my testimony—that there was some discussion and perhaps some misunderstanding that the program was sort of a brick-and-mortar program, solely. Of course, the 1963 act authorized construction, and then the 1965 act authorized the staffing grants, but I think the main thrust that we tried to make in 1963, and that we are trying to make now, is that the comprehensive services ought to be available to the people. And if that takes construction, that is desirable. If it takes staffing, that is desirable. And if it takes both of them, of course, they would both be authorized by the law. But I think our concept is a much more flexible one, to adapt the center to the needs of the community.

If a community doesn't need construction but merely needs to broaden the scope of its services, then the staffing money would be available to the community without the construction money.

Mr. ROGERS. I think this is fine because this would cut a lot of construction money that would have to go in. I agree that this is logical but I am not sure that this has been gotten across to communities that are applying because I think many of them feel that all five services must be located in one central area. So you perhaps are getting applications to build because they don't have all of the facilities in one place which, if it were known, many areas might come in to qualify to provide the services that we are concerned with but presently don't think they can because of this concept that the legislation originally held of bringing them all in one central location.

I would hope that perhaps you could make this very clear in some informational bulletins perhaps to the States and societies that might be involved because I think there is a misconception in many areas that there they just can't qualify simply by tying some of their hospitals together.

Dr. YOLLES. We are attempting to do that through informational material as well as consultation through our regional offices.

Mr. ROGERS. I think this could be very helpful.

Dr. YOLLES. The last is the Muskingum County Guidance Center, in Zanesville, Ohio. (See fig. 5.) Here there were both a staffing and a construction grant. Three agencies were involved, the Good Samaritan Hospital, the Bethesda Hospital, and the Muskingum County Guidance Center.

The three joined together to set in motion the construction of the Community Health Center of Muskingum County. The staffing grant would provide for 75 percent of the initial cost of personnel for 12 inpatient beds in the Bethesda Hospital, and 24 inpatient beds in the Good Samaritan Hospital.

It would provide day care in the Community Mental Health Center, outpatient services in the Community Mental Health Center, and consultation and education to professionals and agencies in the community.

These three services would be housed within the new Community Mental Health Center to be constructed and would be provided to five counties in Ohio that have joined together for this purpose.

Dr. YOLLES. The total population of these five counties is 159,800. This third example is one of combining both grants where there was a need for a physical structure and for staffing as well.

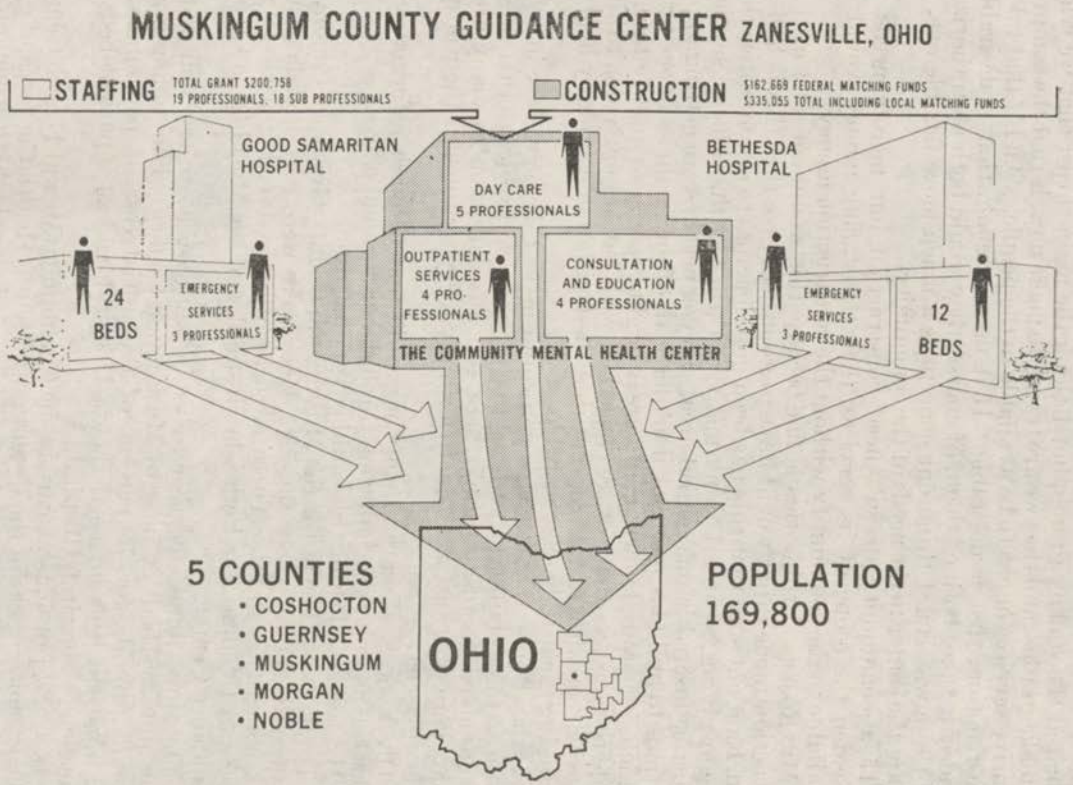
MUSKINGUM COUNTY GUIDANCE CENTER ZANESVILLE, OHIO
STAFFING
TOTAL GRANT $200,758
19 PROFESSIONALS, 18 SUB PROFESSIONALS
CONSTRUCTION
$162,669 FEDERAL MATCHING FUNDS
$335,055 TOTAL INCLUDING LOCAL MATCHING FUNDS
GOOD SAMARITAN HOSPITAL
BETHESDA HOSPITAL
DAY CARE
5 PROFESSIONALS
OUTPATIENT SERVICES
4 PROFESSIONALS
CONSULTATION AND EDUCATION
4 PROFESSIONALS
24 BEDS
EMERGENCY SERVICES
3 PROFESSIONALS
EMERGENCY SERVICES
3 PROFESSIONALS
12 BEDS
THE COMMUNITY MENTAL HEALTH CENTER
5 COUNTIES
• COSHOCTON
• GUERNSEY
• MUSKINGUM
• MORGAN
• NOBLE
OHIO
POPULATION
169,800

FIGURE 5.

This table (fig. 6) shows the status of the program and the number of grants that have been made for the 3 years that we have authorization. I emphasize the difference between grants made and centers funded, because in some cases the center receives both types of grants; so that the number of centers funded would be different from the number of grants made.

The white columns indicate construction. In fiscal 1965 we were able to fund 93 centers with 93 grants. The total is the same, since only construction grants were authorized.

In fiscal year 1964, 54 staffing grants were made and a cumulative total of 194 construction grants had been made. In fiscal year 1967 there will be a total of 131 staffing grants and 294 construction grants.

Mr. ROGERS. Are those total?

Dr. YOLLES. They are not additive, Mr. Rogers, because of the overlap. These are the numbers of centers funded. (See fig. 7.) In fiscal year 1965 there were 93; in fiscal year 1966, 188 centers funded; and by the close of business this year in 1967 there will be 286 centers funded, serving a population of 47.2 million persons in the United States.

Mr. BROWN. They do overlap but they are not additive, is that right?

Dr. YOLLES. The numbers of center grants added to the number of construction grants are not additive, because some centers receive both.

Mr. BROWN. Does the 194 include part of the 93?

Dr. YOLLES. Yes, sir. The 194 is cumulative.

Mr. BROWN. It is cumulative?

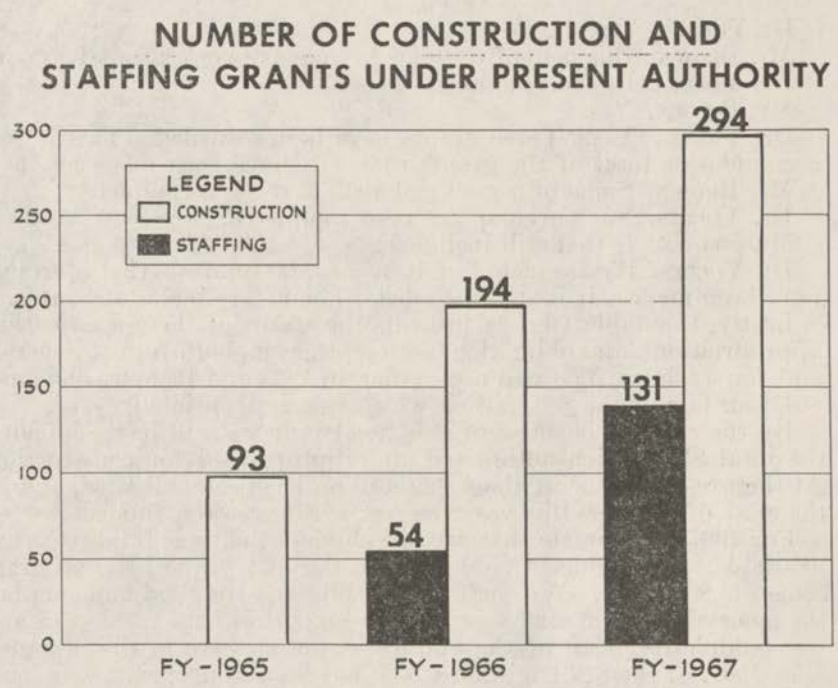

FIGURE 6.

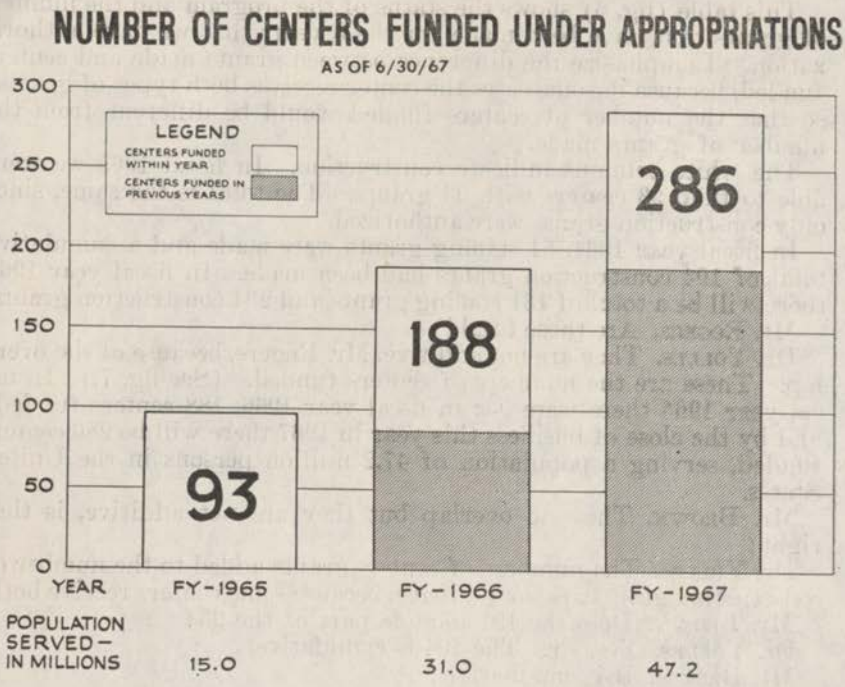

FIGURE 7.

Dr. YOLLES. Yes, sir.

Mr. BROWN. But in 1967 do some of your 93 work themselves out?

Dr. YOLLES. In construction?

Mr. BROWN. Yes.

Dr. YOLLES. Yes. These grants have been awarded. This is just a cumulative total of the grants that will have been made by 1967.

Mr. BROWN. Some of your fiscal 1965 have been completed?

Dr. YOLLES. No; only one has been completed.

Mr. BROWN. Is that still included?

Dr. YOLLES. We are including it in the total numbers that of grants have been made. It is still included. The 93 are included in this.

Lastly, this table (fig. 8) presents the status of the authorization, appropriations, and obligations of the program, both for construction and for staffing. You will notice that, in 1965 and 1966, we obligated $34.3 million of the $35 million which was appropriated.

By the close of business of this fiscal year we will have obligated the total $50 million authorized and appropriated for construction. At the present moment, about $22 million has been obligated, and by the close of business this year the rest will have been funded.

For 1967 we estimate that we will obligate the total funds that are available. In staffing, we obligated in the first year of the program some $15.2 million. We could have obligated the total amount; but the money became available in the last 4 months of the fiscal year, and we couldn't reach all of the applications that were in the institute.

In 1967, of the $19.1 million which has been appropriated we have pending applications totaling 104 percent of that amount, so that we will not be able to fund all of the applications.

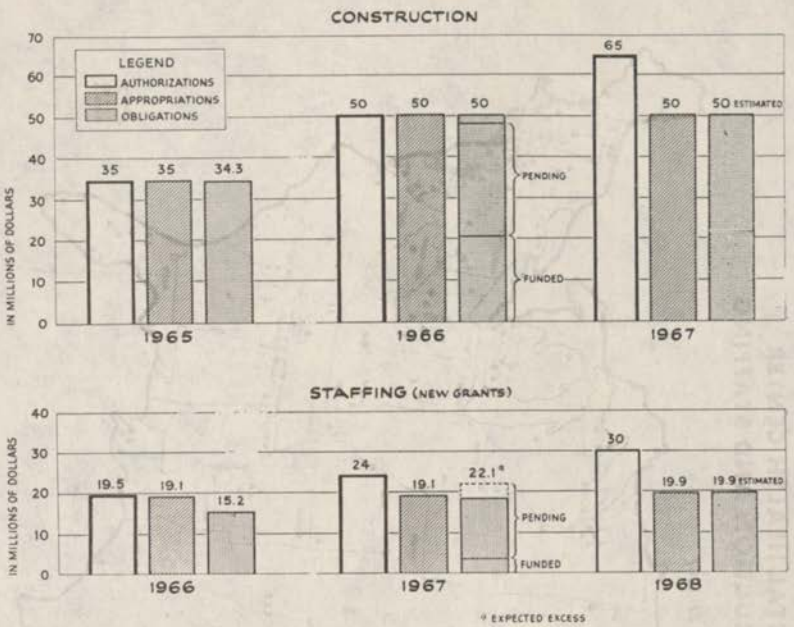

FIGURE 8.

Dr. YOLLES. Of the 1960 funds we estimate that we will use all of the $19.9 million which has been appropriated.

Mr. JARMAN. I think it might be appropriate at this time to ask Mr. Cohen, now that you are on that chart, for a little more information as to funding for the future.

Of course, there is nothing new about the phrasing of the bill but the bill does provide a stated amount and then it says:

and such sums as may be necessary for the next four fiscal years.

Could we get additional information on that, Mr. Cohen?

Mr. COHEN. Yes.

I would be glad to submit for the record, Mr. Chairman, the proposed estimates that the Department has made with regard to the future funding over that 5-year period, both for the construction and for the staffing based upon, of course, the experience we have had up to date.

(The information requested follows:)

Proposed estimates for future funding for construction and staffing, 1968–72

	Fiscal year 1968	Fiscal year 1969	Fiscal year 1970	Fiscal year 1971	Fiscal year 1972	Cumulative total
Construction: Authorization	$50,000,000	$60,000,000	$70,000,000	$80,000,000	$90,000,000	$350,000,000
Staffing: Authorization	30,000,000	26,000,000	32,000,000	36,000,000	38,000,000	162,000,000

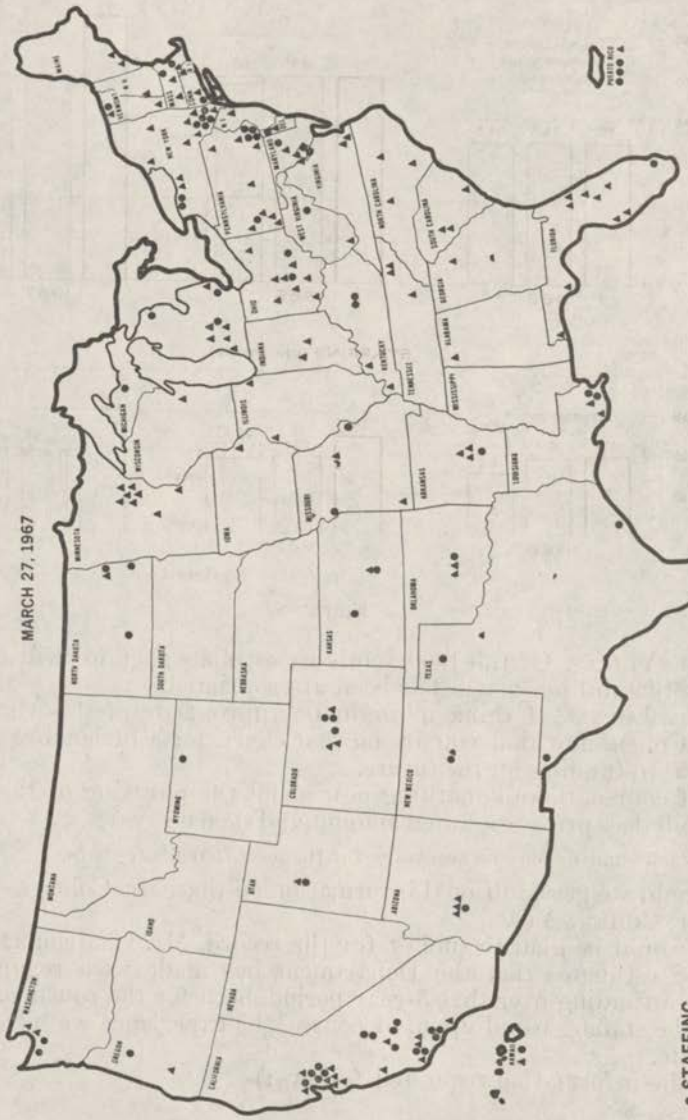
COMMUNITY MENTAL HEALTH CENTER
GRANTS FOR CONSTRUCTION AND STAFFING
MARCH 27, 1967
• STAFFING
▲ CONSTRUCTION

FIGURE 9.

Dr. YOLLES. Mr. Chairman, there is one final chart that I would like to point out. That is the distribution of the community mental health center grants that have been made. (See fig. 9.) The little triangles indicate the construction grants and the circles represent the staffing grants.

There is good distribution across the country.

Thank you.

Mr. ROGERS. Have these charts been reproduced for the committee in the testimony?

Dr. YOLLES. They will be available.

Mr. ROGERS. Thank you.

Mr. COHEN. That completes our formal presentation, Mr. Chairman.

Mr. JARMAN. Before general questioning starts, Mr. Cohen, would Dr. Stewart have any comment to make at this time or would you prefer simply to answer questions?

Dr. STEWART. I think it would be better to just answer questions.

Thank you very much.

Mr. JARMAN. For the subcommittee we want to thank you gentlemen for being with us for what I think is a very good explanation of a very important subject.

There is one question that we would like to clarify for the hearing record: Last year, this committee passed legislation which was signed by the President as Public Law 89-749. This legislation establishes a State health planning agency which is to do comprehensive health planning for the entire State.

Under the mental health legislation which the Congress passed in 1963, a State plan is required for construction of these centers and this plan is required to be administered by a single State agency.

I wonder if you would clarify for the subcommittee the intended relationship between the comprehensive State health planning agency established under Public Law 749 and the operations of a State agency administering the mental health plan.

Mr. COHEN. I will ask the Surgeon General to reply to that, Mr. Chairman.

Dr. STEWART. Mr. Chairman, the intention is that the planning under specific plans such as the mental health planning agency would be complementary to comprehensive health planning. We have in each State in the country planning which is going on toward a specific target or health problem, or the provision of a specific set of services, or the development of a specific set of resources, such as hospitals.

We have planning for mental health services, for mental retardation services, for the development of hospitals. Many of the States have done planning toward the development of the number of physicians in their States and the number of nurses in their States, but nowhere do we have the information in such a way that one can relate all the plans together as to the total development of the services in the State and the total development of the resources in the State.

It is conceivable for a State to be planning the development of specialized services which, when combined, will exceed the State's ability to produce these services because it exceeds the number of physicians or the number of hospitals or the number of dollars available for capital or for operations, either private or public.

The intention of the comprehensive health planning agency is to provide a mechanism for pulling this information together so that the State can have some idea of what the long-range objectives are in the development of resources and services, what their capabilities are, what priorities they might have, what choices there are toward these priorities, given an assessment of their economic development, and of the development of their trained resources and of their facilities.

I think the best way to picture the relationship is to see mental health planning as vertical. It aims at a specific health problem and a specific target population, and it is one of many such vertical health planning functions being carried on simultaneously within a State.

On the other hand, the comprehensive health planning agency has a horizontal role, tying all the vertical plans into a single information sharing and evaluating system, and developing a plan for the total health needs of the total population.

The real function of the comprehensive health planning agency is to collect and then evaluate that information which shows what the health program choices are, whether the objectives are sound, whether they need to be changed.

In a given instance, the mental health agency may be overly ambitious or need some direction. This information would be available through the comprehensive planning agencies to the State government, to the Federal Government, to the private sector—such as Blue Cross—or any other group.

So this is the relationship between the specific planning and the comprehensive health planning agency.

Mr. JARMAN. Thank you.

Mr. Rogers?

Mr. ROGERS. Thank you, Mr. Chairman.

Mr. Secretary, it is a pleasure, of course, to see you again with your associates here. I think the facts that have been presented on the reduction of mental cases actually occupying hospital beds are impressive.

I think we are beginning to make real progress, and this is encouraging, and I commend you and your associates and those from the National Institutes of Health.

There are two or three things I am concerned with in the new request. I notice that where we had previously, I believe, reached a level of $65 million for construction of community mental health centers you are now recommending a reduction of that figure in June 1968 of $15 million.

Could you give us some comment on this? Is it that you don't have enough applications or are we on top of the problem enough where we don't need to go into this program any more?

Mr. COHEN. I think that generally speaking, Mr. Chairman, and Dr. Yolles can amplify, what happens in a construction program in the early years is that the program progresses a little slower than intended as you said, there is a great deal of need for State and local consultation. I think that our original aspirations, projected to the fourth and fifth year from the submission of our original proposals, even somewhat above what we can carry out. I

would have to quite frankly admit that during the preparation of our legislative program, when we had a number of other budget considerations, we were also influenced by a desire not to accelerate construction unnecessarily at a time when interest rates were higher than normal and when there were inflationary pressures.

I would hope now, though, with the program we have presented to you that we could modestly increase the amount of Federal funds in this program to get back upon our original schedule.

Mr. ROGERS. That resulted in this particular figure?

Mr. COHEN. Yes.

Mr. ROGERS. Then you think there are conditions that should be considered by the committee then that might change?

Mr. COHEN. Yes. I think that when you see our revision of our request for authorization for the next 5 years you will see that they will turn out to be a little bit more modest than those we originally submitted in 1963.

We all recognize that it is going to take quite some time to reach our ultimate goal and it is desirable for us to do it in a sound way, enlisting the full support of the communities.

I should also say one other thing: It isn't solely a matter of Federal funds involved here. Once a center is established it is anticipated that the locality will see that it is financed. That means substantial State and local money and money from individual patients and insurance premiums. The locality has to be doubly sure that it can support this operation in the indefinite future.

Mr. ROGERS. I will agree. You have constructed 286, I believe you stated. How many applications do you have on hand?

Do you have applications to warrant this additional appropriation? Is it sufficient? Is it insufficient? Could you give us facts on that?

Perhaps you could submit it for the record.

Dr. YOLLES. Yes, we can do that.

Mr. ROGERS. Maybe you can comment quickly and then submit the details.

Dr. YOLLES. Our experience is to date that we have been able to use all of the funds available to us and we would expect that this would continue for the next year at least.

Mr. ROGERS. The indications from the applications would indicate this?

Dr. YOLLES. Yes.

(The information requested follows:)

COMMUNITY MENTAL HEALTH CENTERS PROGRESS REPORT

During fiscal year 1966 a total of $32.4 million was obligated (FY 65 funds—two year availability) representing 93 projects for the construction of community mental health centers. Additionally, $15.2 million was obligated (FY 66) representing 54 projects for the staffing of community mental health centers.

During fiscal year 1967 an additional 33 construction projects and 19 staffing projects have been approved respectively obligating $20 million (FY 66 funds—two year availability) and 2.6 million. Based upon projects anticipated to be reviewed prior to the close of this fiscal year, June 30, 1967, another 68 construction projects representing $30 million and 58 staffing projects representing $16.5 million will be approved.

Based upon experience to date, we anticipate receiving during fiscal year 1968, 97 construction and 104 staffing applications. These would represent about $60

million for construction and about $30 million for staffing. With the current request for appropriations, $50 million for construction (1967 funds—two year availability) and $20 million for staffing, we would be able to approve approximately 83 of the requests for construction assistance and 66 of the requests for staffing assistance.

Mr. ROGERS. The Chairman has brought out the fact that this committee does not like to use language such as "appropriate such sums as may be necessary," so that I think we need language and specific figures as I think the Department knows.

Now, this contingency account, what precedent is there for setting up a contingency account like this by Federal departments other than for the President?

Mr. COHEN. I will ask Mr. Kelly, our Assistant Secretary, and Comptroller of the Department to handle that.

Mr. KELLY. Mr. Rogers, there are a large number of provisions throughout the Federal Government that either establish contingency accounts or that establish authority to transfer funds from one appropriation to another.

All told, I think we have accounted for about 36 of them.

Mr. ROGERS. How many contingency funds have complete authority other than just notifying?

Mr. KELLY. The Department of Defense has several contingency funds. One that I am looking at now authorizes the Secretary of Defense to spend an additional $200 million if he determines that such is required in the public interest.

There is also a Department of Defense contingency fund which authorizes the Secretary of Defense to transfer research and development funds and to augment them.

Mr. ROGERS. From his contingency fund?

Mr. KELLY. From a separate, additional contingency fund.

Mr. ROGERS. Do you suppose those are CIA funds?

Mr. KELLY. No. I don't believe so. There is one in the Department of Health, Education, and Welfare and one in the Department of Labor that relates to the contingency of increased workload alone.

In the Social Security Administration we are authorized to augment our funds by $25 million in the event that the workload that is received from claimants exceeds that which the budget estimate was based on.

Mr. ROGERS. I think it might be good to submit that into evidence.

(The information requested follows:)

EXAMPLES OF CONTINGENCY FUNDS AUTHORIZED IN FISCAL YEAR 1967 APPROPRIATION ACTS

1. Funds Appropriated to the President—Economic Assistance: "Contingency fund: For expenses authorized by section 451(a), $35,000,000."

2. Department of Defense—Contingencies, Defense: "For emergencies and extraordinary expenses arising in the Department of Defense, to be expended on the approval or authority of the Secretary of Defense and such expenses may be accounted for solely on his certificate that the expenditures were necessary for confidential military purposes; $15,000,000: *Provided*, That a report of disbursements under this item of appropriation shall be made quarterly to the Appropriations Committees of the Congress."

3. Department of Labor—Bureau of Employment Security, Limitation on Grants to States for Unemployment Compensation and Employment Service Administration: "* * * and of which $12,000,000 shall be available only to the

extent necessary to meet increased costs of administration resulting from changes in a State law or increase in the number of claims filed and claims paid or increased salary costs resulting from changes in State salary compensation plans embracing employees of the State generally over those upon which the State's basic grant (or the allocation for the District of Columbia) was based, which increased costs of administration cannot be provided for by normal budgetary adjustments: * * *"

4. Department of Health, Education, and Welfare—Social Security Administration, Limitation on Salaries and Expenses: "* * * *Provided further*, That $35,000,000 of the foregoing amount shall be apportioned for use pursuant to section 3679 of the Revised Statutes, as amended (31 U.S.C. 665), only to the extent necessary to process workloads not anticipated in the budget estimates and to meet mandatory increases in costs of agencies or organizations with which agreements have been made to participate in the administration of Title XVIII of the Social Security Act, as amended, and after maximum absorption of such costs within the existing limitation has been achieved."

5. Department of Health, Education, and Welfare—Welfare Administration, Assistance for Repatriated United States Nationals: "* * * of which $40,000 shall be apportioned for use pursuant to section 3679 of the Revised Statutes, as amended (31 U.S.C. 665), only to the extent necessary to provide for requirements not anticipated in the budget estimates."

6. Legislative Branch—Architect of the Capitol, Contingent Expenses: "To enable the Architect of the Capitol to make surveys and studies and to meet unforeseen expenses in connection with activities under his care, $50,000."

7. Legislative Branch—Library of Congress, Distribution of Catalog Cards, Salaries and Expenses: "*Provided*, That $200,000 of this appropriation shall be apportioned for use pursuant to section 3679 of the Revised Statutes, as amended (31 U.S.C. 665), only to the extent necessary to provide for expenses (excluding permanent personal services) for workload increases not anticipated in the budget estimates and which cannot be provided for by normal budgetary adjustments."

8. Legislative Branch—Government Printing Office, Office of Superintendent of Documents, Salaries and Expenses: "* * * *Provided*, That $200,000 of this appropriation shall be apportioned for use pursuant to section 3679 of the Revised Statutes, as amended (31 U.S.C. 665), with the approval of the Public Printer, only to the extent necessary to provide for expenses (excluding permanent personal services) for workload increases not anticipated in the budget estimates and which cannot be provided for by normal budgetary adjustments."

9. Funds Appropriated to the President—Emergency Fund for the President: "For expenses necessary to enable the President, through such officers or agencies of the Government as he may designate, and without regard to such provisions of law regarding the expenditure of Government funds or the compensation and employment of persons in the Government service as he may specify, to provide in his discretion for emergencies affecting the national interest, security, or defense which may arise at home or abroad during the current fiscal year, $1,000,000: *Provided*, That no part of this appropriation shall be available for allocation to finance a function or project for which function or project a budget estimate of appropriation was transmitted pursuant to law during the Eighty-ninth Congress or the first session of the Ninetieth Congress, and such appropriation denied after consideration thereof by the Senate or House of Representatives or by the Committee on Appropriations of either body."

10. Department of Agriculture—Agricultural Stabilization and Conservation Service, Emergency Conservation Measures: "For emergency conservation measures, to be used for the same purposes and subject to the same conditions as funds appropriated under this head in the Third Supplemental Appropriation Act, 1957, to remain available until expended, $5,000,000 with which shall be merged the unexpended balances of funds heretofore appropriated for emergency conservation measures."

11. Department of Agriculture—Commodity Credit Corporation, Limitation on Administrative Expenses: "* * * *Provided further*, That not less than 7 per centum of this authorization shall be placed in reserve to be apportioned pursuant to section 3679 of the Revised Statutes, as amended, for use only in such amounts and at such times as may become necessary to carry out program operation: * * *"

12. Department of Agriculture—Rural Electrification Administration, General and Special Funds, Loan Authorizations: "* * * Rural electrification program,

$375,000,000 of which $30,000,000 shall be placed in reserve to be borrowed under the same terms and conditions to the extent that such amount is required during the current fiscal year under the then existing conditions for expeditious and orderly development of the rural electrification program; and rural telephone program, $117,000,00 of which $15,000,000 shall be placed in reserve to be borrowed under the same terms and conditions to the extent that such amount is required during the current fiscal year under the then existing conditions for the expeditious and orderly development of the rural telephone program.

13. Department of Agriculture—Farmers Home Administration, Direct Loan Account: "* * * of which $25,000,000 shall be placed in reserve to be used only to the extent required during the current fiscal year under the then existing conditions for the expeditious and orderly conduct of the loan program."

14. Department of Agriculture—Forest Service, Forest Protection and Utilization: "* * * of which $5,000,000 for fighting and preventing forest fires and $1,910,000 for insect and disease control shall be apportioned for use, pursuant to section 3679 of the Revised Statutes, as amended, to the extent necessary under the then existing conditions: * * *"

15. Department of Defense—Military Personnel, Operation and Maintenance, Army: "* * * and not to exceed $3,896,000 for emergencies and extraordinary expenses, to be expended on the approval or authority of the Secretary of the Army, and payments may be made on his certificate of necessity for confidential military purposes, and his determination shall be final and conclusive upon the accounting officers of the Government; * * *"

16. Department of Defense—Operation and Maintenance, Navy: "* * * and not to exceed $10,825,000 for emergency and extraordinary expenses, as authorized by section 7202 of title 10, United States Code, to be expended on the approval and authority of the Secretary and his determination shall be final and conclusive upon the accounting officers of the Government: * * *"

17. Department of Defense—Operation and Maintenance, Air Force: "* * * and not to exceed $3,240,000 for emergencies and extraordinary expenses, to be expended on the approval or authority of the Secretary of the Air Force, and payments may be made on his certificate of necessity for confidential military purposes, and his determination shall be final and conclusive upon the accounting officers of the Government: * * *"

18. Department of Defense—Operation and Maintenance, Defense Agencies: "* * * and not to exceed $3,754,000 for emergency and extraordinary expenses, to be expended on the approval or authority of the Secretary of Defense for such purposes as he deems appropriate, and his determination thereon shall be final and conclusive upon the accounting officers of the Government; * * *"

19. Department of Defense—Research, Development, Test, and Evaluation, Emergency Fund, Defense: For transfer by the Secretary of Defense, with the approval of the Bureau of the Budget, to any appropriation for military functions under the Department of Defense available for research, development, test, and evaluation, or procurement or production related thereto, to be merged with and to be available for the same purposes, and for the same time period, as the appropriation to which transferred: $125,000,000 and, in addition, not to exceed $150,000,000, to be used upon determination by the Secretary of Defense that such funds can be wisely, profitably, and practically used in the interest of national defense and to be derived by transfer from such appropriations available to the Department of Defense for obligation during the current fiscal year as the Secretary of Defense may designate: *Provided*, That any appropriations transferred shall not exceed 7 per centum of the appropriation from which transferred."

20. Department of Justice—Federal Bureau of Investigation, Salaries and Expenses: "* * * and not to exceed $70,000 to meet unforeseen emergencies of a confidential character, to be expended under the direction of the Attorney General, and to be accounted for solely on his certificate: * * *"

21. Atomic Energy Commission—Operating Expenses: "* * * *Provided*, That of such amount $100,000 may be expended for objects of a confidential nature and in any such case the certificate of the Commission as to the amount of the expenditure and that it is deemed inadvisable to specify the nature thereof shall be deemed a sufficient voucher for the sum therein expressed to have been expended: * * *"

22. Selective Service System—Salaries and Expenses: "* * * *Provided*, That during the current fiscal year, the President may exempt this appropriation from

the provisions of subsection (c) of section 3679 of the Revised Statutes, as amended, whenever he deems such action to be necessary in the interest of national defense. * * *"

23. Small Business Administration—Salaries and Expenses: "* * * *Provided*, That 10 per centum of the amount authorized to be transferred from these revolving funds shall be apportioned for use, pursuant to section 3679 of the Revised Statutes, as amended, only in such amounts and at such times as may be necessary to carry out the [business and disaster loan programs]."

24. United States Information Agency—Salaries and Expenses: "* * * *Provided further*, That notwithstanding the provisions of section 3679 of the Revised Statutes, as amended (31 U.S.C. 665), the United States Information Agency is authorized, in making contracts for the use of international short-wave radio stations and facilities, to agree on behalf of the United States to indemnify the owners and operators of said radio stations and facilities from such funds as may be hereafter appropriated for the purpose against loss or damage on account of injury to persons or property arising from such use of said radio stations and facilities: * * *"

EXAMPLES OF TRANSFER AUTHORITY AUTHORIZED IN FISCAL YEAR 1967 APPROPRIATION ACTS

1. Atomic Energy Commission—General Provisions: "Not to exceed 5 per centum of appropriations made available for the current fiscal year for 'Operating expenses' and 'Plant and capital equipment' may be transferred between such appropriations, but neither such appropriation, except as otherwise provided herein shall be increased by more than 5 per centum by any such transfers, and any such transfers shall be reported promptly to the Appropriations Committees of the House and Senate."

2. National Aeronautics and Space Administration—General Provisions: "Not to exceed 5 per centum of any appropriation made available to the National Aeronautics and Space Administration by this Act may be transferred to any other such appropriation."

3. Department of Defense—General Provisions: "During the current fiscal year, the Secretary of Defense may, if he deems it vital to the security of the United States and in the national interest to further improve the readiness of the Armed Forces, including the reserve components, transfer under the authority and terms of the Emergency Fund an additional $200,000,000: *Provided*, That the transfer authority made available under the terms of the Emergency Fund appropriation contained in this Act is hereby broadened to meet the requirements of this section: *Provided further*, That the Secretary of Defense shall notify the Appropriations Committees of the Congress promptly of all transfers made pursuant to this authority."

4. Department of Interior—General Provisions: "Appropriations made in this title shall be available for expenditure or transfer (within each bureau or office), with the approval of the Secretary, for the emergency reconstruction, replacement, or repair of aircraft, buildings, utilities, or other facilities or equipment damaged or destroyed by fire, flood, storm, or other unavoidable causes: *Provided*, That no funds shall be made available under this authority until funds specifically made available to the Department of the Interior for emergencies shall have been exhausted."

"The Secretary may authorize the expenditure or transfer (within each bureau or office) of any appropriation in this title, in addition to the amounts included in the budget programs of the several agencies, for the suppression or emergency prevention of forest or range fires on or threatening lands under jurisdiction of the Department of the Interior: *Provided*, That appropriations made in this title for fire suppression purposes shall be available for the payment of obligations incurred during the preceding fiscal year, and for reimbursement to other Federal agencies for destruction of vehicles, aircraft or other equipment in connection with their use for fire suppression purposes, such reimbursement to be credited to appropriations currently available at the time of receipt thereof."

5. General Services Administration—General Provisions: "Not to exceed 2 per centum of any appropriation made available to the General Services Administration for the current fiscal year by this Act may be transferred to any other such appropriation, but no such appropriation shall be increased thereby more than 2 per centum: *Provided*, That such transfers shall apply only to operating expenses, and shall not exceed in the aggregate the amount of $2,000,000."

6. Veterans Administration—General Provisions: "Not to exceed 5 per centum of any appropriation for the current fiscal year for 'Compensation and pensions', 'Readjustment benefits', and 'Veterans insurance and indemnities' may be transferred to any other of the mentioned appropriations, but not to exceed 10 per centum of the appropriations so augmented."

7. Department of Agriculture—Agricultural Research Service, Salaries and expenses: "* * * *Provided further*, That, in addition, in emergencies which threaten the livestock or poultry industries of the country, the Secretary may transfer from other appropriations or funds available to the agencies or corporations of the Department such sums as he may deem necessary, to be available only in such emergencies for the arrest and eradication of foot-and-mouth disease, rinderpest, contagious pleuropneumonia, or other contagious or infectious diseases of animals, or European fowl pest and similar diseases in poultry, and for expenses in accordance with the Act of February 28, 1947, as amended, and any unexpended balances of funds transferred under this head in the next preceding fiscal year shall be merged with such transferred amounts; * * *"

8. Department of Agriculture—Farmers Home Administration, Salaries and expenses: "* * * *Provided*, That, in addition, not to exceed $500,000 of the funds available for the various programs administered by this agency may be transferred to this appropriation for temporary field employment pursuant to the second sentence of section 706(a) of the Organic Act of 1944 (5 U.S.C. 574) to meet unusual or heavy workload increases: * * *"

9. Department of Commerce—Ocean Shipping, Research and Development: "* * * *Provided*, That transfers may be made to the appropriation for the current fiscal year for "Salaries and expenses" for administrative expenses (not to exceed $900,000) and any such transfers shall be without regard to the limitation under that appropriation on the amount available for such expenses: *Provided further*, That transfers may be made from this appropriation to the "Vessel operations revolving fund" for losses resulting from expenses of experimental ship operations.

10. Department of Defense—Research, Development, Test, and Evaluation, Defense Agencies: "* * * *Provided*, That such amounts as may be determined by the Secretary of Defense to have been made available in other appropriations available to the Department of Defense during the current fiscal year for programs related to advanced research may be transferred to and merged with this appropriation to be available for the same purposes and time period: *Provided further*, That such amounts of this appropriation as may be determined by the Secretary of the Defense may be transferred to carry out the purposes of advanced research to those appropriations for military functions under the Department of Defense which are being utilized for related programs, to be merged with and to be available for the same time period as the appropriation to which transferred. * * *"

11. Post Office Department: "* * * *Provided*, That functions financed by the appropriations available to the Post Office Department for the current fiscal year and the amounts appropriated therefor, may be transferred, in addition to the appropriation transfers otherwise authorized in this Act and with the approval of the Bureau of the Budget, between such appropriations to the extent necessary to improve administration and operations: * * *"

12. General Services Administration: "* * * *Provided further*, That the foregoing limits of costs may be exceeded to the extent that savings are effected in other projects, but by not to exceed 10 per centum. * * *"

Mr. ROGERS. My first reaction is negative to this. I am not impressed with the fact of turning it over to the Secretary, particularly when Congress is in session most of the year. There may be a period of 3 or 4 months when we are not.

Supplementals are available. I just don't see much need for contingency funds as long as we have available the Congress to act on some specific requests.

Mr. COHEN. Could I say a little on that, Mr. Rogers?

Mr. ROGERS. Certainly.

Mr. COHEN. I know you are a man who can be persuaded by the facts. I would like to take a try at it.

I think our experience, Mr. Rogers, has been, first, that such a fund is needed during the time that Congress is not in session. Even when Congress returns at the beginning of a calendar year to deal with supplementals, your study will find that supplementals in many cases—for anything except, I think, of the greatest urgency, perhaps most largely national defense and other related problems—come on the whole early in the spring rather than early in the year. There is a period of time, I would say, ranging from 6 to 7 months, rather than just from 2 to 3 months, in which it is almost impossible for the Department to act in an emergency.

Secondly, even with regard to a request for a supplemental at a given moment of time, our experience has been that, unless there is a supplemental already on its way through Congress, it is exceedingly difficult, even with the gravest type of problems we have, to get the supplemental considered on its own merits because usually the House or the Senate committee wants to group supplementals together, which is a very understandable desire.

We have reluctantly come to the conclusion that the present process really does make it very difficult for us to exploit any of the research breakthroughs or deal with any of these emergencies very promptly.

Mr. CARTER. Mr. Chairman, would the gentleman from Florida yield?

Mr. ROGERS. I yield.

Mr. CARTER. Suppose at the present time we did have this breakthrough on german measles and a vaccine was developed. I can see how the Surgeon General would want some funds immediately to take advantage of this. Certainly, I think that a fund is necessary.

We know that otherwise we have to have a supplemental appropriation that will take months. By reason of this, we have, perhaps, hundreds of deformed babies throughout the United States whose mothers had not had the opportunity of this vaccination.

Mr. ROGERS. I appreciate the comment of the gentleman. It has been my experience certainly that, rather than having to wait on moneys, we generally have to push to get new drugs approved and no vaccine.

In polio it was at the instigation of this committee. We had to push our people to get them to do anything, particularly on the safety devices. I remember very well our hearings on the problem that we had on getting new drugs pushed.

I would think that Congress could keep up pretty well if the breakthroughs come about if we are alert at all to our jobs.

Mr. KELLY. Mr. Rogers, could I comment?

Mr. ROGERS. Yes.

Mr. KELLY. I think that we should bring to your attention the fact that the funds appropriated to HEW are in some ninety accounts. This does give the Congress the opportunity to review each individual program and determine the level of funding, but the more refined you make the individual account the less flexibility you provide for dealing with unforeseen conditions.

Mr. ROGERS. Let me ask you this: I understand that you are talking about measles. We know there is a possibility of this developing.

What is the request of the Department on the vaccination program?

Are you coming in with a new program or are you letting it——

Dr. STEWART. Are you talking about German measles?

Mr. ROGERS. A vaccination program is what I am talking about.

Dr. STEWART. The Vaccination Assistance Act expires in 1968 and we think that this can be included in the Public Law 749 extension act that we are talking about.

Mr. ROGERS. Wait. Let me get this clear. Are you asking for renewal of the vaccination program or not?

Dr. STEWART. No; we are not.

Mr. ROGERS. You are not?

Dr. STEWART. That is correct.

Mr. ROGERS. There is a German measles problem and maybe a breakthrough.

Mr. CARTER. That is a distinct disease?

Mr. ROGERS. So was the vaccination program for distinct diseases as I understand it.

Dr. STEWART. At the present time with the German measles vaccine, of course, it is still in the research stage. We don't know whether there will be a breakthrough to an available vaccine.

Mr. ROGERS. You don't think we need a continuation of our vaccination program?

Dr. STEWART. We think this can be built into the normal program that we have in parts of Public Law 89-749.

Mr. ROGERS. Then there is some flexibility there?

Dr. STEWART. There is flexibility to the point at which you suddenly need to move on something. If a breakthrough on a vaccine should occur right away, assuming that Public Law 89-749 had been implemented, the States have already got programs going under these funds.

Their flexibility is on a year-by-year basis, too.

Mr. ROGERS. Don't you have the flexibility to work in any vaccine that comes in?

As I recall, we gave the Secretary the authority to say which vaccine would be used or included in case of breakthrough. We specifically made provisions in that law for him to have that authority so that you could completely set aside one program for a minute if there was a great emergency come through until you could get some additional funds.

Dr. STEWART. That is correct, Mr. Rogers, but it could be that you have a year in which the States have used the money under the present Vaccination Assistance Act for their regular measles campaign, for example.

Mr. ROGERS. That is what I am saying. Yet you are not asking to continue it?

Dr. STEWART. I think that we are not talking about flexibility within one item of the Public Health Service budget. We are talking about flexibility because we have so many items and one can't tell what contingencies are going to arise. It may be vaccine. It may be a disaster

on an Indian reservation. It may be a disaster on our rivers. It may be something else.

Mr. ROGERS. We have a lot of flexibility there, particularly with our comprehensive health policy that we just passed to give lump sums to the States.

Dr. STEWART. That money is for the States to conduct their health programs as they set priorities on a regular basis. It does not take care of contingencies. They would have the same difficulty of meeting contingencies that we have.

Mr. ROGERS. But you also have project grants that you are continuing for these contingencies?

Dr. STEWART. No; the project grants are not for contingencies. The project grants are for special problems that are not national in scope, or for initiating new programs or this type of thing.

They will be used in a regular movement of the health programs within the State.

Mr. ROGERS. Let's get back to the central point, then. What are you going to do about your vaccination program?

Dr. STEWART. Well, the vaccination program has now become part of the regular program of the States.

Mr. ROGERS. It is still being funded through that program, isn't it?

Dr. STEWART. In part.

Mr. ROGERS. How are you going to fund it?

Dr. STEWART. That money was to fund communities or States on a project basis if they felt they needed the assistance and it can be either for the purchase of vaccine or they can get the vaccine from us. It also pays for the public information campaigns that go with such programs.

Our program has shown that you can develop vaccination programs but the vaccination effort is being built more and more into the regular programs of health departments and other agencies in communities and States.

Mr. ROGERS. Where is the money coming from?

Dr. STEWART. Well, it is coming from private sources. It is coming from State and local governments.

Mr. ROGERS. In other words, you are saying that it is not necessary to have Federal funds for the vaccination programs now?

Dr. Stewart. I think it is only necessary in the future to the extent that the State would choose to use some of the Federal funds under the formula grants in Public Law 89–749 for vaccination programs. There is a vaccination program going all the time and the States use these funds for special purposes under the Vaccination Assistance Act but with Public Law 89–749 they can build this into their normal program.

Mr. ROGERS. You mean for comprehensive health planning?

Dr. STEWART. It is not in the health planning. It is in the section of the Formula grants in Public Law 89–749 which were formerly categorized into heart disease, cancer, and so on, but are now a pool of

funds to the States for the health programs that the States think are important ones for them to be emphasizing within the State.

Mr. ROGERS. That is the theory of the comprehensive health planning as I understand it, isn't it?

Dr. STEWART. It is a major portion of the Comprehensive Health Planning and Public Services Act, yes.

Mr. ROGERS. It is the total grant and they apportion?

Dr. STEWART. That is correct.

Mr. ROGERS. You are saying that vaccination program would be under that administration?

Dr. STEWART. The vaccination program would apply within the program of grants in Public Law 89–749 as the State uses this money for its health programs.

Mr. ROGERS. What I want to know is if you are taking away any money by not continuing the vaccination program?

Dr. STEWART. I don't think I would use that phrase "taking away." The authorization for 1968 in Public Law 89–749 is $62½ million and if the Congress appropriates this fund it is an increase over last year's fund.

Mr. ROGERS. But you are not asking for a continuation as such of the vaccination program?

Dr. STEWART. No. The whole idea of the formula and project grants of Public Law 89–749 was to consolidate the various categories of grants we had in order to give the States and communities more flexibility in meeting the problems they had.

Many communities have been able to put on vaccination campaigns without Federal assistance. Others did not need it.

It varied, depending upon the resources they had available and the community interest they had.

Mr. ROGERS. Then you are saying that if you have a breakthrough in measles they can program it in this overall program they have if they want to put the priority on it.

Dr. STEWART. This is correct; yes.

Mr. BROWN. Would the gentleman yield?

Mr. ROGERS. I yield.

Mr. BROWN. I would like to ask how much timelag there is between proof of a breakthrough and the implementing of it would you estimate under normal circumstances?

Dr. STEWART. The breakthrough for use by the general population would mean that the vaccine had been licensed.

Mr. BROWN. And is that prior to that established medically?

Dr. STEWART. Prior to that is a process of experimenting with the vaccine. Then there is the trial and error testing of the vaccine, meaning the trial that is given in a population group to make sure that it works. And by the way, this is a contingency that comes up every once in a while.

We may have a vaccine that has been tested on small groups and we suddenly need larger field trials. This is the next developmental stage. We can rarely anticipate the field trial stage. It comes very quickly because of the nature of the experiments.

Mr. BROWN. But you have that flexibility in the fund that you can divert from other areas; in research, for example.

Dr. STEWART. No; we do not have the ability to divert funds for these field trials and also for the implementation of a vaccine program after it has been licensed.

Mr. BROWN. You suggested beforehand—I am not talking about after it has been licensed.

Dr. STEWART. We have the funds with which to do the basic research on developing the vaccine and the testing of the feasibility.

Mr. BROWN. You can switch the vaccine to some other areas in the basic research; can you not? You have that discretion?

Dr. STEWART. No. We have difficulty meeting contingencies of need for large-scale field trials of a vaccine prior to licensing.

This situation emerged in the regular measles vaccine program and it could have been so in the polio vaccine development although that was financed mainly by the polio foundation. This is one type of contingency that can come up—the field trials of a vaccine.

Mr. BROWN. How would you resolve that?

Dr. STEWART. The field trials on the regular measles were conducted in Africa using money abroad rather than money of our own.

Mr. BROWN. This is prior now?

Dr. STEWART. Public Law 480.

Mr. BROWN. Prior to its being proven, proven in terms of licensing?

Dr. STEWART. Prior to being licensed. There were massive field trials in Africa.

Mr. BROWN. You don't know whether this vaccine is yet good enough to be licensed?

Dr. STEWART. This vaccine is now licensed. At that time we did not know that it would be licensed. We were as sure as one could be before the field trials. The field trials in this instance depended in a sense—the contingency that had come up, depended upon the availability of Public Law 480 funds in Africa.

Mr. BROWN. That is one contingency that you handled but I would like to return to my point of where you have established through field trials and are ready for licensing.

How much leadtime is there here? I am trying to determine whether or not there is, in fact, time for Congress to act and it seems to me that Congress has gotten itself involved with the doctoring of the economy by the 7-percent investment credit suspension.

We are doing that on a month-to-month basis apparently. We are acting on that kind of economic rate. Can't we move on a month-to-month basis, to appropriate funds for any breakthrough that comes in medicine?

Mr. Rogers made the point that it takes a certain amount of time to establish the validity of the vaccine, the treatment, the licensing, and Congress is available.

Then you could say, "How about a contingency appropriation?"

Mr. KELLY. Mr. Brown, I think that we all know that Congress has demonstrated a capability of acting almost instantly if the requirement

arose for it to do so. We have seen something go through the Congress in a period of 24 hours when that is required, but I think if you were to take the tradition as Mr. Cohen was suggesting on the handling of supplemental appropriations, you would find that the period from the time that there was a determination of need until funds were available to carry out that need by a supplemental appropriation would range anywhere from 7 months to 2 months. It is also unlikely that you can find anything except a very extraordinary incident in which that time lag was less than 2 months in duration.

We had an example of a development involving viruses as the potential causation of cancer, in which there was a desire to exploit the research findings. In this particular instance the Congress became aware of the problem concurrently with our becoming aware of it, and prior to the actual submission of a supplemental appropriation request the Appropriations Committee took testimony on it and put it into our regular appropriation bill which was then under consideration by the Congress.

This was probably the most rapid method by which you could handle that particular transaction. It took about 4 months from the time that this illustration came up until we actually had the funds available.

Now, the particular problem that you were talking about on the development of the German measles vaccine, this work is being done in part by the Division of Biologic Standards of the National Institutes of Health.

This is a relatively small appropriation. The exact amount of it I don't recall, but it is an appropriation of less than $10 million that relates to all of the problems associated with licensing biologic products. Scientists in the Division are the ones that have done much of the work on the development of this vaccine.

The Division does not have any resources except this small appropriation; and, if you want to move this project into expensive field trials, at some particular point you have to find some way of doing it, because within that appropriation, although you think of the National Institutes of Health as being an organization funded in excess of a billion dollars, when you take this into individual pieces, and the planned use of those pieces, and the commitments that have already been made against them, these amounts are not large.

In this particular instance, the problem is associated with a very small appropriation which is within the National Institutes of Health. But there is no availability for transfer of funds between the various accounts of the National Institutes of Health, so that whichever account has the responsibility is the one that has to organize and fund it.

Mr. BROWN. If Mr. Rogers will be patient with me for one moment, further, let's go back to the example of the virus causal effect in cancer.

Let me ask you if in this 4-month lag which you described you had actually any delay in putting the program into effect as a result of that 4-month lag time?

Mr. KELLY. I think that we could have gained from the availability of the 4 months in launching the exploitation of this finding. It turned out to be a long-range investigation that has resulted from this finding including the development of new facilities which had never been developed before.

Mr. BROWN. But with this kind of early commitment by Congress, in other words, this willingness to take testimony in advance of the actual presentation of the request for funds and so forth, isn't it true that you can also go ahead and begin to presume your plans and frequently do perhaps up to the point where you take the legal steps to put them into effect; in other words, sign a contract or in effect commit yourselves?

This is what I am trying to find out. How important is it that the cash be on hand, and how important is it that we presume that the Congress is going to act fast enough?

Mr. KELLY. I think your point is well taken and necessarily, in order to carry out any amount of work, you have to do some planning.

The very presentation of a budget constitutes this planning, that you have identified the problem, how you will approach the problem and what the next steps are; but by and large, this is the planning which was done prior to being able to present the estimate and prior to being able to present testimony with respect to it so that this loss of time is really occurring to a marked degree after this initial preliminary planning has been done.

Don't misunderstand. You know, and I know, that we do divert staff resources to try and get as far along as we can in moving down the road. I thing that we have had examples in the past that indicate the extent to which a greater degree of flexibility would have been useful.

I think that you can foresee this problem occurring in the future that makes this an important piece of flexibility for the Secretary. We are not asking, however, in any sense as I see it for a blank check.

One, we are asking for the legislative committees to authorize the use of a contingency fund. We are asking for the appropriations committees to then implement that provision and tell us each year that we are authorized to use it and the extent that we can use it.

We are suggesing that we give to the Congress a report 10 days in advance of its use of our intention to use it and an annual report on our use of the fund.

Mr. JARMAN. The Chair hates to interrupt, because this is an important and, perhaps, maybe a controversial part of the bill before us, but I might point out that we do hope to finish with this part of the hearing by 12 o'clock this morning, since we have a full agenda of witnesses for tomorrow. If that deadline can be kept in mind with several other members of the committee yet to ask questions, the Chair would appreciate it.

Perhaps this matter can be developed more completely from the Secretary and Mr. Kelly, and others, in the materials which you submit to the committee.

77-607—67——5

Mr. KELLY. We would be glad to submit data on the time lag involved in receiving supplemental appropriations.

(The information follows:)

Chronological history of Department of Health, Education, and Welfare supplemental appropriations, fiscal years 1962–67

[In thousands of dollars]

Appropriation Act	Amount enacted	Date requested	Date enacted
Supplemental Appropriation Act, 1962.	$1,125,222		Sept. 30, 1961
Department of Health, Education, and Welfare items.	253,579	July 13, 1961 (H. Doc. 210); Aug. 8, 1961 (H. Doc. 217); Aug. 14, 1961 (H. Doc. 224); Sept. 18, 1961 (S. Doc. 51).	
2d Supplemental Appropriation Act, 1962.	373,551		July 25, 1962
Department of Health, Education, and Welfare items.	16,526	Feb. 7, 1962 (H. Doc. 333); Apr. 3, 1962 (S. Doc. 83).	
Supplemental Appropriation Act, 1963.	1,467,230		May 17, 1963
Department of Health, Education, and Welfare items.	216,753	Aug. 13, 1962 (H. Doc. 514); Sept. 28, 1962 (S. Doc. 149); H. Doc. 514 resubmitted on Feb. 7, 1963 (H. Doc. 61); Feb. 11, 1963 (H. Doc. 63).	
Supplemental appropriations, Department of Health, Education, and Welfare, 1964.	289,688		Feb. 10, 1964
Department of Health, Education, and Welfare items.	289,258	Nov. 21, 1963 (H. Doc. 174); Jan. 21, 1964 (H. Doc. 203).	
Deficiency Appropriation Act, 1964	1,336,687		June 9, 1964
Department of Health, Education, and Welfare items.	160,350	Jan. 21, 1964 (H. Doc. 203); May 25, 1965 (S. Doc. 77).	
Supplemental Appropriation Act, 1965.	1,117,196		Oct. 7, 1964
Department of Health, Education, and Welfare items.	69,750	July 20, 1964 (H. Doc. 318); Aug. 14, 1964 (H. Doc. 342).	
2d Supplemental Appropriation Act, 1965.	2,227,564		Apr. 30, 1965
Department of Health, Education, and Welfare items.	446,374	Mar. 2, 1965 (H. Doc. 98); Mar. 15, 1965 (H. Doc. 110); Mar. 15, 1965 (H. Doc. 111); Mar. 16, 1965 (H. Doc. 119).	
Departments of Labor, and Health, Education, and Welfare Supplemental Appropriation Act, 1966.	1,223,182		Sept. 23, 1965
Department of Health, Education, and Welfare items.	1,066,655	Apr. 19, 1965 (H. Doc. 147); Apr. 22, 1965 (H. Doc. 149); June 24, 1965 (H. Doc. 220).	
Supplemental Appropriation Act, 1966.	4,741,645		Oct. 31, 1965
Department of Health, Education, and Welfare items.	577,821	Aug. 26, 1965 (H. Doc. 278); Sept. 29, 1965 (H. Doc. 295); Oct. 5, 1965 (H. Doc. 298); Oct. 8, 1965 (S. Doc. 62); Oct. 15, 1965 (S. Doc. 63); Oct. 18, 1965 (S. Doc. 65).	
Second Supplemental Appropriation Act, 1966.	2,788,143		May 13, 1966
Department of Health, Education, and Welfare items.	908,070	Feb. 14, 1966 (H. Doc. 380); Feb. 21, 1966 (H. Doc. 383); Mar. 8, 1966 (H. Doc. 405).	
Supplemental Appropriation Act, 1967.	5,025,265		Oct. 27, 1966
Department of Health, Education, and Welfare items.	2,177,179	Jan. 24, 1966 (H. Doc. 335); Oct. 5, 1966 (H. Doc. 505); Oct. 11, 1966 (H. Doc. 521); June 24, 1966 (S. Doc. 96); Oct. 17, 1966 (S. Doc. 117).	

Mr. JARMAN. Mr. Rogers?

Mr. ROGERS. I have no questions.

Mr. JARMAN. Mr. Nelsen?

Mr. NELSEN. Thank you, Mr. Chairman.

Recently, I received a letter from Dr. Vail, of Minnesota, dealing with the question of flexibility in the program and here is what he said:

> I would bring you up to date on some of the problems we are having in implementing the Federal provisions at the state level, at least here in Minnesota.
>
> The simplest way to do this, it seems to me, is to send you copies of the letters that I have written to Senator McCarthy and Representative Rogers, together with the stock answer received from the Department of Health, Education, and Welfare.
>
> There is nothing to add to this point. I think our quarrel is not with the theory of the Federal concept of community mental health centers, but with the administratives practice, especially the requirement to prepare cumbersome plans for mental health centers in addition to the regular mental health plan which we write each year in order to qualify.
>
> Generally, I would have to say that I favor the categorization of the welcoming of the correction of one comprehensive plan to the state of mental health programs that would require one plan for the entirety of the state mental health program.

I recall a meeting at the White House a couple of years ago in which it was the declared intention of HEW to move in the direction of giving the State more flexibility in the use of the funds. In some of these community health centers the facilities are there, and the staffing problem is more important than the bricks and mortar. In other cases the opposite is true.

I wonder if you wish to comment on this particular complaint?

Mr. COHEN. Yes. Let me make a brief statement and then I will ask Dr. Yolles to talk about it.

I also received a letter from Dr. Vail and I suppose I gave him what he refers to as a "stock answer." But I do wish to say that at the time I received his letter, I immediately communicated with Dr. Yolles, who is in charge of this program, to study the points that Dr. Vail made.

I established, at least to my own satisfaction, though perhaps not to Dr. Vail's, that we were trying to do two things that make it very difficult to carry out what Dr. Vail had proposed.

On the one hand, it is the professed objective both of the President and the Department, to give the States and the localities a greater degree of discretion in the use of Federal funds. But at the same time both the substantive committee—(this committee)—and the Appropriations Committee hold us responsible for making an account of our stewardship in terms of what the money was appropriated for. Many of the so-called provisions and restrictions or requirements in the submittal of information, particularly those of which Dr. Vail has sometimes been critical are an attempt to be able to supply the substantive committee and the Appropriations Committee with all the information that they think is necessary to assure that Federal funds have been spent for the purpose for which they were appropriated. That requires us to collect a good deal of information to assure ourselves that the money has not been misspent, that is, misspent in the sense of not having been directed toward the primary purpose for which Congress appropriated the money.

I do think that there is a basis for giving the States more flexibility in programs once the program has been started. You will recall, for example, that we came in here 4 or 5 years ago requesting that the

States be given greater flexibility in the Hill-Burton program for modernization.

The committee very seriously restricted our ability to give the States that flexibility because they said, "We want to see this primary objective retained." I would say, Mr. Nelsen, that while the objective is sound, I think that also our administrators feel that we must be very carefully responsive to the congressional will. We want to be sure that we can account for the money in terms of the authorization that Congress has given us.

Perhaps Dr. Yolles would like to amplify on that in terms of Dr. Vail's points.

Dr. YOLLES. I would like to comment briefly, Mr. Nelsen.

I might say that I have commented on this point before regarding Dr. Vail. Dr. Vail's principal concern is with the "minutiae" as he calls them, of the State plan which must be submitted.

There are certain requirements in Public Law 88–164 which I consider to be very wise provisions of the Congress.

Before one sets up a program, especially in a field like mental health where there is such a tremendous need for services throughout the United States, the State must take into account which of its own areas have the greatest need. It needs to divide the State into areas which set forth the relative need for services.

It must also provide in the State plan an inventory of resources and services that presently exist so that these can be built into and not be duplicated by the new service to be rendered. It is this type of requirement which is in the law that Dr. Vail objects to.

Perhaps my last point is not entirely germane. However, it is that Dr. Vail has been the most outspoken objector to this requirement for providing such information and yet he was the first to submit a State plan in excellent form.

Mr. NELSEN. I appreciate the problem you face and might also mention that obviously, you are moving in the direction of attempting to provide for greater flexibility which I think is the direction in which all of us would like to move.

At the same time, I understand your concern. Getting to section 401(e) of the bill, this, of course, will also provide for the mental retardation centers; would it not?

Dr. YOLLES. Section 401(e) provides for altering the definition of the term of construction to allow for the acquisition of existing buildings.

Mr. NELSEN. Yes. Getting back to my problem of mental retardation day care centers and training centers, this has been an obvious area where attention is needed.

Out in my district we have under the poverty program one day care center and staffing is a tremendous problem. We have another one, using the little school building that I have talked about so many times, now under operation largely through voluntary subscription.

As far as acquisition of buildings is concerned, this seems to be the lesser of the problems. We find many hospital buildings that are vacated because they need new and larger facilities.

We find many school buildings vacated, very good centers with playgrounds and what-have-you. Looking to the future, is there a

possibility that we may be able to move not in the area of spending money on acquisition but more with the idea that we can give some help to staffing? Certainly there is a very, very crying need in many of our communities.

I believe other legislation may touch on that.

Dr. STEWART. Yes, Mr. Nelsen, there is legislation before the Congress for consideration of the staffing of the mental retardation centers, modeled very much like the initial staffing in the mental health centers.

In the amendment of section 401(e) by inserting the word "acquisition" after "new buildings," it would apply to both the mental retardation and the mental health legislation.

Mr. NELSEN. Now, in your statement, on page 9, you say that H.R. 6431 "would continue the staffing grant program in its present form for an additional 4 years."

In this staffing grant program you presently have, would money be available to a day care center, a mental retardation day care center?

Dr. STEWART. No; this money is for the staffing of the comprehensive mental health centers. There is other legislation before the Congress which proposes the staffing of mental retardation centers.

Mr. NELSEN. Thank you.

And the money that was spent on the Tacoma and Minneapolis centers was not in bricks and mortar but more altogether in staffing, almost altogether in staffing?

Dr. YOLLES. A good part of it.

Mr. NELSEN. Thank you.

I have no more questions, Mr. Chairman.

Mr. JARMAN. The chairman of our full committee is with us this morning and I would like at this time to call on the chairman.

Mr. STAGGERS. Thank you, Mr. Chairman. I would like to ask Mr. Cohen just one or two questions because I don't want to take up the time of the committee.

What is the National Institute of Mental Health doing to improve the care available to patients in the existing State mental hospitals?

Dr. YOLLES. Mr. Staggers, as you may recall, at the time that the so-called new national mental health program was devised in 1963 as a complement to the Community Mental Health Centers Act, we made funds available for demonstrations of improved care and treatment of the mentally ill in hospitals.

This was a grant program available to all institutions for the mentally ill and mentally retarded in the United States. Each could apply on a competition basis for a grant of $100,000 each year for a period of 10 years to improve care and treatment.

These grants have resulted in some of the most interesting and constructive types of treatment programs and have aided in the release of many thousands of patients from mental hospitals. This is an interim program until the community mental health centers can take over the burden of the treatment of the mentally ill.

Mr. STAGGERS. Are there any of the States that do not have an approved plan for community health centers?

Dr. YOLLES. At the present time there is only one State that does not have an approved plan but we expect that before the fiscal year is out that that plan will have been approved.

We are in consultation with the State and they are making modifications of the plan which will make it approvable.

Mr. STAGGERS. You expect to have that one?

Dr. YOLLES. Yes, we do.

Mr. STAGGERS. That is all, Mr. Chairman. Thank you.

Mr. JARMAN. Dr. Carter.

Mr. CARTER. Certainly, I was impressed by the statement, Mr. Cohen, and also by the impressive charts. About the contingency fund, I would like to know if you have available statistics concerning deformities and still-born children resulting from German measles each year.

Do you have that at hand?

Dr. STEWART. Mr. Carter, I don't have it at hand, but I can get this data for you if you wish it.

(The information requested follows:)

It is conservatively estimated that the 1964–65 German measles epidemic resulted in upwards of 30,000 abnormal pregnancies. In addition to thousands of fetal and newborn deaths, some 20,000 infants were born crippled with such defects as cataracts, deafness, mental retardation, and heart disease. Assuming that a vaccine had been ready for use or for testing in 1964, many of these deaths and abnormalities would have been prevented.

Mr. CARTER. I think that would be quite interesting since it is admitted that a delay of from 3 to 7 months takes place in securing an appropriation for vaccination in such cases and we could easily take that proportionate part of a year and estimate the number of deaths and deformities which would result from the lag in an appropriation which could be prevented by your contingency fund.

That is all I have to say.

Thank you very kindly.

Mr. JARMAN. Mr. Brown?

Mr. BROWN. Mr. Cohen, I wonder if I could ask a couple of questions to verify some figures.

New members of the committee have to be educated in the use of figures which the rest of the committee may feel very familiar with but I personally am not.

The $20 billion a year cost, would you work that up for me a bit?

Mr. COHEN. Yes, the estimate of the $20 billion in the economic cost is composed of estimates giving the loss of output due to individuals who have to withdraw from the labor market, or from their other occupations, the loss of tax revenue that is involved in their not working, and in the additional cost for treatment and prevention.

As I said, the treatment and prevention cost is in the neighborhood of $4 billion a year at the present time. The estimated loss in tax revenues for people who can't work is about $3½ billion. The remainder largely is due to the loss in the output because of inability to work or conduct their regular occupations.

Mr. BROWN. And this is based on how many mentally ill people?

Mr. COHEN. This is an annual cost based upon the estimated incidence of mental illness at the present time.

Mr. BROWN. Or those who are mentally ill and not hospitalized.

Mr. COHEN. Yes, including the hospital costs which, of course, are the largest costs. Of the $4 billion, about $2½ billion is inpatient hospital care, and roughly about $1 billion is outpatient care.

Mr. BROWN. If I understood the figures presented on the charts, there are 702,000 persons in mental hospitals at present.

Mr. COHEN. No: that would have been the number; 700,000 would have been the number if the projections from years prior to 1955 remained correct.

Mr. BROWN. Would have been. Are you using those figures?

Mr. COHEN. No; I am using the 1966 figures of the people who were actually, first, hospitalized; second, had a spell of mental illness that required outpatient care; and third, had to withdraw from the labor market because they had a period of mental illness.

Mr. BROWN. 452,000?

Mr. COHEN. Well, 452,000 is the total that were in a State or local mental hospital. That does not include the people who have outpatient care, or who were treated by the psychiatrist in his office.

Mr. BROWN. May I have those figures?

Mr. COHEN. Would you like the detailed figures?

Mr. BROWN. I would like to get those.

Mr. COHEN. I will be glad to get that information for you and supply it for the record, yes.

Mr. BROWN. I would appreciate that.

(The information requested follows:)

The number of patients resident in State and county mental hospitals at the end of December 1966 was 426,300.

The estimated number of patients receiving outpatient psychiatric services in 1966 was 1,885,000. This includes patients under care in outpatient psychiatric clinics as well as those receiving private psychiatric care.

Mr. BROWN. May I ask one other question in connection with the decline in these figures of people in mental hospitals. The problem of narcotics generally in the Nation—has this had an appreciable effect on these figures, or do you estimate that it may have an appreciable effect, and is it included in these figures here?

Dr. YOLLES. A small percentage, Mr. Brown, of that number would be accounted for by narcotics addiction. By and large, addicts are not hospitalized in State or county hospitals. There are a total, it is estimated, of about 60,000 in the United States at the present time. That is an estimate by the Federal Bureau of Narcotics.

Mr. BROWN. Do you have any figures to pick out of this number, those whose mental incapacity may be the result of narcotics use?

Dr. YOLLES. It would be rather difficult to do, Mr. Brown. We can give you figures on narcotic addiction and losses due to narcotic addition but to relate that to an inhospital population would be rather difficult.

Mr. BROWN. In other words, I am trying to determine whether they have people in this figure who are in the hospital because of the use of narcotics or hallucinogenic drugs?

Dr. YOLLES. Relatively few.

Mr. BROWN. You have no exact figure?

Dr. YOLLES. No exact figure.

Mr. CARTER. I notice that there has been a decrease in the number of inpatients of institutions from 702,000 to 452,000. That, of course, is due to more than one thing, is it not?

Dr. YOLLES. Yes, sir.

Mr. CARTER. New drug therapy for mentally ill patients as well as new methods of treatment and establishment of centers.

Thank you, sir.

Mr. BROWN. And it is due also to the fact that some people are being returned home as part of this therapy more quickly.

Dr. YOLLES. In part, yes, and also due to the availability of community facilities to treat them in the community with a more intensive sort of treatment.

Mr. BROWN. I have no further questions, Mr. Chairman.

Mr. JARMAN. Mr. Secretary, you referred on page 13 of your statement to the botulism problem out of which an emergency situation arose in fiscal year 1964. I would only comment that this subcommittee played an active part in that problem with correspondence with the Food and Drug Administration and with the Public Health Service and it might be well to include without objection at this point in the hearing the correspondence that the subcommittee had with those agencies.

(Correspondence referred to follows:)

HOUSE OF REPRESENTATIVES,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C., November 26, 1963.

HON. GEORGE P. LARRICK,
Commissioner, Food and Drug Administration, Department of Health, Education and Welfare, Washington, D.C.

DEAR COMMISSIONER LARRICK: I have become concerned lately, as I know you have also, over the recent outbreaks of botulism poisoning in the United States, arising first out of certain fish products, and more recently out of imported canned liver paste.

I understand that technological studies are being made to develop practices for long-range application to prevent botulism. I would appreciate it if you would send us a report on the current status of these studies.

Sincerely yours,

KENNETH A. ROBERTS,
Chairman, Subcommittee on Public Health and Safety.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
FOOD AND DRUG ADMINISTRATION,
Washington, D.C., December 10, 1963.

Hon. KENNETH A. ROBERTS,
House of Representatives,
Washington, D.C.

DEAR MR. ROBERTS: We have your letter of November 26 referring to the recent outbreaks of botulism. You are entirely correct in your understanding that this is a matter of deep concern to us and we have been anxious to do everything possible to acquire the necessary facts which will lead to the prevention of further outbreaks.

The problem, as we see it, breaks down into three parts at the present time and we are enclosing three summaries which discuss the problems in brief and outline the steps which are being taken to try to solve these problems.

If we can supply further information please let us know.

Sincerely yours,

JOHN L. HARVEY,
Deputy Commissioner.

[Attachment 1]

TYPE E BOTULISM FROM SMOKED FISH

DECEMBER 9, 1963.

Three outbreaks of type E botulism have been traced to smoked fish products in the past three years. An outbreak of three cases (two fatal) in Minneapolis, Minnesota in September 1960 was traced to a vacuum packed plastic bag of smoked ciscoes packed by a Wisconsin firm. An outbreak in the Tennessee-Alabama area in September-October 1963 resulting in 14 cases of type E

botulism, with at least five fatalities, was traced to one shipment of 175 lbs. of vacuum-packed smoked chubs shipped by a Michigan firm to a grocery chain warehouse in Nashville, Tennessee in late September. This shipment was unrefrigerted for a period of four or five days before receipt at the warehouse. The third outbreak involved the death of a man and wife in Kalamazoo, Michigan in early October, 1963 from eating part of a three to five pound smoked whitefish purchased during a weekend trip in upper Michigan. The source of the fish could not be determined but it is believed to have been a whole, smoked fish, not packed under vacuum.

The prior history of the package of smoked ciscoes implicated in the Minneapolis outbreak could not be determined. Toxin could not be demonstrated in other packages of smoked ciscoes from the same firm and bacteriological tests of some 600 fish from this and another manufacturer failed to reveal *C. botulinum* type E. This was the first known outbreak of type E botulism from domestic commercial fishery products.

Further studies and investigations carried out at that time included—

1. Inoculation studies in smoked ciscoes to determine the role of vacuum packing in growth and toxin formation by *C. botulinum* type E under various storage conditions.

2. An inspection survey of 13 fish smoking establishments producing smoked fish by the "hot smoking" process in various parts of the country to determine temperatures, times, and control procedures used.

3. A study or representative samples of bulk-packed and vacuum-packed smoked fish for differences in composition (moisture and salt) which would influence growth of the organism.

In brief, these investigations showed that *C. botulinum* type E can develop toxin in smoked fish exposed to air as well as under anaerobic conditions in vacuum packages without obvious signs of spoilage; that vacuum packing suppresses surface molds and spoilage organisms, greatly extending the shelf-life of the product; that smoking times and temperatures are not subject to measurement and control in commercial operations, the process being an "art" rather than a science; that the composition of bulk and vacuum packed products are essentially the same, though subject to considerable variations.

It was concluded that further studies on the problem were necessary and should include—

1. The occurrence or incidence of type E spores in fresh water lakes (Great Lakes).

2. The occurrence of these spores in commercial smoked fish products and in fish-smoking plants.

3. A determination of the number of spores necessary to initiate toxin production under various time and temperature conditions.

4. A determination of processing requirements and moisture and salt levels in smoked fish necessary to destroy the organism or inhibit its development.

Laboratory studies on *C. botulinum* type E continued through 1961. When it became apparent in early 1962 that our manpower, facility limitations and logistics problems would not permit all the proposed research to be undertaken by existing FDA staff, it was decided to proceed through research contracts at suitable universities. Negotiations were initiated with representatives of the Universities of Wisconsin and Washington in July 1962. A final contract with the University of Wisconsin was signed in June 1963, although laboratory research on methods was initiated there at an earlier date in anticipation of acceptance of the contract. Work is in progress and preliminary reports have been received on the occurrence of *C. botulinum* in fresh fish from the Great Lakes area. The University of Washington was unable to complete contract proposals because of personnel, facility, and space limitations.

The actions taken by the Food and Drug Administration as a result of the recent outbreaks from smoked fish are essentially covered by the enclosed press release of October 25 and enclosed "Report of FDA Advisory Committee on Botulism Hazard" and statement of "Facts Underlying FDA Recommendations." Following discussions with members of the smoked fish industry and a National Fisheries Institute Committee the enclosed additional press releases of October 29 and 30 were issued.

The National Fisheries Institute set up a special committee which has advised us of plans being developed for a substantial amount of investigatory work from the botulism standpoint dealing with the handling and processing of fish.

Each of the 18 FDA Districts is collecting representative samples of smoked fish products produced in its geographical area. These include representative samples of imported smoked fish products previously distributed in their area and are sampling all current entries of imported smoked fish.

Eight field laboratories are engaged in examination of these samples for the presence of *C. botulinum* type E. Because of our limited facilities, this represents the maximum number of field laboratories that are equipped to handle this work.

The field Districts are currently making inspection of all manufacturers shipping smoked fish products in interstate commerce (except Alaskan firms which are being covered by local officials), and in addition, they are inspecting selected manufacturers who ship only in intrastate commerce. During these inspections, they are determining the source of raw material, general sanitary conditions, detailed manufacturing processes, type of equipment being used, and quality controls exercised.

In addition to the extensive work in progress in FDA laboratories, the following steps are being taken:

1. To provide additional financial support under the University of Wisconsin contract to expedite the survey of type E contamination in the Great Lakes area and to enlist the cooperation of the Bureau of Commercial Fisheries, Department of Interior, in support of sampling operations in that area.
2. Contract negotiations are in progress with Oregon State University to undertake an ecological survey of *C. botulinum* type E in marine fish and environment, and in smoking establishments in the Pacific Northwest.
3. To cooperate and coordinate FDA investigations and research with similar programs contemplated by the Bureau of Commercial Fisheries of the Department of the Interior, the Public Health Service and industry groups.

[Attachment 2]

TYPE E BOTULISM FROM CANNED TUNA FISH

DECEMBER 9, 1963.

The emergency measures taken by the Food and Drug Administration, State and local officials to remove the offending tuna fish from the market and consumer's shelves as a public health measure are well known and will not be repeated here. Some 85,000 cases of tuna fish returned to or remaining in the warehouse of the packer (Washington Packing Corporation, San Francisco, California) have been destroyed under the supervision of California State authorities.

In the follow-up investigation of the 1963 Detroit outbreak, FDA inspectors examined 650,000 individual cases of the California firm's tuna fish in shipments distributed throughout the country. Nearly 3,300 cans or 0.5% of these cans were classed as abnormal, a large proportion of which consisted of defective closures of the can lids applied at the cannery. Among such defective cans 22 were found to contain *C. botulinum* and many additional cans were contaminated with non-toxic microorganisms. By contrast, abnormal cans were rare in the shipments of other tuna packers and no evidence of significant contamination was found.

C. botulinum type E was isolated from four locations in the California plant on the equipment used for handling the filled and sealed cans following heat processing. Since the processes applied were adequate to destroy *C. botulinum* it is clear that the product in defective containers became contaminated after this heat processing.

We are most concerned with measures to prevent a recurrence of this episode. Among such measures are—

1. Efforts are continuing to determine the basic reason for the defective can closures in the California plant since it is still not clear whether this resulted from malfunction of can closing machines, faults in can structure or other factors.
2. Bacteriological studies have been conducted in other tuna canneries to detect possible sources of contamination with *C. botulinum*. Findings have been negative.
3. Ultimately, the safety of canned goods depends upon the exercise of strict control of can sealing and processing operations on a continuing basis. This is essentially a commercial necessity to avoid health hazards and losses through spoilage. We have sought advice from outside experts in the

canning area, and we are programming increased inspection activities to check on the adequacy of controls exercised by canneries.

4. We are also examining potential problems which may arise in connection with new can making techniques and materials, from damage resulting from high speed can handling equipment, and from sanitation problems which may occur with improperly designed equipment.

The National Canners Association has pursued investigations in this area to be sure that its technical recommendations to all canners are the best available.

[Attachment 3]

CLOSTRIDIUM BOTULINUM B IN CANNED LIVER PASTE

DECEMBER 9, 1963.

In late October, the Commissioner of Food and Drugs was advised by the Canadian Food and Drug Officials that canned liver paste packed by a firm in Montreal, Canada, had been responsible for the death of one person, the illness of another, and the suspicion that the product was responsible for the illness of several others. Examination by the Canadian authorities revealed *C. botulinum* type B in the remaining portions of the sandwich consumed by the deceased and in an unopened can obtained from the market.

Two shipments had been made to the United States, one to a firm in the New York City area and the other to a firm in New Jersey. Of the first shipment, most of the distribution had been made in New York City, but a few cans had been shipped to areas covered by six of our Food and Drug Districts. Publicity by the New York City Health Department in all local news media together with immediate investigation by the FDA resulted in recovery of the redistributed lots.

The second shipment was found to be largely intact with destination of the remaining portions known to the firm who advised all consignees by telegram and by letter of the circumstances. This prompt action resulted in recovery of the major portion of the outstanding lots.

Examination of samples by FDA revealed a number of cans to be visibly abnormal and contents to be obviously spoiled and contaminated by microorganisms; however, no *C. botulinum* was recovered.

Since this is a meat and food product, it was under the jurisdiction of the Meat Inspection Division of the U.S. Department of Agriculture at the time of entry into the United States. We promptly supplied that agency all of the facts available. We have no information to indicate that any spoilage was detected by them on examination at the time of entry. Informal information received by the Canadian authorities indicates that the manufacturer may not have been subjecting the product to sufficient processing temperatures to insure destruction of *C. botulinum* and of spoilage microorganisms.

We and the Department of Agriculture are continuing to try to get additional information about this incident.

HOUSE OF REPRESENTATIVES,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C., December 11, 1963.

Hon. JOHN L. HARVEY,
Assistant Commissioner,
Food and Drug Administration,
Washington, D.C.

DEAR COMMISSIONER HARVEY: Thank you for your letter of December 10, 1963 together with enclosures replying to my letter of November 26 relating to recent outbreaks of botulism, and outlining the steps which are being taken to meet the problems arising out of these operations.

Would you please let me know if at the present time there is any action that the Congress could take which might aid in the solution of these problems, insofar as concerns programs administered by the Food and Drug Administration. I am also writing to the Surgeon General concerning this subject.

Sincerely yours,

KENNETH A. ROBERTS,
Chairman, Subcommittee on Public Health and Safety.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
FOOD AND DRUG ADMINISTRATION,
Washington, D.C., December 24, 1963.

Hon. KENNETH A. ROBERTS,
House of Representatives,
Washington, D.C.

DEAR MR. ROBERTS: We have your letter of December 11, 1963, concerning possible action by the Congress to help solve the problems relating to the recent outbreaks of botulism.

We appreciate your interest in this matter and thank you for your offer to help meet the serious problems created by the contamination of fish with botulinus E organisms. It may well be that Congress can take action which will aid in solving this problem. We are not, however, in position at this time to make any specific recommendations for Congressional action. We believe we should continue our current investigations to develop more information before reaching any decision about the adequacy of the present statute.

If we can supply further information or otherwise be of assistance in this connection, please let us know.

Sincerely yours,

JOHN L. HARVEY,
Deputy Commissioner.

HOUSE OF REPRESENTATIVES,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C., December 11, 1963.

DR. LUTHER L. TERRY,
The Surgeon General,
Public Health Service,
Washington, D.C.

DEAR DR. TERRY: I have become concerned recently over recent outbreaks of botulism in the United States, and have been in touch with the Food and Drug Administration concerning measures which they are taking leading to the prevention of further outbreaks.

Would you please let me know what the Public Health Service is doing in the field of botulism, specifically with reference to insuring adequate supplies of necessary antitoxins in the United States.

Sincerely yours,

KENNETH A. ROBERTS,
Chairman, Subcommittee on Public Health and Safety.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
Washington, D.C., January 2, 1964.

HON. KENNETH A. ROBERTS,
Chairman, Subcommittee on Public Health and Safety, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This is in reply of your letter of December 11, 1963. The Public Health Service shares your concern over the recent outbreaks of botulism in the United States and has taken concrete steps to fulfill its responsibility in the control of botulism.

The Communicable Disease Center in Atlanta has recently purchased supplies of botulism antitoxin that can be used for the treatment of Type E botlulism. This material is currently being tested for potency and when these tests are completed, the State Health Departments and all hospitals will be notified that this material is avaliable at any hour by calling the Communicable Disease Center. Negotiations are being conducted with producers of botulism antitoxin to increase the available supplies. Unfortunately, the production time approaches two years. The material now available at the Communicable Disease Center will act, however, as an emergency stopgap supply.

In addition to the procurement of antitoxin, the Public Health Service is increasing its activities in consultation, research and training. Courses in diagnosis and detection of botulism are scheduled at the Communicable Disease

Center and the Robert A. Taft Sanitary Engineering Center. In Conjunction with the latter course, a seminar on botulism will be held in Cincinnati.

I hope this answers your questions, but if I can be of any further assistance, please feel free to call on me.

Sincerely yours,

LUTHER L. TERRY,
Surgeon General.

Mr. JARMAN. Mr. Rogers.

Mr. ROGERS. Mr. Chairman, I notice from the tables for measles that you have made considerable progress with the vaccination program against measles, Dr. Stewart.

Dr. STEWART. Yes, sir.

Mr. ROGERS. From 1963 to 1964, when you almost hit 32,000 cases, you are now down to 2,000?

Dr. STEWART. That is correct. This year we are having our measles eradication campaign which the President announced and we are having great success and hope to reach our goal of eradication.

Mr. ROGERS. I notice that where you have a vaccine for, I presume, the regular measles as distinguished from german measles, that there are more of the common cases than there are of the german measles?

Dr. STEWART. Well, there have always been more of the regular measles than the german.

Mr. ROGERS. I mean, even with the vaccine.

Dr. STEWART. There is no vaccine for german measles.

Mr. ROGERS. But we have it for the common measles?

Dr. STEWART. That is correct.

Mr. ROGERS. Yet with the vaccine program we still have more of those than of the german measles?

Dr. STEWART. It is more common than the german measles. Regular measles is a universal disease. Everybody has it. German measles is a less common disease. It occurs across a period of time.

Mr. ROGERS. I understand that. The point I am making is that here we have a vaccine and we have had quite a number take the vaccine, I presume?

Dr. STEWART. This is correct.

Mr. ROGERS. Or we wouldn't have made such progress since 1963.

Mr. CARTER. Mr. Chairman, will the gentleman yield?

Mr. ROGERS. Yes.

Mr. CARTER. That was only made available in 1966 publicly so that we could hardly expect immediate eradication. I want to assure the gentleman that according to the best authorities I know of it will be eradicated within the next year.

Dr. STEWART. Mr. Rogers, if this occurs it will be the first time in the history of man that we have eradicated a disease in a 2-year or 3-year period.

Mr. ROGERS. How long has the vaccine been available?

Dr. STEWART. About 3 years.

Mr. ROGERS. So this is most encouraging?

Dr. Stewart, now I would think that you would keep us advised just as you did in these other vaccines so that the Congress could appropriate whatever money is necessary for the german measles. I assume that could be done?

Dr. STEWART. Yes.

Mr. ROGERS. Would the Department give us sufficient time to know?

Dr. STEWART. Yes, if we have the time ourselves.

Mr. ROGERS. As soon as you have indications of a breakthrough, you would let us know?

Dr. STEWART. Yes.

Mr. ROGERS. You would have to come to get money for trial tests, anyway?

Dr. STEWART. Correct.

Mr. ROGERS. Thank you.

Let me ask one or two other questions. Who determines the contributions to be made by the State or the local interest in building a community mental health center?

Dr. YOLLES. It is done by the applicant himself. The applicant for construction grants will apply to the State for approval before the application can be submitted to the Federal Government.

Mr. ROGERS. I don't know if you got the thrust of my question. In some States I understand they may require a 50-percent contribution by the local interest to get a matching amount. Some other States may have 66-percent Federal grant and only 33⅓ local.

Who makes the determination that varies this from State to State?

Dr. YOLLES. The Federal matching or the Federal percentage is actually determined by the Federal Government in terms of the relative need of the State.

Mr. Rogers, are you talking about the total Federal percentage applicable?

Mr. ROGERS. In each State. For instance, in Florida, I understand you can get more than 50-percent contribution for projects within the State of Florida.

Dr. YOLLES. That is the Federal percentage.

Mr. ROGERS. Whereas in another State they may get 66 percent within that State. Who determines that figure?

Mr. COHEN. That is determined by the Secretary, based on figures from the Department of Commerce. That is a mathematical determination.

The relationship of the States per capita income to the national per capita income is derived from the Department of Commerce figures and promulgated by the Secretary according to these Department of Commerce figures.

Mr. ROGERS. I thought we, under the law, had given him some additional authority.

Mr. COHEN. Once that is determined, then a State has an option between taking that uniform rate, whatever it is, and applying that same percentage to all projects or having a variable rate for various projects.

That is a determination that is made according to the statute by the State agency.

Mr. ROGERS. So the State actually determines how they will participate whether it will be on an overall figure for all of their projects or whether it will vary.

Mr. COHEN. They have a choice to make after the actual rate for the State is determined by the Federal Government. They may choose to make the rate uniform on all projects, or they might create a variable rate for different projects.

Mr. ROGERS. That would be the maximum you mean?

Mr. COHEN. That would be the rate. Then the State may determine if it wants as an alternative a variable that comes out to approximate that total rate.

Mr. ROGERS. Now, is it generally an advantage to have a set rate or a variable rate. What has been the experience?

Dr. YOLLES. The pattern has varied, Mr. Rogers, with the various States. In some cases where there is a great need in some parts of the States where there is an inability to match Federal funds for the construction of projects it would be to the advantage of the State to have variable matching funds.

In other cases, the State makes the determination that it would be to the State's advantage to have a uniform rate.

Mr. COHEN. Actually, Mr. Rogers, this goes back to the Hill-Burton Act, because this same formula and alternative is in the Hill-Burton law. The economic and the statistical data would probably suggest that the better way would be to allow each political subdivision to have a Federal matching percentage based upon its fiscal ability. In any big State, and I am sure in your State, there is a tremendous variation from urban to rural and big cities to small cities. Because we don't have that data for every county or metropolitan area, Congress established a percentage formula of 1 percent for the States but then gave the States the alternative to meet their own kind of situation.

Mr. ROGERS. Let me ask you this: In section 507 grants to Federal institutions you say this has been done by a point of order appropriate language?

Mr COHEN. Up until now, yes.

Mr. ROGERS. Why is the Department of Justice as such put in?

Mr. COHEN. Because of the Bureau of Prisons.

Mr. ROGERS. You have the Bureau of Prisons listed?

You say Bureau of Prisons and then you say Department of Justice and to St. Elizabeths Hospital and the Veterans' Administration.

I can understand the Veterans' Administration but why the Department of Justice as such?

Dr. STEWART. I think, Mr. Rogers, that is the way it is written. It means the Bureau of Prisons of the Department of Justice.

Mr. ROGERS. So you have no objection to changing that?

Dr. STEWART. No.

Mr. ROGERS. Thank you, Doctor.

Thank you, Mr. Chairman.

Mr. JARMAN. Mr. Brown?

Mr. BROWN. I have no questions.

Mr. JARMAN. Thank you gentlemen for a very able presentation this morning.

The subcommittee will stand adjourned until 10 o'clock tomorrow.

(Whereupon, at 12:10 p.m. the hearing was recessed to reconvene at 10 a.m., Wednesday, April 5, 1967.)

MENTAL HEALTH CENTERS CONSTRUCTION ACT EXTENSION

WEDNESDAY, APRIL 5, 1967

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

The subcommittee met at 10 a.m., pursuant to recess, in room 2123, Rayburn House Office Building, Hon. John Jarman (chairman of the subcommittee) presiding.

Mr. JARMAN. The subcommittee will come to order. We will continue the hearings on H.R. 6431. I think the only comment that the Chair would make at the beginning of the hearings this morning is, that we do have seven witnesses. We do intend to try to finish the hearings this morning. So that, I hope that both witnesses and members of the subcommittee will take note of that time limitation that we have.

Our first witness this morning is Mr. Bert Seidman, director of Social Security Department, AFL–CIO.

STATEMENT OF BERT SEIDMAN, DIRECTOR, SOCIAL SECURITY DEPARTMENT, AFL–CIO; ACCOMPANIED BY RICHARD E. SHOEMAKER, ASSISTANT DIRECTOR, SOCIAL SECURITY DEPARTMENT

Mr. SEIDMAN. Thank you, Mr. Chairman.

My name is Bert Seidman. I am director of the Social Security Department of the AFL–CIO, and I am very pleased to have the opportunity to testify here this morning on behalf of the AFL–CIO on the amendments to the Community Mental Health Centers Act, H.R. 6431. With me is Mr. Richard E. Shoemaker, who is assistant director of the AFL–CIO Social Security Department.

We appear here this morning in support of the amendments proposed by the distinguished chairman of the full committee, Congressman Staggers, in H.R. 6431, which extends authorization to continue Federal financial support for the construction and staffing of community mental health centers. H.R. 6431 also includes authority for grant recipients to use funds for the acquisition of existing buildings rather than just the expansion, remodeling, and alteration of such structures. We also support the amendments which would authorize project grants to Federal institutions and the provision for the establishment of a contingency account to meet unforeseen needs.

Mr. Chairman, the AFL–CIO appeared in 1963 in support of the Community Mental Health Centers Act (Public Law 88–164) and

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again in 1965 in support of the Community Mental Health Centers Amendments to provide funds for the initial staffing of mental health centers. We appear again today because of our continuing interest in this vital and exciting program. The people of the Nation are indeed indebted to the late President Kennedy for his imaginative recommendations which formed the basis for the mental health program, the extension of which this committee now has under consideration.

Mental health is indeed America's number one health problem. One out of every 12 Americans is now being hospitalized for mental illness at some time during his life. By providing early diagnosis and early treatment on an out-patient basis through the Community Mental Health Centers, this frightful toll can be substantially reduced. About one-half of the hospital beds in this country are used in treatment of the mentally ill. Through early diagnosis and treatment, many people who would otherwise require hospitalization can be kept on their feet, on their jobs, and in their families and in their communities.

Available evidence indicates early diagnosis and treatment on an out-patient basis can greatly reduce hospitalization for mental illness. The experience of the Massachusetts Mental Health Center, one of our older out-patient programs, is an example. In 1940, only 700 of the 3,171 patients were admitted as out-patients before the emphasis was placed on out-patient treatment. In 1961, this ratio was reversed: only 700 of 3,700 patients needed hospitalization and only 40 of the 700 had to be committed to State mental institutions.

We, in the AFL-CIO, have a very direct interest in this program. Up until the passage of this legislation, workers suffering from mental illness have very rarely received any kind of treatment—good, bad, or indifferent. This has been true, because the overwhelming bulk of our mentally ill have simply been institutionalized, many of them in city and State hospitals where they received mainly custodial care rather than a program of active therapy. Out-patient services have generally been limited to the upper and upper-middle income groups which could afford treatment on a face-to-face basis with a private psychiatrist or psychoanalyst.

This situation is currently changing, and new therapeutic techniques such as drug therapy, group and family therapy, role playing, work therapy, and so forth, show great promise of providing effective treatment for more people at reasonable cost. Our experience with mental health programs that have been negotiated by some of our affiliates clearly illustrates the need to make provision for out-patient facilities. Negotiating money to pay for treatment is not enough. The treatment a member may elect to purchase may not be appropriate or may be prohibitively expensive, such as face-to-face therapy by a private psychologist. We wish, therefore, to emphasize that the initial contact the person needing treatment should make should be with the community mental health center where his condition can be diagnosed and a course of treatment outlined from among a wide range of therapeutic procedures.

Such a program is that of the Retail Clerks in Los Angeles, where psychiatric care is rendered at several centers which are open day and night. The union's welfare fund contracts for the service on a prepaid basis and the membership is encouraged to use the plan

through the union's official journal and through their educational programs.

The Retail Clerks mental health program is built upon four basic principles: (1) immediate service (no waiting lists); (2) continuity of care; (3) flexibility of treatment approaches and methods; (4) comprehensiveness of care. Face-to-face therapy is provided when deemed appropriate, but by stressing early treatment the more expensive therapeutic methods have been minimized. The important thing is that such a full range of services can only be made available through a unified clinical and administrative program. This comprehensive mental health program is financed by a 2 cents per hour employer contribution to the health and welfare fund and by a $2 per-visit fee.

The great promise of the Community Mental Health Centers Act, in our opinion, is that it will enable our affiliates to bargain with employers for similar programs wherever there is a mental health center which could provide the necessary services.

The Community Mental Health Centers Act, as amended, holds great promise for the future, but the program is only in its infancy. As of March 1967, grants totaling about $66 million had been made to approximately 160 mental health centers in 46 jurisdictions to serve a population of some 27 million. H.R. 6431 extends through fiscal 1972 authorization for facilities and staffing of the community health centers. For fiscal year 1968, $50 million is authorized for facilities as compared to $65 million for 1967. The authorization for staffing is $30 million. We believe both amounts should be increased. We should accelerate the program toward the goal of having as many mental health centers as are necessary in order that every person in the United States could have access to a mental health center by 1975.

Thank you, Mr. Chairman.

Mr. JARMAN. Thank you very much, Mr. Seidman.

At the end of your statement you indicate that you think amounts in the bill should be increased. Of course, in the bill there is an open-end provision setting out "and such sums as may be necessary for the next 4 fiscal years." The committee will be interested in any concrete and definite recommendations that might be made to it as to what the figures should be, because there is certainly thinking on the committee that the amounts should be pinpointed in detail rather than leaving it as an open-end provision.

So that any evidence that you might care to furnish us on what you think the authorization should be would be considered by the committee.

Mr. SEIDMAN. Mr. Chairman, of course, we are not in a position to give you a pinpointed figure as to what this might be.

Mr. JARMAN. I might say that I didn't have in mind necessarily that you do so this morning; but if you have evidence to submit on that, submit it to the committee.

Mr. SEIDMAN. I could be very brief in stating what our recommendation would be. Our feeling is, that the original goal of 2,000 mental health centers throughout the country is one which should be reached by 1975, and we think therefore that the amount which is set forth in this bill for 1968 is inadequate. We have no recommendation as to the precise additional amount, but we think it should be

substantially greater not only in fiscal year 1968, but even more so in the years ahead. Because we think that the tooling up phase of this program will have been completed by that time, and that the necessary preparations and construction of centers can go forward more rapidly in the ensuing years.

Mr. JARMAN. Thank you very much.

Mr. Satterfield.

Mr. SATTERFIELD. No questions, Mr. Chairman.

Mr. JARMAN. Mr. Springer.

Mr. SPRINGER. No questions.

Mr. JARMAN. Dr. Carter.

Mr. CARTER. No questions.

Mr. JARMAN. Thank you very much for contributing to the hearing.

Our next witness this morning is Dr. Jack Ewalt, of the American Psychiatric Association; accompanied by Mr. Mike Gorman, of the National Committee Against Mental Illness.

I would like to comment that Mr. Gorman is a longtime friend, dating back to Oklahoma days when he was active in newspaper work and did a very comprehensive study of mental illness in our part of the country.

STATEMENT OF DR. JACK EWALT, AMERICAN PSYCHIATRIC ASSOCIATION; ACCOMPANIED BY MIKE GORMAN, EXECUTIVE DIRECTOR, NATIONAL COMMITTEE AGAINST MENTAL ILLNESS

Mr. GORMAN. I thank the Chairman.

Dr. EWALT. It is an honor, sir, to appear before the committee in support of H.R. 6431. I have a prepared statement which I shall not read. I will try to talk very briefly, at least for a psychiatrist, and try to answer any questions.

Mr. JARMAN. Dr. Ewalt, I also would like to mention the fact that you have served very efficiently as staff director for the Joint Commission on Mental Illness and Health.

Dr. EWALT. Thank you.

Currently we have less than 200 of these mental health centers under construction across the country. If we are to give adequate service of a minimal sort to our 200 million citizens by 1975, we will have to have about 2,000 of these. It takes time and effort to plan these things and raise the local funds which represent about $3 for every Federal dollar expended. It takes time to make the plans that will meet the Federal criteria. The program should accelerate so that by 1970 we will be able to have about 500 of these centers and then double that number in the following 5 years, if we can get adequate support.

In the past years, we have made a great deal of progress. We have the Joint Commission Study, which was authorized under the Eisenhower administration and completed under the Kennedy administration. We have the Kennedy Mental Health Plan, and the States have made a lot of plans.

We have made much progress in the ways we treat patients. You have heard a lot about milieu therapy, the importance of the surroundings to patients; about the flexibility of care—not making them stay

all day or night if they only need part of the day or night to be cared for; the use of group therapy and the use of other professionals as well as psychiatrists.

I will just list one or two highlights. I think it is significant that now more patients are admitted to general hospitals than to all other hospitals combined. The number of mental patients admitted each year increases, but the number discharged also increases. So that over the last 10 years we have reduced the population of these hospitals by about 20 percent by the application of these new methods. That is a very significant figure, because if the hospitals had continued to grow at the rate they had before, rather than decreasing in population, figuring the construction costs of $20,000 a bed, it would have been $4½ billion spent on brick and mortar that we are not spending today.

Mr. Seidman mentioned the Massachusetts Mental Health Center where I make my living. Last year in this hospital (where we admit about 900 a year to the hospital and between 4,000 and 5,000 a year to the clinic, and take the very acute, difficult patients as they come off the street) we certainly didn't "cure" everybody, but we only sent on for long-term hospitalization 1.7 percent of the patients we admitted. We were proud in years past that we have only committed 20 percent of our patients. So we have made a lot of progress in how to do our jobs better, and I don't think there is anything we do that could not be replicated by any well-staffed and well-run mental health center anywhere in the country.

A the end of June 1966 there were 93 centers in 43 States underway. We had spent most of the money made available. I think there are 125 centers under construction. We can't possibly go forward if we don't have authorization for the extension of these programs.

Mind you, the expansion will have to accelerate as the years go on, and we are not magicians, but with expansion I think we can very shortly cut down on the number of people cared for. And these people, of course, in some percentage, will become productive citizens and taxpayers rather than consumers of services.

I think at this time I would like to again emphasize that the money that we get from the Federal Government is really pump-priming money and it is essential. So far 1 Federal dollar has mobilized about 3 private dollars, and not all of this money has come from the States. Mr. Gorman has the figures, but I think about 40 percent of the matching funds comes from non-Government or private sources.

This is, indeed, a very important piece of legislation for the public welfare. I think I will stop at this point. I have submitted the written statement, and I will be prepared to answer questions.

Mr. Gorman might want to say something.

Mr. GORMAN. Mr. Chairman, I thank you for that gracious introduction. Mr. Springer, Mr. Satterfield, and Dr. Carter, after listening to yesterday's testimony by the administration on H.R. 6431, introduced by Mr. Staggers and others, I have decided to testify in an attempt to bring to this committee some sense of urgency concerning the legislation before it.

I want to address myself to your question about the moneys where the administration is vague about "such sums as may be required over the next 4 years." I have some fairly precise ideas. I serve currently

as a member of the National Mental Health Advisory Council. This is the second time I have been appointed to that job. I don't know why. I was originally recommended by President Kennedy, and then by President Johnson. I would like to bring to this committee, if I may, our idea of the financial needs and potential of this program.

Now I speak from a background, if I may say so, of 22 years, going back to the sovereign State of Oklahoma when you and I were young—and you look young now, and I feel old, Mr. Jarman. I testified before this very distinguished committee as a newspaper reporter, in 1946, before Percy Priest on behalf of the legislation which created the National Institute of Mental Health:

1. The administration bill proposes $50 million for construction of mental health centers in the coming year and "such sums as may be necessary during the following 4 years." When asked for the actual sum necessary to implement the program during the subsequent 4 years, the administration witnesses promised to supply figures to the committee at a later date. Under Secretary Cohen so testified yesterday. I know the reason for this. I have been in Washington 17 years, so that I have a suspicion that the Bureau of the Budget has put a clamp on these figures, and I understand the restraints under which Mr. Cohen had to testify yesterday and I sympathize. I am delighted that I don't have the same restraints.

Mr. Chairman, I don't see any point in coming before this distinguished committee with a 5-year bill which includes figures for only the first year. I submit that this is not being fully frank with the members of this committee, who want the fullest information. I am again not criticizing the administration, but I think, sir, I am stating a fact.

Let me recite a brief history of this legislation which you of course know, but I can recapitulate. All of you were members of the committee going back to 1963, when we first passed the legislation, except the gentleman from Kentucky.

In 1963 President Kennedy proposed a 5-year program for construction of mental health centers costing a total of $330 million. The funds were to be allotted as follows: $35 million in the first year; $50 million in the second year; $65 million in the third year; $80 million in the fourth year; and $100 million in the last year. These are the exact figures which he recommended. The Senate in 1963 passed a bill authorizing $230 million for centers construction, eliminating the fifth year of the program.

A few months later, the House passed a bill for 3 years eliminating both the fourth and fifth years. The final bill provided only $150 million over a 3-year period for construction of centers. I am not going into the staffing, because it is too complicated. I use construction as an example—$35 million for the first year, $50 million the second year, and $65 million the third year. These were the authorized figures under the 1963 legislation.

In actual fact, however, we have not even achieved the $150 million level. For example, although the Congress had authorized $65 million for the third year (fiscal 1967), the current year which we are now in, the administration asked for only $50 million and that is all we got.

In the renewal legislation, the first year requests $50 million as against the $80 million passed for that same year by the Senate in 1963. In other words, I am comparing the appropriations with our aspirations. Dr. Ewalt was the medical director of the Joint Commission on Mental Illness which proposed this program. I was a member, and these were our goals at that time. I don't know what is happening at the Bureau of the Budget, but I do know that the contemplated cuts in this program will emasculate it to the point where we will come nowhere near President Kennedy's announced goal of 2,000 centers by 1975.

I heard mention yesterday of this 2,000-center figure. I heard mention of it this morning, and I think that this committee deserves frankness from me and from every witness. We will not come anywhere near 1,000 centers if we drop the program back to $50 million and then "such sums as may be required over the next 4 years." I am a member of the Mental Health Council. I am privy to some internal figures that maybe I should not reveal, but I am going to, because my Irish glandular system is going to exceed my caution and wisdom. I will say that at the present time we have only 125 centers under construction, and this is not a result of a lack of State and local interest. I will come in a minute to the fact that it is a lack of Federal money.

As Dr. Ewalt pointed out, and as was pointed out yesterday, State and local money is outmatching the Federal money $3 to $1, and 40 percent of this money is coming from the private sector. People are ringing doorbells, holding barn dances, doing everything in the world legal or otherwise to match the Federal money. And in most of the States, the States are not putting up a nickel. In the State of Florida, Mr. Rogers, there are eight grants at the present time. There is not 1 cent of State money. Matching moneys have all been raised by localities, including one in Dade County, the only one in Dade County, the Variety Hospital. The other seven are construction grants. It is most impressive to me that the good people in Winter Haven, in Daytona Beach, in Panama City, in Pensacola, and elsewhere, have raised this money themselves to outmatch the Federal money.

I think there is no justification for saying there is a lack of interest, but there is some suspicion that the Federal Government is not meeting its obligation promises. I hear this, because I travel around the country and I was in some 26 or 28 States with my carpetbags last year. That is the thrust of our testimony when asked by the chairman about the figure.

I am not the only one who is worried about the relatively slow pace of the centers program due to inadequate Federal funding. Toward the end of 1965 the National Governors' Conference unanimously passed a resolution requesting the Council of State Governments to convene a conference of State and county officials to find out why the mental health center program was lagging and what could be done to speed it up. At a 3-day conference held in Chicago in December 1965 the delegates passed the following resolution:

I would like, if I may, to introduce into the hearings the text of the resolution and quote one or two paragraphs in this resolution which indicate what the problem is:

"Of the total annual mental health expenditures of $2 billion in this country"—which they used in 1965—"only $115 million, less than 4

percent, is available for ongoing local community mental health services. The share of the Federal Government in this funding is less than 10 percent." This was a 1965 figure in the first year of the actual program we are talking about today, so that the figure would be higher today. But I think what the Governors and the county commissioners said at the Chicago meeting was very important.

I am trying to get away from the idea that this is all "Big Daddy," that the big Federal impetus "Santa Claus" is slipping the money. "Santa Claus" is actually quite a cheapskate in this program. He is supplying less than 10 percent of the ongoing funds for this. I would like to introduce the full text of this resolution for inclusion at this point.

Mr. JARMAN. Yes.

(The resolution referred to follows:)

RESOLUTION UNANIMOUSLY ADOPTED BY NATIONAL GOVERNORS' CONFERENCE ON COMMUNITY MENTAL HEALTH, DECEMBER 15, 1965, CHICAGO, ILL.

This national conference on community mental health programs was called as a result of a resolution unanimously passed by the National Governors' Conference in July, 1965, calling for a thorough "review and critical evaluation of the experience of states under the various kinds of community mental health services acts and other methods of financing community mental health services, and for thorough consideration of the future role of each level of government in multiple-source financing of community mental health programs."

It is well recognized by this conference that in order to meet the pressing responsibilities and burdens in improving the mental health of this Nation there is critical need for an expansion of community mental health programs and of means to finance them, at all levels of government.

Of the total annual mental health expenditure of $2 billion in this country only $115,000,000, less than 4 per cent—is available for on-going local community mental health services. The share of the Federal Government in this funding is less than 10 per cent.

In order for the States and communities to make full use of the 1963 and 1965 Federal legislation, they must complete their plans and provide additional funds. To accomplish this, the enactment of new and expanded community mental health services acts which provide for State-local matching of funds is necessary.

But they cannot do the job alone—their limited tax base prevents many States and localities from responding to citizen demand for these services.

It is therefore imperative that the Federal Government, which receives the largest share of the tax dollar from our people, provide *critically needed* additional seed money for these programs.

It is the consensus of the conference that the national goal of 2000 new community mental health centers to be established by 1975 as envisioned by the landmark 1963 and 1965 Federal legislation will not be realized without expanded Federal, State and local support.

Mr. GORMAN. As a member of the National Advisory Mental Health Council which passes upon all policies and grants of the NIMH, I am privileged to see a great deal of documentation on community mental health center projections. I want to get to the heart of the matter. Late last year, I reviewed a document which indicated that the administration would recommend $475 million for centers construction, just talking about construction, during the next 5 years—$50 million for the first year; $95 million for the second year, and $110 million for each of the next 3 years. However, in listening to the administration witnesses yesterday, I gathered—and this is the understatement of the year—that these estimates have been chopped down considerably.

2. According to the administration witnesses, by the end of the third year of this program they will have financed the construction of less than 200 community mental health centers. This is what Mr. Cohen said yesterday and what Dr. Yolles said yesterday. While this is a good beginning, it is a far cry from the goals of those of us who served on the Joint Commission on Mental Illness and Health from 1955 to 1961 and who participated in the drafting of the historic Kennedy legislation. We envisioned a broad network of centers bringing intensive psychiatric care to hundreds of communities, urban and rural, rich and poor, which were willing and eager to join in building and staffing these centers.

We did not view this program as just one for Los Angeles or New York City or Chicago. This was for all the people.

Mr. Chairman, I heard little in yesteday's formal testimony about the needs of the individual mental patients. How long must they wait for intensive treatment while the Bureau of the Budget does its stretchout work? Does the Bureau of the Budget ever take their needs into consideration when it demands further and further stretchouts of the program?

Let me be specific. For the last 22 years I have toured the wards of State mental hospitals. They have improved considerably in recent years, but there are still thousands upon thousands of patients confined in them who have been there 30, 40, and even 50 years, and this is true today. In fact, I read a report just the other day from a 5,000-bed hospital in Alabama which estimates that one in every four young patients hospitalized today, and I quote from this report which we received at the advisory council, "can anticipate being permanently hospitalized for the next 50 years of their lives." If that was my son, my daughter, my wife, my mother or father, would I want a Bureau of the Budget stretchout? No, thank you, sir.

I saw another survey from the State of Washington, that patients who had remained in the hospital more than 1 year, because 1 year is kind of the magic figure, and if you can get them out in 1 year you can have a high 80-percent discharge figure. If they are in more than 1 year, it begins to get tougher and rougher. Patients in the Washington hospital system who had been there more than 1 year in 1956 remained an average of 12 years and 4 months. In 1965, they remained an average of 11 years and 9 months. In other words, the hard core of patients, many of whom we are still not reaching today.

I read a report from another hospital, considered one of the finest in the United States—Camarillo Hospital in California—I consider it one of the four or five best, in which it was noted that only 4 percent of the patients in that hospital in 1965 received either individual or group psychotherapy. Yes, they got pills from the attendants and they sat in rocking chairs watching television, but there were not enough doctors for individualized therapy. That's their own report, not mine.

Yes, I worry about these people and I worry even more about 2 million Americans who sought psychiatric treatment but were turned away because of lack of personnel or facilities last year. Where did these 2 million people go who were sick enough to want to be helped? They were knocking on doors, but there was no room at the inn.

How do I tell these people about a Bureau of the Budget stretchout? I don't know how to tell them. Will they really understand?

I worry about children, because I have a few myself. The American Psychiatric Association estimates that there are about 4 million children who are in need of some kind of psychiatric help because of emotional difficulties. Of this number, anywhere from a half million to a million children are so seriously disturbed that they require immediate psychiatric treatment.

Very few of these children are getting the treatment which they need. More than 300,000 children were seen in mental health outpatient clinics last year—in most cases the "treatment" consisted of a single diagnostic interview followed by the admission that there were no facilities in the particular area for prolonged treatment. And I have heard it hundreds and hundreds of times, and parents are told that there are no facilities for long-term treatment. How about the other 3,700,000 children who seek treatment? I am just talking about people. Maybe people are out of style, but I am kind of partial to people. I think they are still in style and worth preserving.

I worry about 18,000 children who are still confined this very day in State mental institutions. I may be in the minority, but I don't think one child should be in a State mental institution. I have said this for 22 years and every time I walk through a ward and see a child in a ward with grownups, I say, "There, but for the grace of God, would be my child," and it worries me to this day.

Mr. Chairman, I have lived through the era of the snakepits and no one is more pleased with the fact that we are improving our State hospitals and that through increased personnel and drugs we have succeeded in reducing our State mental hospital population by more than 100,000 over the past decade. I am very happy about it but it is nowhere near President Kennedy's goal. He said that by 1963 we should reduce our population from 500,000 to 250,000, but our present census is 450,000, not 250,000.

However, I would remind the committee of this fact. The State mental institution is no longer the primary source of psychiatric treatment. It is very important, but not the primary resource. Twenty years ago, State institutions handled three out of every four mental patients; in 1965, they cared for only one in every five persons.

There is undeniable evidence that the American people are demanding that the mentally ill be treated in the community in the same way in which the psysically ill are. When asked what we want for the mentally ill, I put it simply: We want equal time with the physically ill. That is all we want, equal time.

The average per capita expenditure for the mentally ill in a State hospital is $7 a day for all care. The average cost in the general hospital is $47.19. Is there that much difference between a physically ill and mentally ill patient? I would refer that question to the distinguished doctor from Kentucky. The American Medical Association says that mental illness is America's most pressing and complex problem. If it is, why in something or other don't we spend an equal amount of money on these people, when there are 6 million people in this country who are being treated for mental illness?

We cannot build this network of mental health centers on the cheap.

I don't want to delude you. We cannot do it with 1-year estimates and "such sums as may be required over the next 4 years."

This was the trouble with the State mental hospital. We never had plans for it. When I was a reporter back in the forties when Mr. Jarman served in the State legislature and was so helpful to us in that program, they never had a long-range plan.

The total per diem cost then in Oklahoma and in Chattahoochee, that garden spot, Mr. Rogers, in Florida, was less than $1 a day. They were just trying to survive and keep their heads above water with thousands of patients and skeleton staffs.

It is a little better today.

Mr. Chairman, may I say this: I believe with all my heart that if we are to meet the promises we made to the American people in 1963, when we asked 30,000 citizens to cover this country and plan for a new era for the mentally ill and they did and they surveyed the State hospitals and they interviewed people and developed the plans and every State has submitted a plan and 30,000 citizens were involved in it, we must renew this legislation for at least 5 years at a cost in the neighborhood of $500 million.

That to me is a minimum figure. We are operating now at a level of $50 million a year and we have built less than 200 centers.

We have to at least double that. I am being conservative. I realize that there is a war going on.

I read the newspapers, too, but so do the American people. I saw in the Washington Post on Monday of this week, and I don't know if the members of the committee saw this, the Harris survey which polled the American people on our domestic programs.

I always hear stories about how the American people want a big space program and want to spend $30 billion to get us to the moon but nobody asks the people.

Lou Harris asked them and the answer was this: They wanted a lot of domestic programs cut, including aid to cities and I don't disagree or agree with this.

This is not my province, but the Harris survey of Monday said that they wanted to cut back aid to cities, cut back aid to welfare and relief programs and cut back the space program and so on but the three most popular programs which they wanted to increase are all within the purview of this committee; air pollution, water pollution, and running No. 3, mental health clinics or centers.

If you want to go to the people and see what they think about it I think that a poll is very eloquent indication of it. Now, I conclude with this statement. This is no luxury item we are talking about. This is no matter of rifles and ruffles as the distinguished House minority leader puts it.

Since when is the mental health of any human being a "ruffle" which we can dispense with at will in wartime or in peacetime. We are talking about what the American Medical Association has described as our most pressing and complex problem and I say finally that I hope to God that all of us here in this room, both members of this committee and all of us here, have the wisdom to act in commensurate fashion.

Thank you very much.

(Dr. Ewalt's prepared statement follows:)

STATEMENT BY JACK R. EWALT, M.D., PAST PRESIDENT, AMERICAN PSYCHIATRIC ASSOCIATION, PRESENTED ON BEHALF OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Mr. Chairman and mmbers of the committee, I am honored to appear once again before a distinguished committee of the Congress on behalf of the American Psychiatric Association to urge legislation which, if passed, will mark another milestone in the nation's struggle against the mental illnesses.

The issue confronting us here today is simply stated. Before the end of this fiscal year upwards of 200 community mental health centers will be under development throughout our country as the result of the Community Mental Health Centers Act. Our national goal is to achieve 500 of these centers by 1970 and 2000 by 1975 in the service of some 200 million Americans. Thus, we have run well in the first few miles of the marathon that started with President Kennedy's wholly new approach to mental illness and mental retardation, an approach that would bring the mentally ill out of the large public mental hospitals back into the main stream of medicine in their own communities. But the final goal is not yet in sight and the hardest miles are ahead. Are we going to drop out or forge ahead? That is the issue.

Speaking for our Association and its 15,000 physician members who specialize in the treatment of the mentally ill, I would leave no doubt in your mind that the extension of the community mental health center construction and staffing program is of absolutely critical importance at this stage in the history of the mentally ill in our country. In all conscience, no other course is open to us. Let me explain why I think so, for we are not dealing here with a mere matter of erecting some new buildings. It is rather a matter of whether we are to follow through on a wholly new concept of how we shall relate to the mentally ill and how we may nurture a mentally healthier nation.

It is an exhilarating observation that we as a people have made more progress against the mental illnesses in the past twenty years than in all the millenia that went before. Nor is it difficult to demonstrate that it has been the federal government, responding to the will of the people, that has provided the foundation stones for that progress. One thinks back on the tremendous advances in psychiatric care generated by the Veterans Administration after World War II. There was the passage of the National Mental Health Act in 1946. In 1955, during President Eisenhower's Administration, Congress approved the Mental Health Study Act which led to the work of the Joint Commission on Mental Illness and Health. Later the stirring report of that Commission (*Action for Mental Health*) led directly to President Kennedy's special mental health message to the Congress in 1963. Then you appropriated funds to help the states make long-range plans for participating in a new national mental health program and concurrently offered to share with the states the expense of constructing and staffing comprehensive community health centers. More recently, the Congress made provision for extending mental health care to the elderly mentally ill in the Medicare legislation.

What has happened as a result of this stimulatory leadership at the federal level? If we were to state it in a sentence we might simply say that we have found out that most of the mentally ill can be treated in the community, providing that the community will supply an adequate range of comprehensive services for them. But we discovered this in a kind of helter-skelter way.

There were the new drugs, for example, that came our way in the 1950s. It was the first time that psychiatrists ever had some really good pills just like other doctors. These pills would cheer the depressed and calm the manics. With them we could treat many highly disturbed patients in our offices without resorting to long-term hospitalization.

At the same time we experimented successfully with new forms of psychological therapies both in hospital settings and in private practice, such as milieu therapy, group therapy, and family therapy. The idea was to get away from always treating a single patient at a time for the better part of an hour and, whenever possible and effective, deal with several patients at once in a group.

Particularly significant in the 1950s was the development of the day and night hospital idea, or part-time hospitalization. It has long since been demonstrated

that many patients can hold a job while they are treated at night, or that they can be treated during the day and return to their homes at night.

Most heartening of all, however, was the growth of short-term psychiatric care in community general hospitals. It is a striking fact that about 500 community general hospitals in our country now have psychiatric departments which admit and treat about 400,000 patients a year, about twice as many as are admitted to public mental hospitals. Many other general hospitals without separate departments also treat many mental patients, and it is probably safe to say that a half-million patients all told are treated yearly in these community hospitals. Moreover, a very substantial percentage of these patients have the greater part of their bills paid by some form of health insurance.

All of these developments, combined, are responsible for the fact that our public mental hospital population has declined by about 20 percent over the past decade—and this in the face of a growing population and rising admission rate.

Concurrently with these auspicious changes came a gradual modification of public attitudes towards the mentally ill by way of an acceptance of their afflictions and support of a realistic national program to help them. Had we expounded the community mental health center idea twenty years ago, our words would have fallen on deaf ears. Even our brethren in other fields of medicine would not have listened. But now it is different.

Another gratifying by-product of this broad movement to bring the mentally ill back into the community and into the medical mainstream has been its effect in quickening the interest of nonpsychiatrist physicians in joining the battle against the mental illnesses. It is a striking fact that about 15,000 general practitioners or family physicians, in the past ten years, have been motivated to take postgraduate courses in psychiatry to enhance their understanding of the patients they see in everyday practice. Indeed, many of them have gone on to specialize in psychiatry. This never could have happened twenty years ago when psychiatry was so largely isolated in public mental hospitals. Psychiatry had to get back into the community where the action is. And, incidentally, every medical school in the nation today sees to it that all of its students acquire basic training in psychiatry.

As for general public attitudes about the mentally ill, there can be no doubt about citizen receptivity to the wholly new approach. I have just recently read the manuscript, soon to be published, of a scholarly survey of public attitudes among adult residents of New York City.* The survey was conducted by Columbia University in cooperation with the New York City Community Mental Health Board. The investigators found that the public was much more optimistic about the treatability of mental illness than formerly. Seven out of ten adults said that they would be willing to have former mental patients as co-workers or neighbors. Nine out of ten think that government should be spending more for mental health services, and there is widespread support for community services, especially emergency services. Interestingly, however, three out of five adults in New York City could not name a hospital that accepted mental patients and three-quarters could not name a clinic where they could go for prompt service. This suggests again how far we have to go in extending community services and educating the public as to their availability.

Moreover, this same twenty-year period has witnessed a quickened interest in psychiatric consultation from industry, the clergy, the courts, schools and colleges, social agencies and all of the others who have a special role in dealing with the troubled people of our times.

Also, twenty-seven states have enacted community mental health services acts to facilitate the development of comprehensive services at the local level.

To sum it all up, let us suppose that twenty years ago someone dear to us had developed a mental illness? What recourse did we have? If we were rich and the illness not too serious, we could look for help from the private psychiatrist or the private hospital. If the illness were severe and we were of modest to poor means, we were almost forced to turn to the public mental hospital, and with the sickening thought that it might well prove to be the end of the road for our loved one.

Now it is different. If we are affluent we can still purchase the very best in psychiatric care. But millions more of us can obtain a comparable quality

*The Public Image of Mental Health Services, Jack Elinson, Ph. D., Elena Padilla, Ph. D., and Marvin E. Parkins, M.D., Mental Health Materials Center, New York City, May 1967, 300 pp.

of care in general hospitals, and increasingly in day and night hospitals, outpatient clinics, half way houses, rehabilitation facilities, nursing homes, and the like. We can do this because more and more of these facilities are becoming available and more and more of the cost of such care is borne by third-party payments.

What I have been talking about, of course, is the community mental health center idea and how it evolved, bit by bit, over the years. If we do not appreciate that the community mental health center is not so much a building as an organization of services, then we cannot truly grasp the import of extending the construction and staffing legislation. Hence I have tried to place the whole development in its historical context.

As you know, to qualify for federal assistance every center project must incorporate five essential services—an inpatient service, an outpatient service, part-time hospitalization, emergency service, and consultation service, and these services should be geared to accommodate from 75,000 to 200,000 persons. None of these services represent new ideas, as I have sought to demonstrate. What is new about the community center idea is the pulling together of these elements into a manageable, coordinated continuum of services in a particular community or segment of a community. If it makes no sense for a patient with pneumonia to be seen by a dozen different doctors and treated in several different facilities, neither does it make any sense for a mental patient to be shunted from a social agency to a clinic to a hospital to another social agency, ad infinitum, seeing different professionals and filling out fresh forms at every stop along the way. The principle of the center operation is that by drawing together the five essential services into a single administrative unit any patient eligible for treatment in any part of it will be eligible for treatment in any other part of it.

Very rarely would a community need to construct a mental health center with *all* of the essential services from the ground up. It is the stated position of our Association, for example, that wherever possible the inpatient component of a center should be provided by the community general hospital. On the other hand, a new building might be needed to house the other four essential services, or any part of them. In a word, the important consideration is not to duplicate existing services but to fill in the gaps and harness all together in a coordinated system to meet individual needs within the same system. For example, in the West Philadelphia area there are six major hospitals and a host of social and community agencies all of whom must share responsibility in providing comprehensive services for that area. If they were to plan independently, the result would be chaos. In 1965, however, they got together in a joint planning effort under the aegis of the University of Pennsylvania and formed what they call the West Philadelphia Mental Health Consortium. This Consortium has just recently submitted a staffing grant application which proposes to use all of these facilities in providing the five essential services for the area.

I hope I have helped to make it clear why the extension of this legislation comes at such a critical time in our history. We are just getting started. Millions of Americans remain outside of the wholly new approach. The states have had less than two years to develop their plans, submit their applications for assistance, and get their new centers under way. It is of no small significance that as of the end of the first fiscal year (June 30, 1966) 93 center projects in 43 states and Puerto Rico had been funded through this program. Ninety-three percent of the construction monies and 80 percent of the staffing funds had been obligated. Has any other bold new program launched by the Congress ever been seized upon more avidly? I doubt it. But the people on the firing line in your state and mine have scarecly had time to catch their breath. We cannot yet, in all fairnes, select out a single center any where and say, in confidence, "this is the way to do it." One does not achieve massive social change in a trice. But we can point with pride to the enormous progress I have highlighted and the promise of quickening our efforts to further the purposes of the community mental health center.

In closing I am reminded of Mr. Winston Churchill's comment after the British had defeated General Rommel in North Africa to the effect that one could not speak of it as the end, or even as the beginning of the end, but it was, he said, perhaps the end of the beginning. I hope, gentlemen, that you will approach this legislation in Mr. Churchill's spirit and that you will pass this legislation with the same degree of unanimity that you approved the original propositions which it will now extend.

Mr. JARMAN. Thank you both for a very good presentation and for advocacy of what you see as the problem here. The problem certainly is before us as a Nation. I think we can take heart in the comment in Dr. Ewalt's statement that developments so far are responsible for the fact that the population of our mental institutions has declined by about 20 percent over the past decade and this has been done in the face of a growing population and growing admission rates.

Mr. Rogers?

Mr. ROGERS. Thank you, Mr. Chairman.

That was a very impressive statement. I have read Dr. Ewalt's statement. I think your testimony is very helpful in pointing up problems that do exist. We were told by the Department, I believe, that there were some 286 centers.

Mr. GORMAN. That was the anticipated figure by June 1967.

Mr. ROGERS. I thought these were committed.

Mr. GORMAN. No; I am on the council and we just had a meeting.

Mr. ROGERS. Those were not correct.

Mr. GORMAN. If you check the record, I think the Department said that this 286 was their projected figure by June 30 of this year. That is in Mr. Cohen's testimony. They would hope to staff and construct that amount. The present number is 173.

Mr. ROGERS. I thought just for construction alone it was 286.

Mr. GORMAN. That is not correct. I am sure of that because we just had a meeting on it.

Mr. ROGERS. Now, I understand that about the time we passed this legislation it was anticipated or projected that the requirement for beds for mental patients had that trend continued would be up to some 700,000.

Mr. GORMAN. That is correct, sir.

Mr. ROGERS. But that since that time it has come down to some 400,000.

Mr. GORMAN. 452,000.

Mr. ROGERS. Who are actually in beds in mental hospitals. Has that relieved the problem of the construction program at all?

Mr. GORMAN. If I might say this, sir, or would Dr. Ewalt comment first?

Dr. EWALT. I think it has relieved the problem of creating custodial or long-term chronic disease construction. I think it does not cut down on the number of active treatment community mental health center types of programs we need. These are not so much beds. There are beds in them but the other thing needed is all kinds of services for day care, rehabilitation treatment, educational programs and things of this sort so that State appropriations for construction of chronic disease beds has undoubtedly been decreased.

I some places they are tearing down buildings; others are relieving crowded institutions by creating buildings, but in terms of the center grants since they are to be away from these big centralized institutions and all out through the community particularly the smaller towns and cities, it has not decreased that and I think the program is projected of needing 2,000 of these by the time the population reaches 200 million is still an accurate projection.

Mr. ROGERS. You feel that that is a correct figure?

Dr. EWALT. Yes, I do.

Mr. ROGERS. Then you were quoting from the State hospitals as to this reduction in beds, not from local communities.

Dr. EWALT. I wouldn't think so. These 2,000 mental health centers if they had an average of 50 beds apiece, which I don't think they will because some will have 200 and some 25, will be no more beds than that, but they will be quite different in their distribution.

Mr. GORMAN. Could I make one comment, Mr. Rogers? I think the thing that I pointed out in my testimony, that 20 years ago the State mental hospital was really the only resource and the fact that today four out of five people seek treatment elsewhere is a great tribute to the State hospitals because the fact that they are discharging two or three times the number of people means that the people go to the community resources.

But factually 2 million Americans last year sought and were unable to find treatment in the community; not enough clinics, not enough psychiatrists, this is the answer. We have more clients than we are able to handle.

Mr. ROGERS. I believe you said that 10 percent only of the ongoing program was a contribution of the Federal Government.

Mr. GORMAN. In 1965, sir.

Mr. ROGERS. That ratio doesn't necessarily follow in this particular program, does it?

Mr. GORMAN. No, sir. This was a total of all kinds of expenditures for community mental health services.

Mr. ROGERS. I notice that the amount of contribution of Federal funds in the construction program varies from State to State. What is your feeling about that?

Mr. GORMAN. I feel that it is really based as you know, Mr. Rogers, in the record of the 1963 and 1965 hearings, upon the Hill-Burton formula; roughly that you allow for low per capita income so that the poorer States are asked for only $1 of matching for $2 in Federal matching and New York State gets $1 in Federal matching for $2 in New York State matching.

This is the theory. I don't know that I have either the wisdom or lack of caution to comment on it. I think we will have to see how it works out. The Hill-Burton formula is kind of sacrosanct. We always use it in connection with construction programs.

I am glad the States have the option within the State not to take the flat formula. They have done this in Florida, used a variable formula. I don't know. I know people in Delaware who are very unhappy because they get only $1 in Federal money for every $2 expended, I think, because the Du Pont Co. is there.

Mr. ROGERS. What is your viewpoint on the manpower problem as to psychiatrists aids? What is our lack of needed personnel, would you estimate, now as to psychiatrists and for technical people to help them?

Dr. EWALT. Well, there certainly is a shortage. When you try to give an exact figure it depends on how they use them. I think we have to move forward on two fronts. I believe we are making progress on both.

First, in the actual expansion of training facilities and this has been done. For example, the schools are now producing about 2,000

psychiatrists a year. We are importing quite a number also and now we question whether the brain drain is a good thing but it is a good thing for us.

Also, the psychologists group has expanded, the social workers, nurses, and so forth, so that we are producing more manpower but I think even more important we are learning more about how to use the manpower so that sometimes in my own place, for example, we have one program where the psychiatrists rarely see patients at all.

They spend their time in consultation working with social workers, indigenous community mental health workers, recreational, rehabilitation, and other paramedical personnel.

They spend time answering their questions, consulting about problems that have come up; so that we are learning to use our trained manpower much more effectively than we did before.

Mr. ROGERS. Could you give us for the record any study that has been made or any projection as to needs of manpower?

Mr. GORMAN. They have been made. The National Institute of Mental Health just made a study in November 1965 and we can supply it for the committee.

It is a very optimistic projection.

Mr. ROGERS. What is the basic finding of that study?

Mr. GORMAN. It is that under Federal and other programs we have added more than 100,000 mental health personnel in the last 15 years but the only problem is we have built a better mousetrap. More people are seeking the treatment than ever before so that we have to keep running to catch up with everybody.

That is the problem. We have increased enormously.

Mr. ROGERS. I wonder about not necessarily the increase but what is the lack of personnel presently? What is the problem?

Mr. GORMAN. It still depends on from what viewpoint. If you take the center one fellow says he needs 10 psychiatrists and the other says he can get along with four.

Mr. ROGERS. Surely the psychiatric study made some recommendation.

Dr. EWALT. There is such a figure. We can send it to you.

(The information requested follows:)

MASSACHUSETTS MENTAL HEALTH CENTER,
DEPARTMENT OF MENTAL HEALTH,
Boston, Mass., April 6, 1967.

Representative PAUL ROGERS,
Congress of the United States,
Washington, D.C.

DEAR REPRESENTATIVE ROGERS: At our hearing you asked a number of excellent questions and also asked for additional information. I will try and furnish this. If I have overlooked something you wanted or if something else occurs to you, would you have one of your staff contact me by letter or phone and I will try and find it for you.

You will recall you were particularly interested in what role the American Psychiatric Association was playing in stimulating interest in teaching and providing leadership for sub-professional persons who might be recruited to work in the mental health field. This type of activity runs in about three groups: (1) Volunteers, that is persons who are otherwise emyployed or are housewives who give some time each day a week to the care of mentally ill persons. The American Psychiatric Association has worked with this group for a long time and has a standing committee on volunteers. We have also

worked closely with the National Association for Mental Health who have felt that the program for volunteers is one of their major operations. I am enclosing a book. You will note that while the conference was sponsored by the Massachusetts Association for Mental Health a lot of the participation was by psychiatrists and other socalled mental health professionals, and with a good representation from the laity. This was and should continue to be a very important activity. I won't go into the detail here, but the mere fact that people will take time from their busy lives to work with mental health problems does a great deal for the morale of the professionals as well as for the patients.

The second large category consists of the sub-professionals who work in our hospitals. These are the socalled aides, attendants, etc. who work with the nurses, the occupational therapists, the rehabilitation group, the social workers, psychologists, etc. The basic purpose is to expand and extend the effectiveness of the trained personnel in psychiatry.

The American Psychiatric Association has a Commission on Allied Service Personnel, headed by Philip B. Reed, a psychiatrist in private practice in Indianapolis. The purpose of this group is to provide leadership for the sub-professional personnel, helping them with funds for further training, further recognition as important allies in the treatment and rehabilitation of patients, etc. The American Psychiatric Association publishes a special little magazine for them called Staff. This is distributed free to state hospitals and other mental health institutions and is directly aimed at improving the morale through recognition and training of this very important group. This latter group actually provides the bulk of care of patients in the large state hospitals, and we are most concerned that they carry over and function in the new mental health centers, particularly as workers in the community. The National Institute of Mental Health has helped a great deal with the further improvement of the technical skills of this group by making hospital improvement grants and in-service training grants to most of the large state hospitals and some of the smaller mental health centers such as the Massachusett Mental Health Center.

The third group overlap somewhat with the preceding one. I separated it out because the preceding group always works under the direction of professional persons. Some of us have thought for some time that in some categories of activity sub-professional persons, properly trained in specific and perhaps rather narrow areas of function, can work with a minimum of supervision. Experiments with using attendants or aides as group therapy leaders, experiments with using people from the community as community leaders, community assistants and community counselors have proven effective in many areas including Massachusetts, some areas in Florida, and in a large delinquency program in New York City.

Dr. Henry Brosin, Professor of Psychiatry at the University of Pittsburgh, who will become President of the American Psychiatric Association at its May meeting, is very much interested in developing new knowledge and a new category of persons known as mental health workers. It is hoped that some of the above group of aides and other non-trained persons might, through the cooperation of junior colleges or other similar educational institutions, receive some more formal type of training that would enable them to function even more effectively than the rather naturally occurring skills that some of these people have. We need to know a good deal more about this than we do now. Experience here shows that if these persons are to be effective they must have access to a skilled psychiatrist or at least to a social worker or psychologist with whom they can consult, discuss some of their troublesome problems, etc.

It is my belief and, with your encouragement I will continue to push for it, that the American Psychiatric Association program will probably embark on a rather extensive program in this area.

If I have overlooked some of the points you had in mind would you please let me know as it will be my pleasure to communicate with you further.

Sincerely,

JACK R. EWALT, M.D.,
Superintendent.

Dr. EWALT. The problem is not in staffing these new mental health centers. The problem is still in staffing the old ongoing chronic diseases or long-term hospitals that are perhaps not as desirable. Wherever they have created these new center programs the people have been

interested and they have been able to recruit people somewhat to the dertiment of these other institutions.

Mr. ROGERS. Let me ask you one other question: Have there been any major breakthroughs in the treatment of mental health that your association is encouraging use of?

Dr. EWALT. Certainly the major breakthrough has been the development of these drugs, the tranquilizing drugs, the antidepressant drugs. We are just now beginning to realize that there is another drug and it is so cheap it is a commodity and not really a drug, lithium, used in the manic-depressive diseases and apparently quite specific, and it may even be used as a prophylactic or preventive.

It is lithium carbonate. You remember some of the old health resorts used to have lithia water. Some people drank too much and it killed them and it was taken off the market. It is used, people tell me, for putting the polish on fine china but in proper doses and with proper laboratory control of the level it is a very effective drug in manic-depressive diseases and even more spectacular in that disorder than the tranquilizers have been in schizophrenia.

Mr. ROGERS. Did the tranquilizer knowledge come out of the National Institutes of Health?

Dr. EWALT. I think the testing and learning more about how to use them did. The first use of the drug itself came from our colleagues in Europe. Whether that was on one of our foreign grants or not I don't know.

Mr. GORMAN. We developed several of the antidepressants here in America.

Mr. ROGERS. In the Institutes?

Mr. GORMAN. Institute grantees, yes.

Dr. EWALT. The first tranquilizers were not as effective as some of the newer ones, all of which were developed by the industry here, some under grants.

Mr. GORMAN. We have the finest screening for drugs in the world. We put them through a very fast and rapid screening.

Mr. ROGERS. Your figures that you suggest to this committee would be what?

Mr. GORMAN. My curbstone figures are roughly that we double the program so that would mean $500 million over the next 5 years.

I saw original figures last fall which indicated that we would reach that level. I understand the budgetary process sometimes better than I understand my own checkbook and I know what happened between November and this month.

But I honestly feel, and I think the commissioners from the various States who are here today will testify to the fact that if we keep it at this low level, the $50 million a year or something like that, because my understanding is that the administration figure which will be submitted—and I want to be careful again but I can't be, my personality is against me—will run about $60 million in the next fiscal year and about $70 million in the next year.

I think the "haves" will get it all. The ones ready with the applications and the ones who are experts in grantsmanship will get it, but the poor guy in the rural area who has to work up the application is going to wait. He is not going to get it because he does not have enough carbon paper.

Mr. ROGERS. Thank you, Mr. Chairman.

Mr. JARMAN. Mr. Carter.

Mr. CARTER. Thank you, Mr. Chairman.

Thank you, gentlemen, for your excellent presentation. Certainly, I appreciate the dedication that you have to this great problem that faces all of us, mental health.

Of course, I further agree with you that not only should we pay adequate attention to mental health, but also air pollution and water pollution, which are great problems to us at this time.

I think regardless of the war we must pay attention to our internal problems. This problem should be solved, war or no, or it might some time affect our internal security.

Another thing, any home may well be involved. Young children as you say are often involved. I have seen this many times. It is heartrending to see a youngster of 14 talking incoherently and it is extremely gratifying to see these minds find themselves. I think you have a wonderful program and I certainly want to do my part.

Dr. EWALT. Thank you.

Mr. GORMAN. Thank you, Dr. Carter.

Mr. JARMAN. Mr. Satterfield?

Mr. SATTERFIELD. Thank you, Mr. Chairman.

Dr. Ewalt, I haven't had a chance to study your statement as I certainly will because I am sure that it will be important and interesting if for no other reason than your experience in this area.

Was I correct in interpreting that you treated 9,000 patients in your center last year?

Dr. EWALT. It would be just under 6,000, I believe, sir.

Mr. SATTERFIELD. The reason I make this point is that I think it might be interesting to this committee and to the record if we might have from you a breakdown of your pattern of staffing during this period of time. I don't know whether you have it at hand now or if you can submit it.

Dr. EWALT. I can tell you but it isn't a fair one. Our institution has three functions and the budget and staffing for the research efforts and the training efforts—it is an integral part of Harvard Medical School—equal that for patient service. I have 70 young doctors in training there in psychiatric residencies plus four under a special program of private funds from Asia to try and introduce methods there.

It takes a vast number of senior doctors to supervise their work if we are to keep them out of trouble. Harvard Medical School has a very intensive educational program. I have the figures right in my head but I think to say that this is what you would need, say, out in western Massachusetts at Pittsfield is not correct.

I will give you them. I have 70 residents. I have 35 senior psychiatrists that are full-time and 35 that work from a half day to a day a week. I will even go further. If you came to our place you would find that our medical program is good and the place is filthy.

I have 22 psychoanalysts and 19 janitors so that our medical program is better than our housekeeping. The Massachusetts Legislature will give me doctors and Harvard will give me doctors but nobody will hire a porter for me. I figured this out once and I could send the figures of what I could run the place on if I didn't have a

teaching or training thing and I think I could handle the thing on about 20 psychiatrists and that many psychologists and 60 social workers but I will send you those figures.

Mr. SATTERFIELD. If it is not too much trouble.

Dr. EWALT. It is no trouble at all.

Mr. SATTERFIELD. Thank you, sir.

(Information requested follows:)

MASSACHUSETTS MENTAL HEALTH CENTER,
DEPARTMENT OF MENTAL HEALTH,
Boston, Mass., April 7, 1967.

Rep. DAVID SATTERFIELD,
Congress of the United States,
Washington, D.C.

DEAR REPRESENTATIVE SATTERFIELD: You asked about the number of staff I would estimate it would take to run a community mental health center for about 100,000 people. I believe the estimate usually kicked around is for about ten psychiatrists and appropriate numbers of other supporting personnel. I have played around with these figures some for our own hospital as I testified. Our experience requires a little free estimation because we have been serving the entire state but not on a giving service to everyone's basis. Further, because we have large numbers of persons here, including myself, who do a fair amount of one-to-one or individual psychotherapy or psychoanalysis, we use up more manpower than may be required in many of the community mental health centers. Also, most of my time for example is spent either in teaching or supervising research projects. By these maneuvers, having warned you that these figures are educated guesses at best, I will proceed.

Our hospital on any day has about 200 to 220 in-patients, about 125 of whom are on a 24 hour care basis and the remainder on a day or night basis. There is a considerable shifting of patients between the above categories as they improve or have temporary relapses. Each patient is seen briefly every day by his physician and has from one to three prolonged interviews or psychotherapy each week. The out-patient department and the emergency service see about 5,000 different persons a year. The hospital admits approximately 900 persons per year. The number of persons coming to the out-patient department means little as the work load depends on the number of patient visits. If one person comes ten times, he uses up more manpower than five persons who come once each. Therefore, most clinics count their case load in terms of "patient visits", that is, each time a person comes to see his doctor he is counted as one. Thus one patient who comes twice a week for a year might account for a hundred patient visits in a year, and another person who comes only three times and then needs no further care would only count as three, etc. Our clinic runs about 47,000 patients visits per year. Again I would emphasize that our patients all have some type of individual therapy as well as some type of group therapy. Because we are a teaching and research institution, this type of approach may be more intensive than is needed—I think we just don't know for sure.

My estimate as figured out on man hours, with appropriate time for vacations, etc., is that it would require about 25 full time people to man the clinics if they did nothing but care for patients. It would take about 15 to man the house or hospital if they did nothing but take care of patients.

These figures are for our present operation. The best estimate I can make at this time for the demands on us from our catchment area is that about 65 percent of the above hours and patient days will be used up by patients from our catchment area which has 225,000 people in it. Thus as we operate I could get by with approximately 10 in the hospital and 16 or so in the clinic for 225,000 people. If we divided this again by half for a catchment area of 100,000 we would then come out with about 13 psychiatrists necessary to operate such a center, that is, psychiatrists or persons working under a psychiatrist doing essentially what they do. Some institutions would operate with a smaller number of psychiatrists and a larger number of social workers or clinical psychologists. Because we are a medical center we tend to use more of the medical personnel and less of the social workers or psychologists. In an ordinary center, however, I would assume they would have approximately two to three social workers for

each psychiatrist, and at least half the number of clinical psychologists. If the psychiatrists in that region were in short supply, a great deal of the work that the psychiatrist does can be done by properly trained social workers, psychologists or nurses, under the supervision of the psychiatrist. Therefore, the numbers might be changed around proportionately.

I have made no estimate of the number of nurses because this would vary tremendously, depending on the proportion of in-patient and out-patient activities carried on, and how much the nurses made home visits.

Again let me emphasize that these are educated guesses at best. I think one will find that the number of persons required in centers in different parts of the country may vary substantially, and one major variant will be the kind of treatment the people there want; that is, do they want predominantly medications and group supportive therapy, or do they want long-term intensive therapy, etc. It will also vary with the amount of use made of psychiatric aides, new categories of mental health workers, etc. However, as far as I can tell the above figures will do for a start.

Sincerely,

JACK R. EWALT, M.D.,
Superintendent.

Mr. ROGERS. Would the gentleman yield?

Mr. SATTERFIELD. I yield.

Mr. ROGERS. What would you say is the population area that you serve?

Dr. EWALT. As of the first of April or March 28, our new mental health plan went into effect and I was given a so-called catchment area and it has 225,000 people in it.

I was given this area because of our relatively large staff and the fact that this hospital was set up to serve the whole State as a teaching and research hospital and the buildings and facilities and staff are there and so we will continue to do this.

Now, it is our estimate that our admission rate to the hospital will be about 300 a year from our catchment area, leaving us roughly 600 a year whom we will continue to serve from less well-sponsored areas of the States.

The clinic breakdown I don't have yet. It is hard to count individuals in the clinic. We run about 47,000 clinic visits a year.

This is a guess and let the record plainly show that it is a guess. Probably there are not more than about 20,000 visits a year; that is the person coming to see the doctor or the social worker from our particular catchment area.

Mr. ROGERS. I wonder about this: When the mental health center was projected it was about 100,000 up to 200,000, 20 psychiatrists and a little over.

Dr. EWALT. That was the figure I gave him off the top of my head. We have 200 beds.

Mr. GORMAN. He is modest. He has the oldest center in the country and does more business than any patient center.

Mr. SATTERFIELD. Mr. Gorman, I have just one question to direct to you. In answer to one of Mr. Rogers' questions, you indicated that we should accelerate more rapidly than you think has been indicated, maybe to the extent of doubling what you think has been indicated.

I am sure that this suggestion will get due consideration and I would be interested in knowing whether or not you feel that we have enough properly trained personnel to permit that kind of acceleration.

In other words, are there sufficient personnel to justify acceleration of the kind you suggest?

Mr. GORMAN. I am delighted, sir, that you asked me that question because in the 5 years I have served on the advisory council the basic problem has been how you get the manpower.

We have it in the State hospitals. As Dr. Ewalt correctly points out, it is awfully tough to get them to work in State hospitals. More than 45 percent of the doctors in the State hospitals are foreign-born physicians, in Florida quite a few Cubans and in New York State more than 50 percent are foreign born.

We don't seem to be able to attract the young American doctor except in the new hospitals.

Let me say that in 1945 there were 3,000 psychiatrists. Today, there are 18,000. It has become a very strong specialty. Last year more postgraduate courses were offered in psychiatry than in any other single specialty. We have come from a very small band into a very broad specialty. The same is true with psychiatric nurses, social workers, and others.

I have been to see a few of these centers under the staffing grants. It seems to me that there are millions of people who lead empty lives, unproductive lives, housewives who are getting tired of playing bridge or being beaten at canasta, who would like to work in a center as a mental health worker.

I think the hand-to-hand relationship, the help one gives to a child who is disturbed indicates that you don't have to have five degrees on the wall. I have seen this in the foster grandparents program.

I have seen mothers working on the wards with children. I have heard doctors say, "This is the most effective person we have in the entire hospital."

We haven't begun to tap the manpower.

I think it has been proven in VISTA, foster grandparents, and other programs that we can use these people effectively. They are the first meaningful contact some of these kids have ever had with another person. I talked to one of these foster grandparents who had a stroke, who sat at home for 4 years. He said he was useless, retired from business, had a barber come in and shave him, wouldn't go out, and so on.

Now he goes to Children's Hospital every day. I said, "Why do you do that, sir?" He said, "Mr. Gorman, there are six children who depend on me getting there every day so I get up and shave myself and get there every morning at 9 o'clock."

He doesn't have any degrees. He is a successful businessman. Now he shaves himself. The barber has less work.

Mr. SATTERFIELD. That is all the questions I have.

Mr. JARMAN. Thank you, gentlemen, for your contribution.

Mr. ROGERS. May I ask just one question before you leave?

I, too, have observed this foster grandparent program in the mentally retarded program in Florida. It is very successful. Some of the children never expressed themselves and are beginning to now.

They say it has been very successful. I wonder if your association has gone into this problem to the extent that you could recommend the use of people in psychiatric centers. I think there is going to have to be some knowledge and some leadership and guidance given before they would bring in people like this to use them. I think there is a hesitancy.

Mr. GORMAN. Exactly.

Dr. EWALT. I agree with you, sir, but there has been a lot of work done in this. I believe our fellow association, the National Association for Mental Health, has really taken the leadership as a lay organization, working with lay people.

Our association has certainly helped. If you would like, I will send you a book on volunteers in mental hospitals which my good wife edited for the Massachusetts Association for Mental Health and which prescribes programs around the country.

You hear a lot about the Harvard College kids getting into trouble but you don't hear about the several hundred under the program working in hospitals giving aid to psychiatrists and we are even using high school youngsters.

We have taken some leadership but mostly it goes in cooperation with the Association for Mental Health.

Mr. ROGERS. I was hoping you would give consideration to having your association actually put forth a plan of this type to get this information out.

Mr. GORMAN. We have, Mr. Rogers.

Mr. ROGERS. The psychiatric association, itself?

Mr. GORMAN. The National Institute of mental Health is directly concerned with manpower. We spend $100,000,000 a year on training programs which you give us through appropriations.

We have called conferences for what we call the middle level mental health worker. Our best source is the junior colleges. We have found a number of junior colleges that will train the 2-year workers.

The Southern Regional Education Board has done a terrific job. Dr. McPheeters, who used to be the mental health director in Kentucky, is now the Associate Director for Mental Health. I am supposed to attend a conference on what helpers you can use, whether you can train them in junior college, in Atlanta next week.

Mr. ROGERS. I think that is excellent. I think there is going to have to be more recognition by the doctors themselves to get acceptance.

Mr. GORMAN. We are bringing them into the conferences?

Mr. ROGERS. Of these nonprofessional people.

Mr. GORMAN. It is a big problem.

Dr. EWALT. I would agree with you, sir. The thing, however, is that it is being done, not perhaps as much as it should be, and it is growing.

Mr. ROGERS. Shouldn't you have a committee go into this problem?

Dr. EWALT. By seeming to pause, I am trying to think. The American Psychiatric Association, I think, has 70 committees and I am not sure whether we have one on this particular problem.

We have one on working with physicians and working with the volunteers. I will look into this.

Mr. ROGERS. I would be very anxious to follow up on this.

As you say, I think the use of the elderly people, perhaps in this program with short courses through the junior colleges would be helpful.

Dr. EWALT. The thing one has to be careful in the professional business is staying out of the other fellow's backyard. If the National Association for Mental Health has a big program, we would tend to help and work with it.

Mr. ROGERS. I am not suggesting that you work at counter purposes but simply to have some leadership that they can follow. I think it has to have some professional acceptance before it will go anywhere.

Mr. GORMAN. But many of the psychiatrists are attending these conferences.

Mr. ROGERS. I would hope that this would be followed.

Dr. EWALT. I will let you know, sir.

Mr. JARMAN. Mr. Kuykendall.

Mr. KUYKENDALL. Thank you, Mr. Chairman, for your courtesy. I am not a member of the subcommittee but I have a few questions to direct to Mr. Gorman.

I am going to ask for some statistics which I would like to have sent to me.

Dr. Carter, my colleague from Kentucky, suggested that the family situation for the mentally ill children is important and I think this is something that we all recognize that a factor is the social situation at home.

However, if you have a correlation between the economic status of the families who produce mentally ill children and the social status correlation, I would like to have it.

The social disturbance from home certainly applies to everyone.

Mr. GORMAN. Before turning it over to Dr. Ewalt, in the Redlich-Hollingshead study, the highest percentage of schizophrenics comes from the lowest educational and income groups.

Mr. KUYKENDALL. May I have a copy of your studies?

Mr. GORMAN. Yes, sir.

(The information requested follows:)

MASSACHUSETTS MENTAL HEALTH CENTER,
DEPARTMENT OF MENTAL HEALTH,
Boston, Mass., April 6, 1967.

Hon. DAN KUYKENDALL,
Congress of the United States,
Washington, D.C.

DEAR REPRESENTATIVE KUYKENDALL: At the April 5 hearings on community mental health centers, the Redlich-Hollingshead Study was mentioned by Mr. Gorman. I remembered some more recent ones. In 1964 there was a conference on delinquency at the Menninger Foundation in Topeka, subsidized by the Maurice Falk Medical Fund. The results have recently been published by Gibbons and Ahrenfeldt, two Britishers, in Tavistock Publications, 1966, page 201. While this conference attempted to cover too much in too short a time, it did tend to bring out the fact that, in spite of the many variables, delinquency, mental disease, etc. in children and adults was associated with poor education and poor socio-economic status—this irrespective of the general economic level of the community in which the person lived—i.e. the poor in the rich countries and the poor n the poor countries were both worse off than the well-to-do in either country. Another one also occurs in Tavistock Publications, 1966, page 208 called Troublesome Children by D. H. Stott. This is a very elaborate study of children, mostly Scottish. While he is attempting to show that these problems are due to what he calls primary neuroticism, which one gathers he thinks is genetic, the book contains a large amount of data to show that most people would feel that it was associated in his cases with poor socio-economic status and the stress which goes with poverty and the very strict Scottish homes in the cases of some of the children.

The most scientific study is by Harold Skeels. Twenty some years ago he participated in a research program in which twenty-three children were studied in a home for the retarded. It was a typical under-privileged, snakepit type home. They divide them into two groups but some were lost so they ended up with ten in the control series and eleven in the experimental series. Briefly, the

control series were left in the home. The experimental series were removed into a new school where there was a great deal more stimulation in terms of attention, experience in training, learning, etc. Over the first three or four years there was a rapid increase in the I.Q. and performance level of the experimental group, while the control group remained unchanged—in fact, the experimental group improved so much that they were all placed in adoptive or foster homes where they received a lot of love and attention in these specially selected homes. Some twenty odd years later the experimental group members are without exception achieving at an average level. Most are working, many have completed their education and most are married. The members of the control group on the other hand were all in institutions of one sort or another, and had been throughout the experimental period except for one who died of some infection. While this is not directly related to socio-economic factors, it is the most carefully done series to show the effect of the kinds of environment that go with better socio-economic circumstances in homes, etc.

Sincerely,

JACK R. EWALT, M.D.,
Superintendent.

Mr. JARMAN. Thank you very much, Mr. Gorman and Dr. Ewalt. We here on the committee appreciate very much your fine testimony this morning.

Mr. GORMAN. Thank you, Mr. Chairman.

Dr. EWALT. Thank you.

Mr. JARMAN. Our next witness is Mr. George J. Otlowski of the National Association of Counties.

STATEMENT OF GEORGE J. OTLOWSKI, REPRESENTING THE NATIONAL ASSOCIATION OF COUNTIES

Mr. OTLOWSKI. Mr. Chairman and members of the committee, I was extremely impressed as an elected county official by the testimony that just preceded mine. I think that the members of this committee were undoubtedly impressed as I was.

Frankly, the problem as presented by these two gentlemen was not only dramatized here this morning, but I think pinpointed in the fact that we are going to have to get more and more community involvement in this whole program aside from the professional direction and guidance.

We are going to have to involve all people in the community, the older people, the younger people, on a voluntary basis, on a nonprofessional basis, under the proper guidance and supervision of the professional people if we are going to be able to cope with this gigantic problem that confronts us.

I would like to point out that I am an elected county official of Middlesex County and I am representing the National Association of Counties, and, of course, the national association is supporting H.R. 6431 which extends Public Laws 88–164 and 89–105, providing Federal assistance for the construction and initial operation of community mental health programs is well-known by the Congress and the Federal administrative agencies.

We have long supported, in principle and in fact, treatment of the mentally ill close to their homes.

The recent flowering of the "community" treatment concept is an exciting innovation to some. But it has been a reality with county government in the United States for many years. So, Mr. Chairman,

it is an understatement for us to say we "support" a concept which we in the counties virtually initiated in this country.

For example, 2 years before the enactment of Public Law 88–164 in 1963, the county governments were operating 392 community mental health treatment clinics—or "centers"—in 36 States.

It is true that these 392 county facilities did not provide "comprehensive" treatment services. The were principally "out-patient" clinics. But they were in the community and part of the community, and we welcomed—in 1963—the chance to upgrade them into "comprehensive treatment centers" by adding "in-patient" and other essential services.

The Congress gave us that chance with Public Laws 88–164 and 89–105. However, even before Public Law 88–164, the counties in some States were operating comprehensive mental health treatment programs, including in-patient care.

In my own State of New Jersey, six counties have been operating comprehensive treatment mental hospitals since the beginning of the century.

Let me say this about my own State, one of the greatly gratifying things that should be of interest to the committee: the States and the counties are vitally interested in this program, they are spending the money, they are willing to spend the money, they know the money has to be spent in this area.

For example, at this very moment, the New Jersey Assembly, the lower house, unanimously passed a bill, and the Governor has indicated that he is going to sign it, which would provide $7½ million for contributions for construction, $7½ million unanimously passed by the lower house without one dissenting vote.

I think this is the kind of indication that you want that indicates that States and counties want to spend this kind of money.

These hospitals today have a resident population of 6,500 patients. This means that county government in my State of New Jersey operates community mental health treatment programs larger than the mental hospital programs of 30 States.

In the State of Wisconsin, since 1881, the counties have operated their own local mental hospitals. Today in Wisconsin there are 35 county mental hospitals, serving 71 counties and covering 84 percent of the State's population.

In Iowa, the counties run 84 after-care facilities for aged ex-mental patients, and at present there are almost 3,000 patients in the Iowa county facilities. Also, in Iowa, the counties pay full cost of treatment of county residents who are committed to Iowa State mental hospitals.

Here, I think, that you can see that counties, and I am going to show more specifically, are becoming more engaged in this problem, more and more willing to pay the moneys that have to be spent here and, as has been indicated by the testimony that was given by my distinguished predecessors, frankly, the Federal Government has not been spending the kind of money that it should be spending in this area and the time has arrived now for a real partnership between the Federal Government, the States, and county governments in this area of mental health.

Thus, we see a clear record of interest on the part of the American county government in the treatment of the mentally ill in, or close to, their own communities. This is important, so very important, in their own communities. There is a big difference between a mentally ill person going to a State institution and going to his neighborhood community center the moment there is an indication of mental illness because he doesn't go to a State institution 9 times out of 10 until he is committed, until the mental illness is so progressive that, as the testimony indicated, after that it is a matter of years before he comes back to the community.

I would just like to point out this to the committee: I have been in this business for 12 years. I have had the good fortune to serve as chairman of the welfare committee in my county for 12 years and I distinctly remember when I first came on the board in my county and I started to advocate mental health clinics.

Most of my colleagues on the board 12 years ago thought I was talking about some kind of proposed retreat for retired politicians. They had no concept of what the mental clinics would serve in the county.

The amazing thing after 12 years in my county, which has 600,000 urban and suburban people, is that today the mental health clinics in that county vary in their concept of diagnosis and treatment for children and adults including additional alcoholic treatment centers, narcotic treatment clinics, crises intervention clinics, after-care clinics, and companion houses.

In 12 years, this has been accomplished in my county. The fantastic change that has taken place is not only amazing but pleasing, and here again is an example where Federal, State and county governments can form an effective partnership in the expansion of this kind of a program, and here again, we are talking about this bill that we are testifying about today because this is the beginning of that partnership.

This is the beginning of getting into the home, getting into the neighborhood, reaching out into the families. The great tragedy, Mr. Chairman, and members of the committee, with these clinics that we have established in my own community, is the wail and cry of the people who are on the waiting lists and cannot be treated. That is the great tragedy, when you sit there as an elected official and you have great big lists of people who are breaking the doors down to get into the clinics and you cannot take them because the clinics are not sufficiently comprehensive or sufficient in number to take care of the great needs that exist.

In 1963 and 1965 the National Association of Counties came before this committee in support of the proposed community mental health construction and staffing legislation.

In 1963 the administration proposal called for a 5-year program of $330 million starting on a 75-percent matching basis. The proposal was cut by 2 years and $180 million, with the matching formula reduced.

Now, we come back with 3 years of good, practical experience behind us and we ask for an extension of the program to get it moving at a pace originally envisioned.

Thirty-one county mental health centers are now underway. At this point, Mr. Chairman, I ask that a list of the 31 county projects be made a part of the hearing record. I am going to submit that.

Mr. JARMAN. Mr. Otlowski, how many States are those?

Mr. OTLOWSKI. They represent six or seven States, Mr. Chairman. They include such States as Florida, California, Kentucky, and so on.

Mr. JARMAN. Very well, without objection, at this point in our hearing record we will include those statistics.

(The information referred to follows:)

COUNTY-OPERATED MENTAL HEALTH FACILITIES RECEIVING GRANTS TO DATE

(Submitted by the National Association of Counties)

Olive View Hospital, Olive View, Calif	$791,627
County of Santa Barbara Mental Health Services, Santa Barbara, Calif	108,915
Santa Clara County Community Mental Health Center, San Jose, Calif	378,853
Panama City Memorial Hospital, Panama City, Fla	269,750
Mental Health Center of Manatee Memorial Hospital, Bradenton, Fla	331,500
Escambia County Guidance Clinic, Inc., Pensacola, Fla	185,900
Community Mental Health Center, Athens General Hospital, Athens, Ga	614,962
Marion County General Hospital, Indianapolis, Ind	545,163
Hopkins County-Madisonville Hospital Corp., Madisonville, Ky	223,090
Prince Georges General Hospital, Cheverly, Md	290,931
Vista Larga Center, Albuquerque, N. Mex	504,622
Cape Fear Valley Hospital, Fayetteville, N.C	815,220
Alamance County Mental Health Center, Burlington, N.C	126,000
Muskingum County Hospital, Zanesville, Ohio	162,669
General Hospital of Monroe County, Stroudsburg, Pa	93,170
Mental Health Guidance Clinic of Butler County, Butler, Pa	211,464
Anderson-O'Conee-Pickens Mental Health Center, Anderson, S.C	120,000
Whatcom County Outpatient Clinic and Psychiatric Day Center, Bellingham, Wash	171,873
King County Hospital-Harbor View Center, Seattle, Wash	1,017,049
Brown County Hospital and Community Mental Health Center, Green Bay, Wis	664,800
Adams County Comprehensive Community Mental Health Center, Adams City, Colo	94,763
San Luis Obispo County Mental Health Center, San Luis Obispo, Calif	112,118
Franklin County Public Hospital, Greenfield, Mass	319,691
Mental Health and Mental Retardation Center of Boulder County, Boulder, Colo	147,591
Mental Health Center of Anderson and Roane County, Inc., Oakridge, Tenn	387,547
Milwaukee County (*6 centers*)	1,040,232
Total	10,902,532

Mr. OTLOWSKI. In the next 5 years we would expect that, if this bill is enacted, the counties will develop 200 more mental health centers.

As President Johnson said in his 1965 health message, "Few communities have the funds to support adequate programs, particularly during the first years." The key word here is "adequate."

In order to develop adequate; that is, comprehensive, community mental health programs, the counties need financing help from State and Federal Governments.

In the 31 projects now underway we have demonstrated the intention of the counties. The Federal-State-county cooperative financing program is a demonstrable success.

I think that no more telling tribute could be paid to the devotion of most county officials to the care, close to the home, of the mentally ill than a recent statement by a Minnesota county commissioner.

This commissioner said: "Our board would sooner reduce its county highway program than to cancel out our participation in our regional mental health center."

This, I think, Mr. Chairman, is the spirit of all U.S. county officials. They see this as a workable program of high priority for their constituents.

We not only ask you for its renewal; frankly, I would like to be humble enough at this point to say that we beg you to extend this program because county government to bring this kind of treatment into the neighborhood, to bring this kind of treatment into the home, does not have the financial resources to do it alone and they will never have them to do it alone.

We have to have the strong arm, the strong resources, of the Federal Government into the partnership that we are calling not only the Federal Government but the State, and in these 12 years that I talked to you about this in my own county when the mentally ill patient went to the State hospital in most cases he saw an imaginary sign on the gate that read "Abandon All Hope, All Ye That Enter"—but in his home, in his neighborhood, in his community, there is the hope, there is the friendship of his neighbors, there is the possibility of the total community involvement, there is the possibility of better professional involvement who shy away from the snakepits at the present time and who are waiting for decent community neighborhood facilities.

Congress, and particularly this committee, can open this door wider for the American people to get their treatment on a neighborhood level and almost on a home level with the kind of program that is envisioned here.

Gentlemen, I want to thank you for giving me this opportunity to testify.

Mr. JARMAN. We appreciate your being with us and the contribution you have made to this hearing.

Are there any questions?

Mr. Rogers?

Mr. ROGERS. Thank you, Mr. Chairman.

I would like to thank you for your testimony and for being here, and also for the initiative your area has taken. What is your problem with staffing? Do you have any staffing problem?

Mr. OTLOWSKI. Well, let me give you an example in our own county. With our clinics we haven't had a problem of staffing, and I like to believe it is because of the fact that we pay well.

I like to believe that our quarters are pleasant and I also like to believe that our professional people have a feeling of accomplishment, and for that reason, of course, we don't have the problem of staffing, but in addition to that we have done something else that was indicated by my predecessors who testified and that is the fact that we are now beginning to engage in the community nonprofessional people.

As I indicated in my testimony, we have the companion house that provides after-care people where nonprofessional people are engaged in helping these people.

Congressman, I would just like to say this, and it was so amply brought out this morning: That in many cases what is needed is the immediate warmth and the immediate sympathy.

Mr. ROGERS. I understand that. I don't want to take too much time of the committee.

Perhaps you would like to submit it for the record.

Mr. OTLOWSKI. We haven't had a problem with staffing.

Mr. ROGERS. This is in your county where you pay for all the care?

Mr. OTLOWSKI. We pay for all the care. The State provides 50 percent of our operating budgets.

Mr. ROGERS. You anticipate using this program for staffing?

Mr. OTLOWSKI. I am glad you asked that question, Congressman. We have two applications in at the present time. We are hoping that one will be approved by April 30.

Mr. ROGERS. Is this within your county?

Mr. OTLOWSKI. Yes, the two are within our county. One is for what we call the Raritan Bay area. The other is for the Rutgers University area.

Mr. ROGERS. They have these county facilities?

Mr. OTLOWSKI. Right.

Mr. ROGERS. What is the average time for the inpatient treatment at your hospital? I understand you have a resident population there of 6,500?

Mr. OTLOWSKI. As a matter of fact, our county now is closely working with the State in our State hospital for which our county pays.

Mr. ROGERS. I am not thinking of the State hospital. I was thinking of your county mental health population. You may want to furnish this for the record.

Mr. OTLOWSKI. I would say on the average a year and one-half.

Mr. ROGERS. For inpatients admitted?

Mr. OTLOWSKI. No, for outpatients. We do not have any inpatient facilities in our county because the inpatient facilities are provided by the State for which the county pays the State.

Mr. ROGERS. I misunderstood your statement on page 2 where you say six counties have been operating comprehensive treatment mental hospitals and these have a resident population of 6,500. That is the statement.

Mr. OTLOWSKI. You are talking about the entire statement. In Bergen County and the other counties, we have these counties furnishing inpatient care and the average stay there, 40 percent of the stay there is 30 days as inpatient.

Mr. ROGERS. Thank you. I appreciate your testimony.

Mr. JARMAN. Are there any other questions?

Thank you so much, Mr. Otlowski.

Mr. OTLOWSKI. Mr. Chairman, may I present this to the committee? This is the national association's county platform.

Mr. JARMAN. Thank you, Mr. Otlowski for taking the time to be with us this morning.

Mr. OTLOWSKI. Thank you, Mr. Chairman.

(A series of articles on the psychotic child, from the Perth Amboy Evening News, and a letter from Dr. Samuel Breslow endorsing same, submitted by Mr. Otlowski, may be found in the committee files.)

Mr. JARMAN. Our next witnesses I am pleased to say are two prominent people from the State of Oklahoma, Dr. Albert Glass, director

of the Department of Mental Health of the State of Oklahoma, accompanied by Dr. Hayden Donohue, director of the mental health center in Norman, Okla.

In fairness to Mr. Kuykendall, I should add that they are accompanied by Dr. Nat T. Winston, the mental health commissioner of Tennessee.

Dr. GLASS. May I also introduce Harry Schnibbe, the executive director of the National Association of Mental Health Program Directors, which group we represent here.

STATEMENT OF DR. ALBERT GLASS, DIRECTOR, DEPARTMENT OF MENTAL HEALTH, OKLAHOMA; ACCOMPANIED BY DR. HAYDEN DONOHUE, DIRECTOR, MENTAL HEALTH CENTER, NORMAN, OKLA.; DR. NAT T. WINSTON, MENTAL HEALTH COMMISSIONER, STATE OF TENNESSEE; AND HARRY SCHNIBBE, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS

Dr. GLASS. As you may be aware the National Association of State Mental Health Program Directors is comprised of those directors who direct the programs for the mentally ill in the 50 States and the several territories.

As administrators for the vast majority of the mental health services in this country, we have a vital concern in these proposed mental health amendments of 1967 and our association unanimously urges its passage.

We have also here the messages from Governors and directors of mental health of some 24 States, including the States of Massachusetts, North Carolina, Illinois, Wisconsin, Kansas, Kentucky, Arizona, Arkansas, South Carolina, Connecticut, Delaware, Ohio, Vermont, Utah, New York, Washington, West Virginia, North Dakota, Pennsylvania, Louisiana, Missouri, Indiana, Texas, and Iowa, which I would like to submit to the committee.

Mr. JARMAN. They will be received.

Mr. ROGERS. You have no requests from Florida?

Dr. GLASS. We are awaiting it.

Mr. ROGERS. I would be interested to know if Florida responds.

Dr. GLASS. We are getting them in this morning and they are being added to the list. We expect a communication from the State of Florida.

Mr. SPRINGER. May I ask, have you heard from Illinois?

Dr. GLASS. Yes, Governor Kerner.

(The material referred to follows:)

STATE OF ILLINOIS,
OFFICE OF THE GOVERNOR,
Springfield, Ill., April 3, 1967.

The Honorable HARLEY STAGGERS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN STAGGERS: On Thursday, March 4, 1965, I appeared before the Interstate and Foreign Commerce Committee, then meeting to consider H.R. 2985, and testified on behalf of the bill with the hope that it would allow our states to embark on a program which would make community-based Mental Health

services available to all citizens. At that time, I described the direction taken by the State of Illinois and the Illinois legislature which authorized the creation of Zone Centers throughout the State. Seven centers, at that time, were planned and programmed. Since that time, two centers in the Chicago area have begun operating. Also centers in Rockford, Decatur and Champaign have initiated programs of a comprehensive mental health nature. The remaining centers in Peoria and Springfield will be completed by mid-summer of this year.

The purpose of these centers is to provide intensive short-term care in an environment designed to keep the patient in his own community. These centers which, in terms of geographic catchment area, i.e., the numbers of population which they serve, are larger than those proposed under the Federal Construction Act. In part, this was because our planning for these centers was initiated in 1961, two years before the passage of the community Mental Health Centers Act and, in part, because of our program of decentralizing the Department of Mental Health in order for the regionalization of planning and services to be specific to the needs of the communities which they serve. The community Mental Health Centers program, therefore, is being used to set up a sub-network of community Mental Health Centers serving more discreet populations and regions as subzones which then relate to the zone center program in Illinois. In essence we are building a zone center complex in which state hospitals, outpatient clinics and community mental health centers are related in a network of services serving the population of relatively large geographic regions and sub-regions, providing a continuum of care and comprehensive services. This requires the highly-integrated planning and organization between those agencies responsible for human services—that is, the Department of Public Health, the Youth Commission, the Division of Vocational Rehabilitation, the Public Aid Department; the Division for Crippled Children, the Universities, and, of course, the Department of Mental Health. All these agencies have regional offices in the same zone cities where the Zone Centers have been constructed.

In Illinois, we have sought an enlightened approach to a partnership for planning and service. We welcome federal monies coming into our state, matched by state efforts and local community efforts. To achieve this partnership several progressive steps have been taken since my last appearance. Federal money for construction of Mental Health centers is not used by the Department of Mental Health, but rather is directed to local communities seeking to build resources necessary for providing services and reaching out in a service linkage to our new state facilities. In this legislative session, we have proposed an enabling act which would allow the state to implement the efforts of the Federal government by subsidizing local programs up to 30 per cent to match the 39 per cent provided by the Federal Mental Health Centers Construction Act. In 1963, a law was enacted in Illinois permitting local government units to tax themselves for mental health services subject to referendum. Eight such referenda have passed, and eight were to be voted on at the general election April 4. Therefore, you can see we are striving to truly effect a partnership between the Federal government, State government and local communities. The state sees its charge in this partnership for planning and service as stepping in *only* where communities are unwilling or unable to provide the resources and the services for their citizens.

We have reviewed, favorably, the budget proposals of the Department of Mental Health for this coming biennium to provide the expansion of those programs which we have initiated for comprehensive mental health services at the community level. Programs for the prevention and treatment of mental illness and retardation have expanded rapidly and have changed in concept during this decade. Today, we admit more persons to our programs than ever before in a greater number of facilities throughout the state. Through improved diagnostic and treatment methods we return a higher percentage of these persons to their homes and jobs in a shorter period of time. Our resident population in institutions for the mentally ill decreased 19 per cent from 31,912 patients on June 30, 1965, to 25,899 on December 31, 1966, and we are continuing to improve staffing at these institutions and zone centers to make them modern and effective treatment facilities. In all of our zone centers a substantial amount of community organization work has been completed. This work will be increased and intensified during the next biennium, and this has been a priority item budget request of all of our zone centers. Government must place as much emphasis on providing resources for the treatment and prevention of mental illness and retardation as it does on communicable diseases and physical impairments.

The Department's program is, therefore, to encourage communities to provide adequate front-line resources for the prevention, early diagnosis and treatment of mental illness and retardation. To this effect, we have requested a budget of $414,174,039, excluding reappropriations, for the coming biennium. This represents an increase of some 120 million dollars from General Revenue Funds over the last biennial appropriation.

I, therefore, request your support for the Mental Health Amendment of 1967 under H.R. 6431 which extends the construction and staffing of community Mental Health Centers under Public Law 88–164 and Public Law 89–105. If we are to diminish the serious, crippling effects of mental illness and retardation, and to increase the social competence and potential of our citizens, it will be through the efforts of these bills, providing service at the local level in conjunction with state efforts. In our ever-changing society, it will be those services provided by our staffs and our communities in the centers of populations where people live, trade, and congregate that will make the significant impact on our ever-changing, ever-exploding society. Society, because of its size, because of its gross potential, because of the very nature of its technological explosion, creates a multitude of problems and stresses on its citizens. These stresses must be dealt with through treatment, prevention and rehabilitation. These services must be added to our growth as a nation and as a society which cares for its own on its own home front.

Thank you.

Sincerely,

OTTO KERNER, *Governor.*

STATE OF NORTH CAROLINA,
GOVERNOR'S OFFICE,
Raleigh, N.C., April 4, 1967.

The Honorable HARLEY STAGGERS,
Chairman, Interstate and Foreign Commerce Committee, House of Representatives, Washington, D.C.

DEAR CONGRESSMAN STAGGERS: Adoption of S. 1132 (H.R. 6431) will enable North Carolina to continue implementation of its long-range plan to establish community-based services for the mentally ill and retarded.

Since the Facilities Construction Act (Public Law 88–164) was adopted in 1963, North Carolina has made considerable progress toward that objective. Under this act, Federal funds have been committed for construction of four comprehensive community mental health centers. Two of these will be in the eastern section of our state, one is in the Piedmont and one will be in the western section of our state. The latter is designed as a combination mental health-mental retardation facility to be housed in the same structure.

A number of other communities are in various phases of developing their plans for a comprehensive center. We estimate now that fifteen additional comprehensive community mental health centers can be established during the next biennium, provided funds are available.

Currently our recommended state budget, now before the Legislature and expected to pass, appropriate state funds sufficient to provide the state matching portion for construction of the fifteen new centers. Many of the communities already have their portion set aside.

The state simply could not support its own and the Federal share of this program. We are already putting about all we can afford into support of our mental health program. Currently, North Carolina is spending forty million dollars a year on its mental health program. For the next two years I have recommended an increase of 22.8 percent per year in mental health appropriations, the largest single portion of which will go to community mental health centers. I point this out to emphasize that we in North Carolina are not abdicating our financial responsibilities and shifting them to the Federal Government.

Our mental health program in North Carolina is in a very critical transitional period. We are making a concerted effort to build up our community programs with the resulting need for increased budgetary support, while still carrying the same responsibilities for maintaining a high standard of care in our state hospitals which currently receive over 12,000 admissions each year. Until we work through this period to the point that community programs are numerous enough to enable significant numbers of patients to be treated at home

instead of entering our state hospitals, continued Federal support for community mental health development is essential if we are to continue to move forward.

Many of our communities in North Carolina are just now moving into the final phases of the rather long and involved process of community organization through which an application for construction funds is developed. This has been a time-consuming process in North Carolina for two reasons. First, it has involved bringing together multi-county groups for joint planning and negotiation. Secondly, because we decided to tie in our comprehensive community mental health centers with general hospitals, our center construction plans have had to be phased into the long-range plans (under Hill-Burton) for hospital development. In some cases it is possible to do this quickly but in many others it may involve a period of several years.

Let me emphasize that the process of community development and involvement which has come about as plans for a community mental health center take shape has been very healthy and stimulating for our state. The people of our communities have responded to this challenge by working together to a degree that has been inspiring. So, while North Carolina has used only a portion of the Federal construction funds originally allocated to us, there has been no lack of interest or work by our people. And now many of our communities are ready to move forward. The funds simply must be made available so that the plans and hopes for a comprehensive community mental health center may become a reality.

Equally as important as the "bricks and mortar" part of this Act is Section 3 of S. 1132 which extends the staffing grant program (P.L. 89–105) through fiscal 1972. This is absolutely essential in order to help the new community mental health centers bear the initial burden of employing the new personnel which their effective operation requires. Recruiting and hiring of professional mental health personnel cannot be done quickly. They are in great demand and in scarce supply. While we are committed in North Carolina to meeting the manpower shortage through expanded training programs and opportunities, it again takes a period of several years before these training programs can begin to bridge the gap.

Our long-range mental health plan in North Carolina envisions the eventual establishment of thirty-two comprehensive community mental health centers. Each of these is going to require a full staff of qualified personnel. I can think of no more productive and creative way for Federal tax dollars to be used than in helping these communities meet some of the initial financial strain of acquiring the staff needed to carry out our responsibilities toward the mentally ill and retarded.

May I sincerely urge your favorable consideration of S. 1132 which will do so much to help our state through this very crucial period in its mental health program development.

Sincerely,

DAN MOORE, *Governor.*

STATE OF NORTH DAKOTA,
EXECUTIVE OFFICE,
Bismarck, N. Dak., April 3, 1967.

The Honorable HARLEY O. STAGGERS,
Chairman, Committee on Interstate and Foreign Commerce,
House Office Building, Washington, D.C.

DEAR CONGRESSMAN STAGGERS: It is my understanding that hearings will be held soon on extension of the Community Mental Health Centers Construction and Staffing Acts and the grants authorizations as provided for in H.R. 6431 and a companion bill S 1132. This is to inform you that I strongly support this proposed legislation.

North Dakota has been able to provide care, near their home, for many patients suffering from mental illness through two new Centers, located in Grand Forks and Bismarck, during the last several months. Two other Centers, located at Fargo and Minot, will open within the near future. These four centers eventually will provide care for patients for approximately 60% of our state's population.

This marked progress could not have been accomplished without the assistance from federal funding through the Community Mental Health Centers Acts. In addition, construction funds have been made available for the St. Michael's

Hospital in Grand Forks and for the Neuropsychiatric Institute at St. Lukes Hospital in Fargo.

I believe that a continuation of this program, as embodied in H.R. 6431 and S. 1132, will be of great benefit to North Dakota and to all other states in the nation in meeting the mental health needs of our citizens. I respectfully request your Committee's favorable consideration. I appreciate this opportunity to submit my views.

Sincerely,

WILLIAM L. GUY, *Governor.*

STATE OF WASHINGTON,
Olympia, Wash., April 1967.

Hon. HARLEY STAGGERS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives, Washington, D.C.:

As Governor of the State of Washington I want to convey to you my wholehearted support of H.R. 6431 entitled the "Mental Health Amendments of 1967." I have observed closely the salutary effects of the original federal laws providing financial support for the construction and staffing of community mental health centers. I think it is fair to say that the concepts embodied in those laws, and the opportunities they have made possible, have stimulated degrees of interest, enthusiasm and support at all levels which would have been long delayed, if forthcoming at all, in the absence of a national posture and national leadership.

While our state and its several communities have moved a great deal, it would be unfortunate, indeed disastrous, if federal support were to be withdrawn at this time. Community mental health programs are quite costly. As a result they require the assurance of substantial amounts of public funds from state and local sources to supplement those from the federal government. Because ours is a biennial legislature, only now have we reached the point where these monies might be made available. With combined federal, state and local funding, I expect to see considerable progress in the years just ahead. To the extent that any part of this funding is diminished, we may expect a set back in our programs. We are not yet ready to carry the entire program alone.

DANIEL J. EVANS, *Governor.*

STATE OF VERMONT,
EXECUTIVE DEPARTMENT,
Montpelier, Vt., March 31, 1967.

The Honorable HARLEY STAGGERS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives, Washington, D.C.

DEAR MR. STAGGERS: I understand that your committee will hear testimony on April 4th and 5th on H.R. 6431, a proposal to extend authorization for construction and staffing of community mental health centers. I urge you and the members of your committee to support the utilization of this beneficial program.

The Mental Retardation Facilities and Community Mental Health Centers Act of 1963 has had direct and indirect effects on many facets of mental health programs in Vermont. It has stimulated program development which would otherwise have been difficult if not impossible.

The northeastern part of our state, a sparsely populated and economically undeveloped area, has been the recipient of both construction and staffing grants to develop a comprehensive community mental health program, the scope of which would have been unimaginable and unrealizable without the provisions and funds available through this federal legislation. This has been brought about by citizen interest within the area and by the stimulation of professional imagination which the act has made possible.

Under the terms of Public Law 88–164 the Bennington area has received a grant for construction of additional facilities to their existing clinic building which is presently being strained beyond its capacities. These funds will not only enable an expansion but will strengthen the program and bring it even more closely into the orbit of comprehensive mental health services to meet the needs of the people in this area.

Under another title of the same act, our state operated training school for the retarded in Brandon has received a grant for construction of a pre-placement cottage for boys and men which will aid the transition from the institution to the community. We expect that this too will have a major effect on the total program for mentally retarded persons in Vermont.

I know there are many areas throughout the United States which will reap benefits equal or similar to those which we are beginning to see in Vermont and I urge your favorable consideration of the legislation to continue necessary aid to ease a major health problem throughout all of our states.

Sincerely,

PHILIP H. HOFF, *Governor.*

STATE OF IOWA,
DIVISION OF MENTAL HEALTH,
Des Moines, Iowa, March 31, 1967.

Hon. HARLEY STAGGERS,
Chairman, Interstate and Foreign Commerce Committee,
Washington, D.C.

DEAR SIR: I sincerely hope that Federal legislation, H.R. 6431, continues to support the Community Mental Health Centers program. Also, that the proposal to extend for five years authorization for construction and staffing of Community Mental Health Centers will be approved.

Sincerely,

J. O. CROMWELL, M.D.,
Director, Division of Mental Health.

STATE OF DELAWARE,
DEPARTMENT OF MENTAL HEALTH,
Wilmington, Del., March 31, 1967.

Hon. HARLEY O. STAGGERS,
Chairman, Interstate and Foreign Commerce Committee,
House Office Building, Washington, D.C.

DEAR CONGRESSMAN STAGGERS: As Commissioner of Mental Health for the State of Delaware and representing the Board of Trustees of that Department, I endorse H.R. 6431 which will extend for five years the financial support required for the construction and staffing of Community Mental Health Centers.

Those of us who are engaged in the day-to-day and long-range development of programs for patients are convinced that Community Mental Health Centers are essential if we are to achieve our primary purpose of providing rapid and effective treatment for that substantial percentage of our population which suffers from mental illness.

Recently, I was asked to supply two basic reasons for my position favoring the support of the Community Mental Health Center plan as envisioned in the present legislation.

I replied that, first, Federal assistance is needed because under present tax structures there are not sufficient funds for local and State governments to provide the services that are needed in a Community Mental Health Center.

And, second, the Community Mental Health Center plan makes it possible to treat the patient close to his home and close also to all of the resources he will need for rehabilitation.

There are, of course, many other reasons. Our Delaware State Mental Health Plan includes as a major development for the future the establishment of these centers to cover the entire State.

It is likely that some members of this honorable Committee, as well as others attending the hearing, have seen the new documentary picture, "Bold New Approach," which was premiered in the New Senate Office Building on March 21 under the sponsorship of Senator Lister Hill. This picture daramtically portrays the advantages of the Community Mental Health Center. The ability of the facility depicted to receive and begin immediate treatment for the two patients is most striking.

A succession of Congresses has shown strong interest in the problems involved in mental therapy in the onrushing 20th Century. What is proposed in House

Resolution 6431 is far-sighted and is in keeping with creative legislation of recent years in this field.

The bill extends the construction program through 1972, a wise move, since it gives planners in the States a chance to look ahead and plan carefully. It extends the staffing program, a basic requirement because competent staffing is the heart of modern treatment programs. This legislation would also permit recipients to use funds for the acquisition of existing buildings—and for the remodeling or alteration of existing buildings. It further requires that State mental health plans must include enforcement of adequate community center standards.

This bill, if enacted into law, will assist in the improved treatment of many thousands of men and women suffering from mental illness. It will mean that they will be able to return to their families more swiftly and with more assurance that their rehabilitation will be successful.

Thank you for permitting me to take this much of your time.

Sincerely,

DANIEL LIEBERMAN, M.D.,
Commissioner.

STATE OF INDIANA,
DEPARTMENT OF MENTAL HEALTH,
Indianapolis, Ind., March 31, 1967.

The Honorable HARLEY STAGGERS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN STAGGERS: I am writing to express the State of Indiana's support for H.R. 6431 which extends federal programs for the construction and staffing of community mental health centers.

Indiana's Plan for Development of Comprehensive Mental Health Services, developed by the Indiana Mental Health Planning Commission, strongly recommended the continuation of federal programs for both construction and initial staffing. In point of fact, the Commission's recommendations and subsequent legislation were predicated on continuation of federal support. It was the initial federal legislation, first for planning, then for construction, and finally for initial staffing that inspired the State of Indiana to move strongly into the community mental health progam.

Important measures passed by the 95th Indiana General Assembly show the state's willingness to participate with the Federal Government and County Governments in the development of desperately needed community programs for the mentally ill and retarded. One measure replenishes the state's matching fund for construction and operation of community centers to the extent of approximately $10,000,000 over the next four years, the money to come from a portion of cigarette tax revenues. Another act broadens the definition of community centers for the mentally ill and retarded, gives counties permission to issue bonds as well as levy a 10 cent property tax to finance facilities, and says that counties may support a center in a neighboring state that serves Indiana residents.

Indiana has truly put into practice the philosophy expressed in the late President Kennedy's mental health address to the Congress in which he called for a sharing of the responsibility and cost among the three major subdivisions of government—Federal, State and Local Governments. Every region in the state is actively planning for community mental health services. Our state hospitals are rapidly readjusting their treatment programs to become an integral part of these expanding community programs. By June 30, 1967, Indiana should have five approved mental health centers.

At least three more applications will be submitted during the 1968 fiscal year. It would be disastrous to the mental health program in Indiana if federal support was to stop with the end of the present authorization which is June 30, 1967.

The Indiana Mental Health Planning Commission and all interested agencies, organizations and individuals join with me in requesting approval of all sections of HR 6431.

Sincerely yours,

J. R. GAMBILL, M.D.,
Acting Mental Health Commissioner.

STATE OF KANSAS,
STATE DEPARTMENT OF SOCIAL WELFARE,
Topeka, Kans., April 3, 1967.

The Honorable HARLEY STAGGERS,
U.S. Representative, Chairman, Interstate and Foreign Commerce Committee, House of Representatives, Washington, D.C.

DEAR CONGRESSMAN STAGGERS: Please let us express our earnest endorsement of H.R. 6431, which would extend for five years the authorization for construction and staffing of Community Mental Health Centers.

Our experience with the current legislation has been quite encouraging because it has stimulated in a number of ways improvements in the mental health program. First, it has aroused interest in adequate, thorough, and timely treatment of mentally ill patients wherever they need treatment. Secondly, it has stimulated interest in preventive measures and brought out some effective social action in areas closely related to mental health. Third, it has improved morale of mental health workers and encouraged them to make more effective use of facilities already present in the community.

We are especially eager to see the extension made not only because two centers have been established, but because others are potentially in the planning stages. Four communities at least are making efforts to provide the local matching funds and to educate the elements of the community to the needs for the service. With the extension of the bill we can foresee the development of comprehensive services in four or five areas within the near future that would fulfill a great need on the part of a very large number of people.

Thus, both because of the effective help this bill has given our state in the past three years and the effective help we foresee in the near future, we would like to add our request that your committee consider the bill favorably.

Very truly yours,

R. A. HAINES, M.D.,
Director, Division of Institutional Management and Community Mental Health Services.

THE COMMONWEALTH OF MASSACHUSETTS,
DEPARTMENT OF MENTAL HEALTH,
Boston, Mass., March 31, 1967.

Congressman HARLEY STAGGERS,
Chairman, Interstate and Foreign Commerce Committee, House of Representatives, Washington, D.C.

DEAR CONGRESSMAN STAGGERS: As Commissioner of Mental Health in the Commonwealth of Massachusetts I would like to put myself on record as strongly supporting H.R. 6431.

Sincerely yours,

HARRY C. SOLOMON, M.D.,
Commissioner.

STATE OF VERMONT,
DEPARTMENT OF MENTAL HEALTH,
Montpelier, Vt., March 31, 1967.

The Honorable HARLEY STAGGERS,
Chairman, Interstate and Foreign Commerce Committee, House of Representatives, Washington, D.C.

DEAR MR. STAGGERS: I understand that the House Interstate and Foreign Commerce Committee will convene on April 4th and 5th for the purpose of considering extension of the community mental health centers construction act and the provision for aiding in the cost of staffing such centers.

This act has made possible major strengthening and improvement of comprehensive community mental health programs in many states. In Vermont in one of our less economically developed areas which is sparcely populated, the federal aid for both construction and aid in the cost of staffing have provided part of the cost of development of such a program and has stimulated both in professional

people and the entire community to take effective action in development of a unique mental health program.

I know there are many other such programs throughout the United States in early development stages which will be significantly impaired if this act is not continued. I urge the support of your committee in making a favorable report for extension of the community mental health center construction and staffing act.

Cordially,

JONATHAN P. A. LEOPOLD, M.D.,
Commissioner.

THE STATE OF WISCONSIN,
STATE DEPARTMENT OF PUBLIC WELFARE,
DIVISION OF MENTAL HYGIENE,
Madison, Wis., April 3, 1967.

The Honorable HARLEY STAGGERS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives, Washington, D.C.

DEAR CONGRESSMAN STAGGERS: It is my understanding that your Committee will be considering H.R. 6431 concerning the extension of authorization for construction and staffing of community mental health centers.

Although there have been some problems in the implementation of this program, it is my opinion that it is a most valuable one and an essential one to extend.

In Wisconsin, local communities have long had considerable financial responsibility in the development of mental health services. We have a great deal of investment in the continuation of the development of such services. The state agencies of Wisconsin having responsibility in this matter are working aggressively to assist communities to use the provisions of this legislation, and it is our opinion this program will develop very soundly during the next five years and will result in mental health services being available to people in their local communities on a much more uniform basis.

Sincerely,

L. J. GANSER, M.D.,
Director, Division of Mental Hygiene.

UTAH STATE HOSPITAL,
Provo, Utah, March 31, 1967.

Congressman HARLEY STAGGERS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives, Washington, D.C.

DEAR CONGRESSMAN STAGGERS: It is my understanding that hearings will be held Tuesday and Wednesday, April 4th and 5th, by the House Interstate and Foreign Commerce Committee, on the Administration's proposal to extend for five years authorization for construction and staffing of Community Mental Health Centers (H.R. 6431).

Many states, particularly in the intermountain region, have difficulties in having enough time to plan and to finance Comprehensive Centers. The State of Utah has had particular difficulties in this area. At the present time we do have one Comprehensive Mental Health Center in operation and this was accomplished only through the staffing and construction grant. Further development of any Comprehensive Mental Health Centers or mental retardation centers within the State of Utah will be contingent upon an extension of the legislation.

I strongly support and urge that the House Interstate and Foreign Commerce Committee recommend the Administration's proposal to extend for five years authorization for construction and staffing of Comprehensive Mental Health Centers.

Sincerely,

GORDON S. JOHNSON, M.D.,
Superintendent Utah State Hospital, and Member, National Association of State Mental Health Program Directors.

[Telegram]

Congressman HARLEY O. STAGGERS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives, Washington, D.C.:

Urge favorable consideration of Administration's proposal to extend for five years authorization for construction and staffing of community mental health centers (H.R. 6431). Much planning and essential community organization presently underway in West Virginia with involvement of major communities throughout the state. However, it is vital that authorization be extended for orderly planning and phasing of projects over a five year period in line with existing state and community resources. Community mental health services and facilities considered only feasible approach to meeting burgeoning problem in the state and in the nation.

HULETT C. SMITH,
Governor of West Virginia.

[Telegram]

ALBANY, N.Y., *April 6, 1967.*

The Honorable HARLEY O. STAGGERS,
Chairman, House Interstate and Foreign Commerce Committee,
House Office Building, Washington, D.C.

The provisions of P.L. 88–164 and P.L. 89–105 have been important factors in assisting the State department of mental hygiene and local governments in the construction and staffing of mental health centers throughout New York State. According to the State mental health plan, 112 more community mental health centers are needed. Only 16 of these are in the construction planning phase. An even greater disparity exists in regard to mental retardation facilities. It is urgent that Federal assistance be continued so that these present needs for facilities can become future realities.

I strongly urge enactment by Congress of H.R. 6431, Mental Health Amendments of 1967, so that the Federal Government can continue in cooperation with the States and local governments to assure all residents the best in mental health services.

NELSON A. ROCKEFELLER, *Governor.*

[Telegram]

HARTFORD, CONN., *April 4, 1967.*

Congressman HARLEY STAGGERS,
Chairman, Interstate and Foreign Comerce Committee,
House of Representatives, Washington, D.C.

Urge favorable consideration by your committee of H.R. 6431 proposing to extend for five years authorization for construction and staffing of community mental health centers. This program is one of the most useful ever sponsored by the Federal Government to aid and stimulate the most forward looking programs for care, treatment and rehabilitation of the mentally ill. In Connecticut the program already has been of great value in one mental health center now operating in the city of New Haven and in the development of a second planned for the city of Bridgeport. Continuation of the program will provide encouragement and support for further development of plans on which rest the hopes of thousands of citizens.

JOHN DEMPSEY, *Governor.*

[Telegram]

TOPEKA, KANS., *April 7, 1967.*

HONORABLE HARLEY STAGGERS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives,
Washington, D.C.

I urge favorable consideration of H.R. 6431, which would extend the authorization for construction and staffing of community mental health centers. The present legislation has stimulated interest in the communities throughout the

State in preventive measures and has encouraged mental health workers to make better use of facilities already present in the community. With extension of this bill Kansas can look forward to additional comprehensive mental health services in at least four or five communities.

ROBERT DOCKING,
Governor of Kansas.

[Telegram]

TALLAHASSEE, FLA., *April 6, 1967.*

HON. HARLEY STAGGERS,
Chairman, Interstate and Foreign Commerce Committee,
Rayburn Office Building,
House of Representatives,
Washington, D.C.

The future of mental health treatment programs in Florida is contained in House bill 6431 which your committee conducted hearings on April 4, 1967. We have many porgrams awaiting additional Federal funds in this area and it would be a serious setback to Florida's mental health program if bill was not reported favorably and passed by the House of Representatives. I urge you to steer the measure to a successful conclusion.

Sincerely,

CLAUDE R. KIRK, JR.,
Governor of Florida.

[Telegram]

COLUMBIA, S.C., *April 4, 1967.*

CONGRESSMAN HARLEY STAGGERS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives,
Washington, D.C.

South Carolina now has a number of comprehensive community health centers in the initial planning stage, therefore urges extension of the authorization for construction and staffing these centers as proposed in H.R. 6431.

ROBERT E. MCNAIR,
Governor.

[Telegram]

LITTLE ROCK, ARK., *March 3, 1967.*

CONGRESSMAN HARLEY STAGGERS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives,
Washington, D.C.

Hope you and your committee can see fit to continue community mental health center program for next five years.

GEORGE W. JACKSON, M.D.,
Superintendent.

[Telegram]

COLUMBUS, OHIO, *April 13, 1967.*

BUREAU OF PLANNING AND GRANTS
Attn: Dr. Wayne Chesso

On behalf of Governor James A. Rhodes I want to convey Ohio's support of H.R. 6431. Federal aid to construct and staff mental health centers vital incentive to communities to improve services for mentally ill. Detailed letter of Ohio position to follow.

MARTIN A. JANIS,
Director, Ohio Dept. of Mental Hygiene and Correction.

[Telegram]

ALBANY, N.Y., *April 6, 1967.*

The Honorable HARLEY O. STAGGERS,
Chairman, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

P.L. 88–164 and P.L. 89–105 have led to greatly accelerated growth of community mental health and mental retardation services in New York State. A relatively small amount of Federal money ($15 M.) has led to applications for facilities with a total value of $55 million. Moreover these acts and the guidelines and regulations developed therefrom have directly assisted New York State in implementing the kind of broad range programs with continuity and responsibility which will provide definitive services for the mentally ill and retarded in the communities where they reside. The construction now planned will provide for only 16 mental health centers of a total of 112 needed according to State plan. Even a greater disparity exists in the field of retardation centers and the public has become keenly aware of the unmet needs. We have letters of intent for 21 additional mental health centers and 6 mental retardation facilities at a total cost of $76 M. Unless this legislation is extended as proposed in H.R. 6431 we fear loss of momentum in this great program.

ALAN D. MILLER, M.D.,
Commissioner,
New York State Dept. of Mental Hygiene.

[Telegram]

CHATTAHOOCHEE, FLA., *April 6, 1967.*

Hon. HARLEY STAGGERS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives, Washington, D. C.

The Florida Division of Mental Health is extremely interested in the prosposal to extend the present program of construction and staffing of community mental health centers, H.R. 6431. Under the present program Florida has made excellent progress by having nine projects approved for construction of community mental health centers. There are a number of other projects pending approval that will qualify should this program be extended. The staffing provision of the program is extremely important to these community mental health centers which will allow them to develop their program on a more comprehensive basis at a more rapid rate. Considerable State funds are presently involved in the staffing of the existing mental health clinics which will include future clinics under this program. Favorable consideration of H.R. 6431 by your committee will be appreciated.

W. D. ROGERS, M.D.,
Director,
Division of Mental Health.

[Telegram]

OLYMPIA, WASH., *March 3, 1967.*

The Honorable HARLEY STAGGERS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives,
Washington, D.C.:

I would like to express my very strong support of H.R. 6431 (Mental Health Amendments of 1967). I believe this bill to be vital to the continued development of community mental health services in the State of Washington. At the present time enthusiasm is high among those responsible for planning at the community level. Within the past two years these individuals have invested enormous amounts of time and energy in the task of laying a foundation for local mental health programs. The withdrawal of Federal funds at this time would constitute a serious blow to this concern and morale which, as you well know, has been so long in coming.

Here in Washington there are several communities which are, quite literally, on the brink of submitting applications for Federal construction or staffing

monies. For example, the St. Luke's Hospital in Spokane wishes to include a psychiatric in-patient unit in its new construction program; the community mental health service of South King County has sent us a preliminary draft of a mental health center staffing grant; and there are many others. Our citizens have responded well to the challenges posed by the original Federal legislation. They gained acceptance for community based services in a State where the care of the mentally ill traditionally has been a State responsibility; they have developed reasonable and feasible plans even in the face of severe manpower shortages; they have, through the legislature, begun to make increasing amounts of public funds available to pay for local mental health services. This latter is all the more remarkable when one realizes that up until now Washington has invested only about 7 cents per capita per year in community mental health programs.

If Federal support is curtailed at this time, much of this effort will have been for nothing. Again, therefore, let me convey my support of H.R. 6431.

WILLIAM R. CONTE, M.D.,
Department of Institutions.

[Telegram]

PHOENIX, ARIZ., *April 4, 1967.*

Hon. HARLEY STAGGERS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives,
Washington, D.C.:

It is of utmost importance the community mental health centers program be extended, particularly as it will be the less affluent portions of the State—those most in need of help—who will now be attempting to develop services.

Community acceptance of this program as evidenced by the rapid development of centers, plus the continuing need makes it most urgent that H.R. 6431 be supported and passed. We strongly request your support of this measure.

RAY LEWIS, *M.D.,*
Director,
Division of Mental Health.

[Telegram]

HARRISBURG, PENN., *March 31, 1967.*

Hon. HARLEY STAGGERS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives,
Washington, D.C.:

I strongly support H.R. 6431, which extends the grant programs for construction and initial staffing of community mental health centers. I urge also increased funds for the construction program, since Pennsylvania program is hampered by low allocation. Strongly recommend that staffing grants be made through the States instead of directly to the community.

MAX ROSENN,
Secretary of Public Welfare,
Commonwealth of Pennsylvania.

[Telegram]

FRANKFORT, KY., *April 3, 1967.*

Congressman HARLEY STAGGERS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives,
Washington, D.C.

I am taking the liberty of forwarding to you the position advocated by the Kentucky Department of Mental Health with respect to the extension of the community mental health center program. I sincerely urge and hope that you

support such an extension to a State with economic and professional problems such as ours, this program has been an absolute lifesaver. Through the stimulation provided by P.L. 88–164 and P.L. 89–105 we have touched off a real revolution in the provision of mental health services in this State. Without it, there is serious doubt that any substantial progress in community mental health would have been obtained. We are now in a position of moving forward, which can either be greatly assisted by the continuation of the program, or seriously retarded by its abrupt termination.

A bond issue which provided only 1.2 millions of dollars for assistance to communities for construction has rewarded us with a Federal share utilization (either projected or certified) of 100 percent in mental retardation thru 1968 and 100 percent in mental health thru 1966. Four construction projects in mental retardation and four in mental health have been approved at the State level, and of these three have already received Federal approval; the others are now being reviewed.

In addition, thru provisions of P.L. 89–105, we have been able to obtain full utilization of our 1966 monies and have pending an additional ten staffing grants which hopefully will obtain any unused monies from other States to the extent of about 1.2 millions in Federal assistance.

These programs have stimulated community interest and community cordination of planning beyond our fondest hopes. We have been able to initiate programs which have recruited people into the State of Kentucky and which we presume will continue to operate.

Plans to insure continuation of the programs once initiated is essential in this program as Federal funds are withdrawn. However, continuation of the initial Federal staffing assistance is needed if the remaining regions in Kentucky are to ge started. I am sorely afraid that these nine other regions of the State will find the cupboard bare, if there is not a continuation of this remarkable program.

This State and others like it, without the benefit of large metropolitan populations and strong State tax bases, have found the initial assistance given by these programs to be invaluable; I again urge that the Congress continue to assist us in provision of a totally new concept in the care of the mentally ill and the mentally retarded. In order not to belabor this, may I say that this department stands ready to forward to you any specific details which you might care to have relative to our development.

O.S. text will be sent to you in letter form.

DALE FARABEE, M.D., *Commissioner.*

[Telegram]

JEFFERSON CITY, MO.,
April 4, 1967.

Congressman HARLEY STAGGERS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives,
Washington, D.C.:

Have learned that your committee is holding hearings on H.R. 6431, to extend authorization of staffing and construction of community mental health centers. This is to advise that we in Missouri wholeheartedly endorse this step and urge support by your committee.

The reasons for continuation are: (1) many States did not have sufficient time to develop administrative staff and procedures to implement fully P.L. 88–164 and P.L. 89–105; (2) community representatives have required considerable time to organize and raise funds in order to apply for Federal matching monies to build centers; (3) as centers are developed there is an impetus to other communities to build mental health centers, thus an extension would make it possible to construct and staff additional facilities; (4) some States are without mental health service acts and thus have no financial resources to match with local funds to build and staff centers.

GEORGE A. ULETT, M.D.,
Director,
Missouri Division of Mental Diseases.

[Telegram]

AUSTIN, TEX., *April 12, 1967.*

Congressman HARLEY STAGGERS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives,
Washington, D.C.:

The Texas Department of Mental Health and Mental Retardation of the State of Texas is vitally interested in passage of H.R. 6431 which would extend for five years authorization for construction and staffing of community mental health centers. Texas has recently undertaken a comprehensive community mental health centers program and the financial assistance afforded by this measure would be of inestimable value.

JOHN KINROSS-WRIGHT, M.D.,
Commissioner.

[Telegram]

BATON ROUGE, LA., *March 31, 1967.*

Congressman HARLEY STAGGERS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives,
Washington, D.C.:

I heartily endorse the bill, H.R. 6431, extending for five years the existing programs for construction and staffing of community mental health centers. Louisiana has 14 projects scheduled for construction, however, Federal funds will only permit 7 centers to be built. In addition the 1967 Louisiana State plan recommends the construction of 15 new centers and additions to 6 existing centers.

WILLIAM P. ADDISON, M.D.,
Louisiana Commissioner of Mental Health.

[Telegram]

COLUMBIA, S.C., *April 3, 1967.*

Congressman HARLEY STAGGERS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives, Washington, D.C.

Extension of the Community Mental Health Center programs, as proposed in H.R. 6431 and S. 1132, would be most welcome in South Carolina. This State's comprehensive mental health plan leans heavily on the community center concept. Three applications for construction grants have been approved and two others are being processed, along with one staffing grant application from a sixth area which will submit a construction application later. It appears that virtually all, if not all, of this State's construction grant allocations will be used. All matching funds are being supplied by local communities, giving evidence of grassroots support.

Five other area mental health boards have expressed interest in expanding clinics into comprehensive centers but cannot meet current program deadlines. Two other clinics just getting underway would be prospects for centers later, as would one other area not now having a clinic.

If the program is terminated as scheduled, less than half of the need will have been met in South Carolina and the neediest areas, by and large, will be the ones left untouched.

Extension of the staffing grants is most important. The original deadlines for staffing applications were too close to the construction grant deadlines, so that many centers being constructed under current authorizations will not be completed in time to obtain a staffing grant. If construction grant legislation is extended, the need to extend the staffing grants will be even more imperative since many communities will not project centers without initial staffing aid.

WILLIAM S. HALL, M.D.,
South Carolina Commissioner of Mental Health.

Dr. GLASS. Our first witness will be Dr. Winston.

Dr. WINSTON. I am Dr. Winston and I will briefly go over my written statement.

Governor Ellington was invited to be with us this morning and could not because the legislature was in session but he has asked me to express his regrets, and let me say as commissioner of mental health that he has given overwhelming support for our program and has given us the highest increase in our budget, hopefully which will be approved at any time, in the history of our department.

What I have done in my statement is to briefly outline the three revolutions that I have seen occurring in psychiatry, the first being the advent of Dr. Freud, the second revolution which is the tranquilizer in 1954, and third the comprehensive mental health center and I really see this as the most significant of all and I would like to confine my verbal testimony to my experience as the superintendent of Moccasin Bend Hospital, a small State hospital which opened 2 years prior to the comprehensive centers but which was run similar to the centers and just briefly outline our experience there because I think it is relative to the staffing questions which have been asked.

Mr. JARMAN. I think it would be appropriate to say that the Chair has announced that we will try to finish the hearing by 12 o'clock. Apparently we cannot do so. So, our intent is, in fairness to the witnesses who have come to the hearing, some from outside the Washington area, to ask for permission to sit this afternoon at 2 o'clock to conclude the hearing if we don't finish this morning.

Dr. WINSTON. Moccasin Bend Hospital, as I say, opened in 1961 actually. The results that we had there with this type of program similar to the comprehensive center we feel are almost miraculous. We cut the average first stay from 6 months to 5 weeks in the first year of operation.

We started new programs that were not capable of being started previously because of the small comprehensive concept that we envisioned and that is now in operation elsewhere, too.

We did this, I might add, with only one other psychiatrist serving an area of some 600,000 people. Let me make the remark that we rely heavily—in fact, solely, I should say—on the aid staff and the use of tranquilizers and not one patient there received the sort of treatment that I as a psychiatrist was trained to give; that is, the 1-to-1 psychotherapy relationship.

Yet we got these patients out, we kept them out and they are continuing to give what I think is a real testimony to the value of how these comprehensive centers can work without necessarily the staffing pattern that we have been accustomed to in the past and would like to have but cannot apparently have in light of short staff.

Let me read my concluding paragraph.

The impact of the comprehensive community mental health centers making treatment available to any aggregate population of 75,000 or more is indeed staggering.

It is my firm, sincere judgment that the farsighted thinking on the part of the National Institute of Mental Health in instituting this program will be by far and away the most significant of all of the three revolutions.

Although it will in no way eliminate mental illness any more than general hospitals eliminate physical illness, it will alleviate much of the suffering, the agony, and the despondency to which only those who have had mental illness can testify.

I urge this committee to consider not only the extension of the present program but a large expansion of it.

(Dr. Winston's prepared statement follows:)

STATEMENT OF DR. NAT T. WINSTON, JR., COMMISSIONER OF MENTAL HEALTH, STATE OF TENNESSEE

I am Dr. Nat T. Winston, Jr., Commissioner of Mental Health for the State of Tennessee. Governor Buford Ellington of our State was invited to participate at this committee hearing, but because of pressing legislative matters currently under consideration in the General Assembly of Tennessee, he is unable to come. He has asked me to express regret that he could not be here and may I say as commissioner of mental health, that his interest in our problems and in our overall program has been overwhelmingly positive. He has asked the current legislature for a greater increase in our budget than anytime in the history of the department and has given his wholehearted endorsement and support to our program.

I shall make my remarks quite brief in urging you to consider the extension of the Community Mental Health Centers Construction and Staffing Act (H.R. 6431). In my judgment, there have been three revolutions in psychiatry. The first occurred around the turn of the century with the advent of the theories of the development of mental illness first advanced by Dr. Sigmund Freud, the father of modern day psychiatry. The original postulates of Dr. Freud have been altered somewhat, but his most significant contribution was his pointed observation that there were causal factors in childhood resulting in adult disturbed behavior. This meant that no longer could we complacently sit back and place patients in "insane asylums" and wash our hands of the matter. We would now have to look for methods of treatment of a definitive nature.

The second revolution occurred in 1954 with the advent of the first true tranquilizer. Although we had methods of physical treatment prior to 1954 and although we had drugs which would produce sedation, we had no drugs which would produce tranquilization without crippling side effects. These miraculous drugs do not cure in the strict sense of the word, but merely control symptoms thus altering many age-old concepts we have had about the mentally ill. They have, for example, permitted new ideas in design and architecture for mental hospitals. They have completely modified and changed our programs for the mentally ill by permitting a freedom and versatility of programs never before possible. They have led in my opinion directly to the third revolution.

This revolution came about because of you, the legislative body of the United States. You appointed in 1955, a five year study group to look at the problems of the mentally ill. The famous "action" report released by this group in 1961 held as its primary recommendation that the mentally ill, if he was to receive the best chance for recovery and to remain well, must be treated at home in small intensive treatment units just as we treat physical illness in our many local general hospitals. The report held that it was just as absurd to congregate patients in large regional mental hospitals as it was to send the average case of pneumonia or appendicitis to the university hospital 200 miles away.

In backing up this recommendation, you then passed in 1963 the Comprehensive Community Mental Health Centers Act, which in my way of thinking has revolutionized our entire approach. It has placed the mentally ill back where they belong—in the community. It has done much already to reduce the stigma and the fallacious thinking of individuals about mental illness.

It was my privilege to have opened, as the first superintendent, the Moccasin Bend Psychiatric Hospital in Chattanooga in 1960. This small, intensive treatment unit is operated much as the comprehensive centers are being operated following 1963. Here we had the chance to see what new ideas coupled with tranquilizers could do for the patient who was treated right at home in his own environment. The results were almost miraculous. We cut the average length of stay for a first admission acute case in the State of Tennessee down from six months to five weeks in our first year of operation. We started new programs never before conceived of in mental institutions such as 24-hour around the clock visiting, sending patients home who were still presenting symptoms for weekend visits, but who with the confidence that they would not be separated from their families returned readily and improved more rapidly. We utilized every recreational facility of the city of Chattanooga itself in our recreational

program and we did away with many of the traditional practices of searching, keeping doors locked, etc. We utilized many community agencies and brought volunteers into the institution thus keeping the institution and the community closely associated. This program as well as others have demonstrated beyond any doubt that keeping the patient at home does make a significant difference in how he responds to the definitive treatment offered him and even more importantly, how well he stays at home.

The impact of the comprehensive community mental health centers making treatment available to any aggregate population of 75,000 or more is indeed staggering. It is my firm, sincere judgment that the far sighted thinking on the part of the National Institute of Mental Health in instituting this program will be by far and away the most significant of all of the three revolutions. Although it will in no way eliminate mental illness any more than general hospitals eliminate physical illness, it will alleviate much of the suffering, the agony, and the despondency to which only those who have had mental illness can testify.

Ladies and gentlemen, as a professional person with the responsibility of caring for the mentally ill of a State, I would urge you to consider at all costs not only the extension of the present program, but a large expansion of it. To do less would be more than foolhardy and would potentially endanger the lives and the emotional health of every one of us here.

Dr. GLASS. I would like to follow with my statement. I have a prepared statement. I will not read it because I feel that Dr. Donohue has a story to tell and does not have a prepared statement.

I should like to summarize my remarks by pointing out that you have heard of the decade of effort to obtain this community program, going from the studies that Dr. Ewalt had in the Joint Commission on Mental Illness and Health and you know about Public Law 88–164 which launched the community mental health center program.

It not only launched a construction program but a whole new way of doing this, not new techniques, but a new operation, how to use people, how to treat people as outpatients, how to treat them in alternatives to hospitalization.

So that the program launched not just construction but a new way of handling the problem. Now it is almost as if the military medical services, and I am an old military psychiatrist, confined their operations only to base hospitals and didn't have followup field service to support troops in the field.

This is what the new program did. Necessarily it took time to get started. It had to be written. It had to be understood.

Enthusiasm had to be stimulated and we have gone through the first 3 years of this. Now we are moving. We have a momentum going. There are only 128 construction grants and 72 staffing grants as of April 1.

Now, many of these are complementary. Our one grant which Dr. Donohue will talk about is both staffing and construction. If we at this time fail to renew this program we have broken faith with everything that we have tried to do in stimulating it.

For example, this would stop a whole decade of progress. We are on our way now. We are getting more and more interest. More and more people are exploring this idea and understanding it. I don't know how much time I spent in Oklahoma explaining what a community health center was.

It was always mixed up with a clinic. The substance and spirit of this law strongly indicates that a continuing program was contemplated, not only President Kennedy's 2,000 centers.

For example, there is the insistence that the State plan shall provide for adequate community mental health centers for all of the people in the State—not a few of them—and it shall set forth a program for construction of seven community mental health centers based on a statewide inventory and I am quoting from the law.

It should be evident that if we don't fully renew the center program, we will be discriminating against those regions and communities in which approved applications have not yet been completed or are on their way. Often this delay is due to a shortage of mental health people in this community and often those communities need the mental health care the most.

For example, failure to review this legislation would do the following in Oklahoma: we have three grants, two approved, one in the process. Those three grants will use up most of the money available under the present 3-year program.

Yet, when completed they will supply services to less than a fourth of the population, to 600,000 which is less than one-fourth of our population.

This is what I mean. Yet, this excellent beginning has stimulated Muskogee, has stimulated Ardmore and other places to get going on this project. If we fail to renew it we block all of the efforts that we have done all these 3 years.

With that, I would like to turn this over, unless you have questions at this time, to Dr. Donohue, who will show you what a center looks like, at least from planning and somewhat from an operational stage.

(Prepared statement of Dr. Glass follows:)

STATEMENT OF ALBERT J. GLASS, M.D., DIRECTOR DEPARTMENT OF MENTAL HEALTH, STATE OF OKLAHOMA

Mr. Chairman, I am Dr. Albert Glass, Director of the Oklahoma State Department of Mental Health and a member of the Board of the National Association of State Mental Health Program Directors. I represent these Directors of the state programs for the mentally ill in the 50 states and several territories.

As administrators for the vast majority of metnal health services in the United States, the State Mental Health Directors have a vital concern in the proposed Mental Health Amendments of 1967 and unanimously urge its passage. This act will make possible a continuation of the nationwide movement to improve and increase the availability of treatment resources for mental disorders, which was launched in 1963.

PROPOSED AMENDMENTS

1. Renewal of the Centers Program for an additional 5 years.
   (*a*) Extends the community mental health construction program through Fiscal 1972. Authorizes $50 million for Fiscal 1968 and such sums as necessary for Fiscal 1969–1972.
   (*b*) Permits construction grant recipients to use the funds for acquisition of existing buildings instead of only new construction, remodeling, alteration, expansion, etc.
   (*c*) Provides for enforcement after 1969, in state plans, of maintenance and operation standards.
2. Renewal of Staffing Program.
   Extends funding of staffing program for community mental health centers through fiscal 1972; also provides authority to continue making grants through fiscal 1976 to centers already receiving grants.
3. Contingency Fund.
   Establishes "contingency fund" for the Secretary of H.E.W. Secretary would have control of $50 million of expiring unobligated funds out of various HEW grant programs. Has no direct bearing on mental health centers program.

BACKGROUND

In order to appreciate the importance and need for the proposed Mental Health Amendments Act of 1967 it is necesary to review the origin and present status of the Community Mental Health Centers program.

Over a decade ago the Joint Commission on Mental Illness and Health was established by Congress to study and make recommendations on this most common and most disabling health problem of the nation. As a result of the Commission's findings and report in 1961 and the rising awareness of the increasing dimensions of mental disorder by many prominent lay and professional citizens, PL 88–164, the "Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963" was enacted by the 88th Congress.

In essence, this Act authorized funds to begin the construction of community based facilities for the mentally ill and the mentally retarded. It should be recognized that, at this time and even today, the majority of mental disorders were either neglected or because of the absence of an alternative to hospitalization are referred to state mental hospitals, many of whom were located at some distance from the community. This lack of local mental health facilities is in sharp contrast to surgical, medical, and other non-psychiatric medical services which were present mainly in or near the community. In effect it is as if military medical services were provided mainly in base hospitals with little or no facilities to follow and render prompt medical support to troops living and fighting in the field.

While the 1963 act seemingly only provided for the construction of community mental health facilities, in actuality it introduced new concepts and programs for the management and treatment of mental disorders. Since new methodology and concepts require considerable time for understanding and acceptance and because of the scarcity of mental health personnel similar to the general shortage of health personnel, initially, implementation of the Community Mental Health Centers Construction Act proceeded slowly. But with time and effort there came more and more awareness and increasing appreciation of the "Centers" concept. This program was given considerable impetus in 1965 by passage of the Amendments of Public Law 88–164 which authorized financial assistance toward meeting the cost of technical and professional personnel serving community mental health centers during the first 51 months of their operation. With this assurance of staffing support more community and public agencies moved to explore ways and means of establishing centers and submit feasible applications for their operation and construction.

In the several years of its operation, PL 88–164 has encountered inevitable problems in its regulations and administration which have been or are being resolved. For example, initially regulations and attitudes due to the anxiety and effort to stimulate "center" applications unwittingly fostered the impression of a rivalry between community mental health centers and state mental hospitals. It seemed that a dicotomy was being established between these two systems of mental health care. Indeed it was "rumored" that community mental health centers would do away with state mental hospitals. However, with time and experience it has become clearly and widely evident that comprehensive mental health care requires the integration of services between community centers and state mental hospitals. Further, that Community Mental Health Centers, must be supported by facilities of state mental hospitals, else cases requiring prolonged care will absorb the energies of the Center and prevent its function as a flexible facility which can promptly respond to local problems and needs. It has become recognized that state mental hospitals can and should provide community mental health services either alone or in concert with local community agencies for citizens residing in its environs. This more flexible use of state mental hospitals is of particlar pertinence in view of the shortages of the mental health professional manpower which are even more scarce in rural areas where many state mental hospitals are located.

The overall events and experiences of the past several years has produced increasing implementation of the Community Mental Health Centers Act until at this time (1 April 1967) 121 construction grants have been made along with 73 staffing grants.

RENEWAL OF THE CENTERS AND STAFFING PROGRAM

1. Failure to renew the Centers and Staffing program at this time would be disastrous to a decade of progress that has been made in community psychiatry.

It should be recognized throughout the country that there are many applications in various stages of preparation. The withdrawal of federal support at this time would make it virtually impossible to reestablish such favorable climate and interest in providing services for the mentally ill.

2. The substance and spirit of PL 88–164 strongly indicates that a continuing program was contemplated. For example, there is the insistance that the state plan "shall provide for adequate community mental health centers for people residing in the state" and shall "set forth a program for the construction of community mental health centers (A) which is based on a state-wide inventory of existing facilities and survey of needs."

3. It should be evident that the non-renewal of the Centers program would be discriminatory for those regions or communities in which approved applications for community mental health centers have not been completed. Often such a delay is due to the shortage of mental health professional manpower which frequently occurs in communities where there are the greatest needs for "Centers." In effect, only certain communities would enjoy federal support for their mental health programs, whereas other areas of need would be denied.

4. An example of what would occur in the event of failure to renew the "Centers" program can be envisioned in Oklahoma. In Oklahoma, three approved or current applications for Community Mental Health Centers Construction will absorb most of the federal funds made available to the state under PL 88–164. However, these three centers will serve less than ¼ of the state's population. But this excellent beginning has stimulated other communities who are now exploring ways and means of making application for community mental health centers. A denial of the "Centers" program at this time would not only eliminate planning, but also any future efforts to establish community psychiatry.

In summary, the state directors of mental health programs who are in daily and intimate contact with the mental health problems of the country strongly urge pasage of the Mental Health Amendments of 1967. Failure to enact this legislation will impede a decade of progress in establishing improved and modern mental health care.

Mr. JARMAN. Doctor, I think it would be well if you go ahead with your part of the presentation and then perhaps there will be some questions.

Dr. DONOHUE. This is a community mental health center. These are the essential services that are offered. As you may know, a community mental health center includes outpatient, inpatient, partial hospitalization emergencies, consultation and education services. These are the required. These are the ones that are recommended and in addition, diagnostic precare and aftercare, rehabilitative, research evaluation, and training.

These are the services that we have in the center which we will show you that we have now in actual operation. We began operation a month ago. We have both a staffing and construction grant and at this time I want to show the reason for the need for this.

Somebody asked a while ago about the number of patients. This yellow line shows the admission rate into the central State hospital in Norman, Okla., which serves a million population in density, 24 counties in central Oklahoma, but reflects what happens not only in Oklahoma but in most other States.

In 1953 and 1954 as Congressman Jarman is well aware, we were admitting about 1,000 patients. We were kind of in the snakepit area in 6 or so years after Mike Gorman but we started coming up and as you can see this is the way it is all over. Our number of patients in the hospitals is dropping down but this has only decreased the overcrowded and other things because if we had not decreased the census look at that admission rate which is now going up.

We started with 1,000 admissions a year and are now over 4,000. Personnelwise, in order to take care of these custodial patients we were using 880 some employees on a 48-hour workweek and now we have a 17-percent increase but they are professional people who came in to do this job.

Incidentally, we are estimating that the center now that we are operating is going to serve one section of this area which has 256,000 people in it. We estimate that out of that 256,000 that we will admit the same as we admitted out of this million. Why? Because we are there where these people can come and get this treatment and get it when they need it immediately.

The don't have to drive 40 or 50 or 100 miles.

This is a cross-section of the proposed new mental health center. The plans are up here now and I was talking to the National Institute of Mental Health yesterday and we are ready to break dirt. This shows the whole new philosophy, not the old type mental hospital building.

This has all the latest things. This is, of course, showing the new type. These cupolas, for instance, are towers so that the patients know immediately where they are located in relation to these buildings.

If you notice, they are built in pairs and we will show you why.

This is the in-patient division. Notice that instead of having the great mammoth wards that you have in the mental hospitals throughout the country these are based on 16-patient units.

There are two patients to a room with a bath instead of having 40 or 50 sharing one bath if you were that lucky. When I went into Oklahoma we had 100 and maybe more to one bathroom. This has the facilities for emergency care and treatment. It has the lounge in here if you will notice.

There are no great massive areas. Incidentally, working with the National Institute of Mental Health, this is a 6-foot corridor instead of 8, which saved millions of dollars for the Government and us because we were able to design these things differently.

This has wall-to-wall carpeting to keep the sound levels down, and give you a softness in relation to your patients. It has a fireplace. It doesn't cost much more but it gives you a warmth and feeling for these people.

This is the new idea, a little privacy in their own little section for every 16 patients and a visiting room. In the old days in the mental hospitals the last thing they wanted was visiting.

Now here it is very important because we are doing family therapy. We are treating the whole family. So we want the visitors in.

We have 24-hour-a-day services in the offices. In the old days of mental hospitals there were no offices.

This is the gymnasium in which we can do psychodrama. These are music listening areas. This can be used as an auditorium but it is actually a gymnasium. You move the chairs and you have a gymnasium.

Here is the lounge where people can go. There is a fireplace here again. This is, as you can see, a place where patients can rest as in a lounge in a hospital. It has a warmth, and incidentally, there are no shadows in here. This is all top lighted with skylights and fluorescent lighting so that there are no shadows to frighten the patient.

This is what is called a day hospital. This big room here is for patient government. Incidentally, in order to economize and make the maximum use of these things, as you say, that gymnasium could be made into an auditorium.

This is the patient government room and here you pull this down and you have two group-therapy rooms. Each doctor and social worker has an office. The occupational therapists—all these people provide treatment and therefore must have facilities to provide it.

This is the occupational therapy area which we use in the day hospital as an ongoing therapy during the daytime. These patients come in at 9:30 in the morning and go home at about 4:30 in the afternoon. We don't keep them at night. They are back with their families where they belong in the evening and this helps us with the therapy.

In here is the kitchen. Here is the hairdressing facility for these patients because if they are here all day the girls can't get their hair fixed so we have facilities for it and also this is good therapy in the case of women.

Here is the out-patient area. These are the wonderful new things that we have. These are all treatment rooms, treatment for the patient.

Here is the group therapy room using group therapy so we can treat eight patients where we used to treat one. Not only are the doctors doing group therapy but under the supervision of our doctors and psychiatrists the OT's are doing it.

In the Army during the war we developed the mental health worker. Here are our two mental health workers and we are trying to work out a situation where they can go out on calls—actually house-to-house calls in case of emergency like suicides and things—so that we get right on the situation immediately.

Notice here that we have gotten away from any long corridors getting away from this look of a hospital when the outpatient comes in here and knows that there are people in this area.

The banks have done this. They have come out from behind their grills and we ought to. This has television caremas with videotapes so that we can train people. This hospital is built jointly in connection with the Central State Hospital at Norman which is affiliated with the University of Oklahoma School of Medicine.

I met with 15 of the professors from the University of Oklahoma because we are going to work with the different types of people; the gerontologist and so forth, and they can come out of their ivory towers.

We took 40 of the honor students at the University of Oklahoma. Twenty of them stayed to the second year. Eight of them changed their courses and are going into the behavioral sciences.

They work together directly with patients.

Here is aftercare. This group doesn't go out and diagnose or work with an individual patient. They work with the judges and school systems and things like that so that this is a whole new day, a whole new area.

When I was in Arkansas in 1948, we had a clean up of their state hospital system and revised it and when I was in Texas in 1950 we were crying for this type of thing to be put in somewhere into the community, between the community and the hospital.

This building will start immediately. Its plans have been approved, as I said. It is a whole new area.

This last one shows the arrangement of these. This is the out-patient and the after-care. This is the day hospital here. That is occupational therapy.

Here is the recreational therapy, the lounge, and this is the emergency and in-patient service.

These things, as I said, were colored because they show the patient where he is. This is an ampitheatre. It is warm in Oklahoma a lot of the year so that we can have band concerts. This is a band shell in there. This is a whole new philosophy.

Incidentally, this is built about a half mile away on some ground that the hospital owns in proximity to the University of Oklahoma and to our hospital, the idea being that we can train people in this technique.

So these are our plans and what we are going to do. On the back you can see the actual picture.

What have we done? Let me give you an example of the first month's operation. Normally, we would admit into our hospital from this district about 84 people. In the first month we have already admitted 123. Of these, 55 of them have gone into our out-patient division.

We have 28 out of the hospital and we have 23 remaining but these were ones that cumulated. We estimate that only about 10 percent of these that will come in will go into the state hospital.

Speaking about personnel as we were asked: Within the first month I have been able to put together a staff of 50 composed of two psychiatrists, two residents in psychiatry, young psychiatrists in training, one psychologist and we now have another one since I left.

We have 6 social workers, 3 registered nurses, 1 vocational counsellor, 2 occupational therapists, 3 recreational therapists, and 21 psychiatric aides.

In addition to this we have a training person and the other administrative people like personnel clerks and others needed for backup services.

So that we now have within one month 51 people working. The question was asked what would it take to staff one of these. We propose to handle the 4,000 admissions that we estimate will come in here and probably will be nearer Dr. Ewalt's 6,000 eventually.

We estimate that that would take 8 psychiatrists, 6 residents in psychiatry, 4 psychologists, 2 psychological interns, 11 social workers and we are affiliated with the University of Oklahoma so that we would have about 10 student social workers, 16 registered nurses, and we are a training center for nurses so that we would have about 10 student nurses there, too.

We would have 2 vocational counsellors, 3 occupational therapists, 3 recreational therapists, 32 psychiatric aides, and in addition to that we would have the usual supportive services in administration.

We would actually have 146 people working, 87 professional and technical and 146 gross as against the 51 we now have.

The question was asked a while ago, what the States and the communities are doing. We presented the legislature our budget. Predominantly because this is going to be Oklahoma's teaching center and we hope here to train the cadres that will go out and supply the

professional personnel because the lay people are fine but this is a serious illness and somebody has to supervise them to make sure we are not going off on the wrong thing.

The budget presented was that the Federal Government the first year on the 75 percent match would give us $32,790 but the State would have to put up $678,974. Under our grant, we get $382,000 the next two, $92,000 the next, and $202,000 the next, and down to $44,000.

As that goes down the community and State share will have to go up. So these are the things that I thought you might be interested in. This is a going concern. I have been commissioner or assistant commissioner as the chairman is well aware in three States, in Arkansas, Texas, and Oklahoma.

Since 1948, I have been trying to see whether we couldn't get this thing going. Now that we have gotten it going, I think that it would be catastrophic to decrease in any way. In fact, I think it must be accelerated upward in order to meet the needs of these people.

Mr. Chairman, in Oklahoma we have them backed up now. We have done the footwork. We have gone out now and convinced people that this is the answer and people believe us and I am sure it is.

Now we can't say, "No, you can only have them over here and not over there. You can have one at Norman, Oklahoma. We will cover the lower third of Oklahoma County, Cleveland and McClain, but you can't have one in Osage County," and, incidentally, on that one we hope to take in a county in Kansas.

So you can't stop now. We are in it too far.

Thank you.

Mr. JARMAN. Thank you gentlemen for an excellent presentation.

Doctor Donohue what did you indicate as the target date for completion of your center?

Dr. DONOHUE. We are estimating 11 months for construction. Approximately a year from now we will have the opening. We didn't wait on this. We went ahead and took some of our State hospital area, dedicated it to this and broke it away from the State hospital and set up in business.

We could have done it downtown, but we had the buildings and the facilities and everything right there so that we just started there.

Mr. JARMAN. Do I understand that with the progress you have already made on the staffing problem that you anticipate no real difficulty in fully staffing?

Dr. DONOHUE. It is not going to be a real gung ho thing. It is going to take a little time but we will do it. We are out 1 month and we are this far along. I don't see that it is going to be an extremely difficult thing.

We are having some difficulty getting residents in training because this calls for six residents in training even though we are getting more residents to go into training in psychiatry in this country they are just hard to come by but other than that I don't look for grave problems.

People are interested in going into these, Mr. Chairman.

Mr. JARMAN. As I understood your testimony, you now have nearly one-third of your staff selected?

Dr. DONOHUE. That is right.

Mr. JARMAN. Mr. Rogers?

Mr. ROGERS. Thank you, Mr. Chairman. I have been impressed by the testimony here. What is the cost of this facility?

Dr. DONOHUE. Of the actual facility? When we get it all constructed it is going to cost approximately $900,000 as our estimates are now.

Mr. ROGERS. And what would be the Federal contribution?

Dr. DONOHUE. The Federal contribution in that is $531,000.

Dr. GLASS. The figure on Federal proportion in Oklahoma is 59 percent.

Mr. ROGERS. All one figure?

Dr. GLASS. Yes.

Mr. ROGERS. In establishing the facility, are you, in effect, raiding any other facility?

Dr. DONOHUE. We are taking some out of the mental hospital moving over there but we can afford to do this because we are going to be handling that portion of their patients.

Mr. ROGERS. So that you don't feel that it is a case of pulling people out of another facility where they would leave a vacancy that they have to fill? They don't have to replace those personnel?

Dr. DONOHUE. We wouldn't dare do that because I happen to have them both under my control and if I did that, I would be in trouble on the other side.

I am watching that closely but we are getting them from the outside, Mr. Chairman, and Mr. Rogers.

I think this is going to be a lot easier to staff than the State hospitals. People like to work there and these are going to be "in the community."

Mr. ROGERS. This is what I wondered about, some of these programs, for instance, some of the veterans hospitals. I think their pay scale may not match some of the suggested pay scales in this program and this may vary from State to State. I wonder what the impact will be, for instance, on the veterans hospital with their psychiatric program.

Dr. DONOHUE. I pay more than they do and I can't raid them right now because they have a lot of hidden benefits that we don't have in the state services. They have retirement programs and things so that you have to add this altogether.

Then, Mr. Rogers, I think there is another thing. This psychiatrist and other personnel who like to work in Federal and State, they pretty well stay in their own categories.

In the State service we move around much more than they do in the Federal.

Mr. ROGERS. Are your services paid for?

Dr. DONOHUE. If we can collect. I think this is a wonderful thing. We have never in the State of Oklahoma ever forced anybody. If they could under the law, I have to collect it and this would be the same here.

Mr. ROGERS. Let me ask you this question, and I may want to branch out to others, too. As to the theory, of course, of separating even here the Institute of Mental Health into a separate bureau and now talking

about building mental health facilities separate and apart from regular hospital overall care, is this a good trend over the long run, or don't you think eventually we are going to have to put all of the physical as well as mental care in the overall approach?

Dr. GLASS. What do you mean by long run? Do you mean a time frame of 1980 or something like this?

We do know that the facilities for the physical care are now located and pretty well set. We do know that a number of these general hospitals will elaborate community mental health centers as part of their activities and this is indeed going on now, as you know.

However, the problem is mental health can't wait for this. We need to get centers in now. It may well be that in time they may locate, but I want to point out that you don't have to have them actually together.

You can have an umbrella of services in the same area and all you need to do is have a free passage of patients. The word here is continuity of care, just as we have in the center. You don't have to have all phases of the center under one roof.

You can have the outpatient clinic in one place and the inpatient five miles away, so that we are not concerned with putting them altogether now.

Mr. ROGERS. What I want to know is this: From what I have observed, there seems to be a tendency to make a direct separation of the treatment of mental problems from physical problems.

I just wonder if some efforts should be given to tie the two together, but I would think that some of the physical patients have mental problems along with their physical difficulties because of the physical problem they have.

This doesn't seem to be the approach there and I was wondering if our philosophy is right here. Perhaps this program in itself is throwing us away from bringing comprehensive health care to the community.

Dr. WINSTON. May I comment?

Mr. ROGERS. Yes.

Dr. WINSTON. Of the three approved in Tennessee, two are in connection with general hospitals.

Mr. ROGERS. Do you think this probably is the approach that we should take, to require this program to be put in with general hospitals?

Dr. WINSTON. Of course, some general hospitals do not have the space and cannot expand.

Mr. ROGERS. You are going to build a mental health center. If you are building for them is it advisable to build them with the general hospitals or isn't it?

Dr. WINSTON. It is not inadvisable. I think it is optional.

Mr. ROGERS. Which is more advisable from your experience?

Dr. WINSTON. Again, I don't have any experience because we haven't had any of these built yet. I think there would be testimony to both sides. I think keeping it in the medical stream is healthy, but in other ways it is crippling, too.

Mr. ROGERS. You said your staffing needs for a population of 75,000 has shown that you don't have to follow the old pattern that we had previously.

Has this been expanded? Is this being brought to the attention of people in this field?

Dr. WINSTON. This is the case.

Mr. ROGERS. Has your experience been brought to the attention of people?

Dr. WINSTON. Well, it was in Reader's Digest, I don't know if you call that necessarily brought to the attention of everyone. What I say by traditional patterning is that we don't have this in most state hospitals because we don't have the staffs available and it wasn't out of choice that we had the patterning.

It was out of the necessity. When we opened the new hospital, I had only one other psychiatrist that I could employ, but this did not keep us from getting the patients out through the selection of tranquilizers, et cetera, and the aids who had the feel for people.

Mr. ROGERS. I am talking about the psychiatric society, the mental health association.

Dr. WINSTON. Yes, sir. This is not the unique experience by any means.

Dr. GLASS. Mr. Rogers, there is no traditional pattern. Everyone is experimenting and moving with various kinds of mental health workers, social workers, using their scarce psychiatrists much more in a supervisory relationship than in a one-to-one relationship.

When you say, "Is there a trend in this direction", that is the trend entirely in the direction.

Mr. ROGERS. The reason I asked the question is when the testimony was presented to us when we passed the bill, it was that they envisioned a center of 8 psychiatrists, or it was 10, for 100,000 population.

Now, Dr. Winston tells me it was 75,000 and he treats the population in the area with two. This is quite a change from basic thinking even just a few years ago.

Dr. GLASS. I don't think it was thinking. I think these were guesstimates.

Mr. ROGERS. I would think guesstimates are based on what they felt was necessary. I hope they wouldn't tell us they need 10 psychiatrists for every mental health center and it is going to cost a tremendous sums of money to provide the staffing down to 35 unless it was needed.

I heard of these new ideas coming up but I don't know that they are being actually acted upon by people here in trying to encourage a new approach or think it is easier to say, "I get more money if I say I need 10, although that may not be what I need."

Dr. DONOHUE. We went over this with the National Institute of Mental Health and discussed it at length. The American Psychiatric Association is extremely interested in this and we have the Journal on Hospitals and Community Psychiatry which produces articles constantly on this as do the programs of the American Psychiatric Association but also the people in the National Institute of Mental Health whom I have dealt with. We have worked to come up with new answers and one thing would be what is your caseload, where are you, where are you located.

For instance, this will affect your staffing patterns, too, whether you have a lot of poverty and a low educational area, distances into your hospital, the type of structures you have, how many psycholo-

gists, social workers, and others you have to throw into the fray, but I don't know that there is any real set standard.

At least the National Institute of Mental Health didn't present me with one. They wanted me to prove that I could treat the number of patients that I estimated with what I was asking for the money for.

Mr. ROGERS I presume there would be a minimum?

Dr. DONOHUE. Yes, sir, I think there would be a minimum but I would think this would vary with your proposed caseload and the type of things you could handle.

We are going to take all comers in Oklahoma so that it is going to be different than if you didn't take alcoholics or psychotics or this or that.

We are going to use our hospitals and the National Institute of Mental Health has encouraged that we use our hospitals and as back up services so that these centers don't get filled up.

We are 12 to 16 days on our inpatient stay. If we would extend that and keep the patients there longer, we will fill these up like they have done in other countries so that we wouldn't be able to operate.

It is according to what your back up is going to be; are you going to use full-time psychiatrists and psychologists or have part-time coming in?

There are many factors that will affect your staffing pattern.

Mr. ROGERS. I was thinking of the minimum required and presented to us in the testimony on this whole subject. The figures given which I won't go into on page 101 of our hearings were 10 psychiatrists for a population of 100,000, 8 psychologists, 8 social workers, 19 nurses and so forth.

Dr. DONOHUE. They didn't stick me with that minimum anyway, because I couldn't have found that many and I don't think I needed that many now.

Mr. ROGERS. But this is the point I wanted to develop, that unless we do go into a new approach rather than a set minimum——

Dr. DONOHUE. Mr. Rogers, the National Institute of Mental Health in my dealing with the people and I have seen a lot of them because they have been real interested and we were one of the first off the ground, have been very considerate in going over in detail what we are going to be and have never held me to anything.

I think they have made me prove that I was going to realistically handle these things. I think they are doing a good job.

Mr. ROGERS. What amount of money do you think we should authorize to be appropriated for the continuation of this program?

Dr. DONOHUE. I am not at that level of operation any more but we will have to accelerate it. I know you are going to have to accelerate it because you are going to keep adding to it.

All us guys in business are already in business and then you are going to have to accelerate these new ones coming in.

Dr. GLASS. It is the considered opinion of the National Association involved in this and which has most knowledge about the plans that there needs to be an increase because more centers are coming aboard and we would support the statements that are made that it may well be doubled as to the present 1968 amount of money.

Mr. ROGERS. Should the Hill-Burton law require a psychiatric unit in every hospital?

Dr. GLASS. I think that one of the problems of Hill-Burton is this: For example, let's say there is a 25-bed hospital in a certain area that needs one. If you require them to have a psychiatric unit they may not be able to operate it so you are already requiring something that is functionless to them.

So one would hate to have this legislation restrictive on particularly small hospitals.

Mr. ROGERS. It might not in a 25-bed hospital.

Dr. GLASS. You would have to have a larger hospital.

Dr. WINSTON. I think this new program does away with this.

Mr. ROGERS. To have psychiatric from the hospital?

Dr. WINSTON. From 1963 on. The community mental health center does away with this need for a new Hill-Burton facility, let's say, is my feeling.

Dr. GLASS. The hospital by merging in a number of the services of the community can become the inpatient facility but these negotiations should be left to the community to do. There may be several hospitals that would want to do it, one a Catholic and one a community hospital and so forth, so that I don't believe that we should take every hospital and say, "You must do thus and so."

I think we wouldn't be wise if one hospital wants to specialize in a lot of surgery and someone else does something else. I think it would be unwise to insist that they build a certain number of beds and work to operate a certain number of beds.

Mr. ROGERS. You don't think the problem is such that general hospitals of a reasonable size should have psychiatric beds or treatment?

Dr. GLASS. I think they should be encouraged to and a lot are doing it spontaneously.

Mr. ROGERS. Why should it not be required?

Dr. GLASS. When you require something you have to lay a yardstick against circumstances which we absolutely don't know. There may be three hospitals in an area. One of them has a good psychiatric service which all the psychiatrists logically use. That doesn't mean the one a block away should have the same thing.

Mr. ROGERS. Suppose there is no hospital that has the good psychiatric department.

Dr. GLASS. Then we will have to plan which areas.

Mr. ROGERS. Is this duplicating our program to say we have to build community health centers when it can be incorporated in the hospitals which are going to be built and must be built?

Dr. GLASS. There are hospitals which are going to be renovated. There are a number of areas. For example, you are talking about inpatient services but to our minds the inpatient service is the smallest element.

Mr. ROGERS. I will agree. This may be so but I am saying should that be incorporated. It may not be the largest. It may not need but 25 beds. I don't know.

Dr. GLASS. True, but it may not be the appropriate place to have it.

Mr. ROGERS. Should we just completely disregard the mental health problem in building community hospitals?

Dr. GLASS. On the contrary, I don't think we should disregard it but now community hospitals are entering, as you know, into this program very heavily so we are not disregarding them.

We are inviting them. For example, St. Anthony's Hospital in Oklahoma City has an approved mental health center and are entering into it voluntarily. That doesn't mean that Mercy Hospital three blocks away has to do it.

Dr. DONOHUE. There ought to be some private beds in addition to the community part.

Mr. JARMAN. Mr. Brown.

Mr. BROWN. If you can properly separate treatment of mental illness in community hospitals into prevention which means outpatient care and treatment which means inpaitent care and then, incarceration, definite assignment of a mentally ill patient to a hospital because there is no hope of treatment, what kind of breakdown do you get on that basis, percentage-wise? Where is your need greatest?

Dr. GLASS. Let's say this: We can't agree with your definition because we have treatment as outpatient and treatment as inpatient and day care, but nevertheless, I understand what you mean that if you consider those cases that require prolonged care, institutional care, if you are talking about psychiatric patients and get away from the physically disabled the older patient who needs a supervised living enviroment like a nursing home, if we exclude those and talk about physically able but menatlly ill patients who have to be kept in an institution for a prolonged period, we don't feel it is more than 1 to 2 percent of admissions.

Experience indicates that 1 to 2 percent of admissions would reach such severity as to be kept for that long.

Mr. BROWN. Let me pursue this question just a step further. There is in crime control and prevention a trend away from incarceration and into treatment so to speak, the social approach and now perhaps a trend into prevention.

We are doing this in welfare to some extent. Is there a Federal involvment here in the prevention of mental illness that we are overlooking and merely spending all our funds on treatment?

Dr. DONOHUE. No, all your poverty programs—I was on the discussion of Ozarkia today which crosses some of our area and these things are being well considered. If you are going into the prevention of mental illness you get into a real complicated area, getting into poverty, education, pre-school.

Mr. BROWN. Alcoholism, drugs.

Dr. DONOHUE. You are getting into a cross structure of family relationships, sociological relationships in families and many things which under the present programs are ongoing.

I don't know whether there are letters for them but in general the poverty programs, the Appalachia-Ozarkia type things where we are really going into the redevelopment of our cities and things like this, these in the final analysis would be preventive programs in the mental health field.

You get into the outpatient and actual care and treatment to prevent the individual from getting sicker. Yes, we are doing that. In the Oklahoma Medical Association, for instance, to show you the interest in

this in the State of Oklahoma, we have had two conferences in which the medical association financed a conference to bring in the people who were interested and we had 1,000 come in who work in these various areas in Oklahoma who came in because there is this much interest.

We had one for doctors and had over 200 doctors. There is a marked interest and the American Psychiatric Association working with another grant is training physicians to understand more about psychiatry.

We have Thursday afternoon programs on those because when I went through medical school it was a hit and a lick. So we are shifting this whole thing. You see, there are actually 7 levels in the mental health field. You start down here with 42 percent according to the Joint Commission Report of people going to ministers before they go anywhere.

So, you start with the minister, the police officer, the schoolteacher, and another layer of counsellors, court counsellors and public health nurses and the layer of general physicians who see these people alone and mental hygienic clinics and advisory clinics.

Then you have psychiatrists and then here comes this new mental health center and then you have the State hospital. We have a compendium of service already structured. I agree we need to train the people.

For instance, in Oklahoma now we have a school for police officers. The police officers from Oklahoma City come and spend 2 days working and taking courses in the state hospital, in this area and we also have 14 hours of courses in psychology for them and things like that.

The other day I was talking to them about subsequently having these guys in these cars that make rounds——

Dr. GLASS. I would like to pursue your question. That part of the community mental health center that deals with preventions, the consultation and education, is one of the essential services.

Now, the actual prevention is really indistinguishable from what goes on with all the other programs under welfare and poverty and so forth.

The consultation and education arm of the center meets with those people, police, judges, welfare workers, and others to bring the contribution of the mental health center to them.

Mr. BROWN. Thank you.

Mr. JARMAN. Thank you again, gentlemen, for being with us and for your testimony.

A roll call is in progress so that we will ask for permission to sit again at 1:30 here in this room to conclude the hearing.

The Committee will stand in recess until 1:30 p.m.

(Whereupon, at 12:40 p.m. the hearing recessed to reconvene at 1:30 p.m. the same day.)

AFTER RECESS

(The subcommittee reconvened at 1:30 p.m., Hon. John Jarman, chairman of the subcommittee, presiding.)

Mr. JARMAN. The subcommittee will please come to order.

The House is in session, but we have secured permission to continue hearings during general debate on the bills on the floor of the House

now. Members of our subcommittee are detained on the floor but will be joining us shortly after the hearings, so we will continue with the next witness, Mr. Sandford F. Brandt of the National Association of Mental Health.

Mr. Brandt, we are pleased to have you join us.

STATEMENT OF SANDFORD F. BRANDT, MEMBER OF THE NATIONAL ASSOCIATION FOR MENTAL HEALTH; ACCOMPANIED BY MICHAEL FREELUND, ASSOCIATE DIRECTOR OF THE NATIONAL ASSOCIATION FOR MENTAL HEALTH, NEW YORK CITY

Mr. BRANDT. Thank you, Mr. Chairman.

I am accompanied by Mr. Michael Freelund, associate director of the National Association for Mental Health, New York City.

Mr. Chairman, I am Sandford F. Brandt, and I reside in Norris, Tennessee. I am appearing today in behalf of the National Association for Mental Health. I serve on the legislative and public policy council of NAMH, and I am also first vice president and legislative chairman of the Tennesse Mental Health Association.

In the past, I have served as board member and finance chairman of a community mental health center. I greatly appreciate the oportunity of presenting our views before this subcommittee. I have a prepared statement here for the record and I will read parts of it and skip parts.

The National Association for Mental Health is a volunteer, nonprofit organization with one million members and associated volunteers in 800 chapters throughout the United States. We speak for the more than one and a half million patients in mental hospitals, and for the uncounted other millions being treated as outpatients.

Mr. Chairman, it is our hope that by appearing here today we can, in some measure, alleviate the misery and suffering of the 1 in 10 of us, some 19 million in all, who at one time or another in our lives fall prey to mental illness. I do not have to describe to this committee the magnitude of the mental health problem in this country.

I would, however, like to submit for the record, if the committee is agreeable, this fact sheet prepared by the National Association for Mental Health which more fully describes the problem.

Mr. JARMAN. It will be inserted.

Mr. BRANDT. Thank you.

(The material referred to follows:)

FACTS ABOUT MENTAL ILLNESS

(National Association for Mental Health)

THE EXTENT OF MENTAL ILLNESS

At least 1 person in every 10—19,000,000 in all—has some form of mental or emotional illness (from mild to severe) that needs psychiatric treatment.

There are more people in hospitals with mental illness, at any one time, than with all other diseases combined, including cancer, heart disease, tuberculosis and every other killing and crippling disease.

Mental illness is recognized by doctors to be an important factor in many physical illnesses, even heart disease and tuberculosis. At least 50% of all the millions of medical and surgical cases treated by private doctors and hosiptals have a mental illness complication.

HOW MANY ENTER AND LEAVE MENTAL HOSPITALS?

The latest figures show that over 1,500,000 persons are on the books of public and private mental hospitals, psychiatric services of general hospitals, and Veterans Administration psychiatric facilities. (This includes patients in hospitals at the beginning of the year, plus those admitted during the year.)

One any one of the year about 760,000 persons are under the psychiatric care of these hospitals, including about 150,000 who are not actually in the hospital but are on "trial visit" or a similar form of supervision.

Currently about 800,000 perosns are admitted during the year to public and private mental hospitals and the psychiatric services of general hospitals. Of these, nearly 300,000 have already been hospitalized one or more times.

WHAT ARE CHANCES OF LEAVING A MENTAL HOSPITAL?

With good care and treatment, at least 7 out of 10 patients admitted to a mental hospital can leave partially or totally recovered.

Data from a number of states show that about 75% of those admitted for the first time leave the hospital within the first year.

In the case of the most prevalent mental crippler, schizophrenia, the chances of release within a year for newly admitted patients have jumped from about 20% to about 80% in the last 40 years. The higher rate occurs, however, only when proper treatment is promptly administered.

In the case of two other serious mental illnesses, involutional psychosis and manic depressive psychosis, the chances of recovery or improvement are about 65% and 75%, respectively.

In the past, readmission rates have been as high as 35% of the patients discharged within a year. Recent research has shown that this figure can be reduced to about 10% with continuing and thorough rehabilitation service, including medical, social and vocational after-care.

MENTAL ILLNESS AMONG CHILDREN AND YOUNG ADULTS

Mental illness occurs at all ages, including childhood. It is estimated that there are more than half a million mentally ill children in the United States classified as psychotic or borderline cases. Most of these children are suffering from the psychiatric disorder known as childhood schizophrenia.

Only a very small percentage of the total are receiving any kind of psychiatric treatment.

The latest annual figures show that 24,438 children and young adults were admitted to public mental hospitals for the first hospitalization for serious mental disorder. Of these, 3,247 were *under 15*, and 21,191 were between 15 and 24.

On any given day in that year there were 27,686 children and young adults with serious mental disorders in our public mental hospitals. Of these, 4,547 were under 15 and 23,139 were between 15 and 24.

In private mental hospitals, first admissions of children and young adults totaled 4,636, of which 243 were children under 12 and 4,393 were between 12 and 21 years of age.

Conservatively estimated, an additional 300,000 children under 18 are served in psychiatric clinics each year, for less severe mental disorders.

During a one-week period, psychiatrists in private practice saw about 49,600 children (under 12) and adolescents (12–17 years). This figure represents about 24% of all patients (207,400) seen by psychiatrists in private practice.

CLINIC FACILITIES IN THE COMMUNITY

Last year there were about 2,000 public and private outpatient clinics in the United States. Many of these are part-time, and most of them have long waiting lists.

An estimated one million children and adults are served in these clinics.

Almost half of these clinics are in the northeastern states, principally in urban areas.

The best-informed mental health professionals estimate that a full-time clinic is needed for every 50,000 people. This would mean 3,880, or twice as many as now exist.

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MENTAL HOSPITAL FACILITIES

There are 497 mental hospitals in the United States. They include 244 state hospitals, 45 county hospitals, 41 Veterans Administration neuropsychiatric hospitals, two other Federal hospitals, and 165 private psychiatric hospitals.

Approximately 495 community general hospitals, or about 1 out of every 11, have separate units for treating psychiatric patients. About the same number more admit psychiatric patients to their regular medical facilities.

CARE AND TREATMENT OF MENTAL HOSPITAL PATIENTS

The great majority of patients in state mental hospitals receive only custodial care. Only a small percentage receive intensive psychiatric treatment, even though research has demonstrated that some patients who have been in the hospital as long as 5, 10 or 20 years do recover when they receive intensive treatment. The reason for this situation is that few state hospital systems have the necessary funds to provide adequate staff and equipment for intensive treatment. A key index of this inadequcy is the amount which the hospital spends per day for the maintenance of each patient. (Maintenance covers the salary of all personnel, treatment supplies, plus equipment, food, clothing, and overhead.) Latest figures show that the average daily expenditure for maintenance in public mental hospitals is $6.74 per patient. One state spends as little as $3.18. By contrast, short-term general hospitals spend more than $44 per patient per day, private psychiatric hospitals, $33, and VA psychiatric services, more than $16 per patient per day.

PSYCHIATRISTS: THEIR NUMBER AND DISTRIBUTION

In 1965 the number of practicing psychiatrists totaled about 14,650, providing approximately 721,000 man-hours of work activity per week. However, only 60% of work activity was devoted to direct services to patients, with the remaining time spent in consultation, teaching, administration, and research.

In a recent comprehensive government survey of psychiatrists, in which 88% reported information about themselves, only 9% reported that their major specialty is child psychiatry.

More than half of the nation's psychiatrists are located in five states: 21% in New York, 13% in California, 6% each in Pennsylvania and Massachusetts, and 5% in Illinois; 13% reside in areas which represent 35% of the population. One state has as few as 11 psychiatrists.

COST OF MENTAL ILLNESS

About 2 billion dollars is spent annually for the treatment of mental illness in state, county, Federal and private mental hospitals and in psychiatric units of community general hospitals.

Annual expenditures for community mental health programs (including outpatient clinics) total $112,122,419.

COST OF MENTAL ILLNESS TO INDUSTRY

Business authorities conservatively estimate that the annual loss to industry directly related to emotional disorders is staggering, amounting to many billions of dollars each year.

Mr. BRANDT. The record shows the need for comprehensive mental health services, and I think the fact that the need has been translated into demand for services speaks to the effectiveness of the program which the Congress inaugurated in 1963, which was expanded to include staffing grants in 1965 when the vote in the House was 389 to nothing, and which you are now considering for extension.

The great demand for funds under this program continues. We anticipate that funds presently available will fall far short of the amounts ultimately required.

NAMH knows that hundreds of communities are now planning new community mental health centers in contemplation of Federal support being available for their construction and/or staffing.

In my own State of Tennessee, Governor Ellington has asked the legislature to appropriate an additional $700,000 during the coming biennium to enable the Tennessee Department of Mental Health to help finance the operation of six comprehensive centers.

This amount is in addition to the State's contribution to existing community mental health clinics and also is over and above local funds which, in Tennessee, constitute more than half the operating funds of the community clinics. The total Tennessee budget for State financial assistance to local clinics—just operations; not construction—will more than double during the 3 years ending June 30, 1969.

We have in Tennessee 17 community clinics, and eight of them are planning on going comprehensives, three have already been approved for construction grants, three are in the pipeline, and two in the planning stage.

In Indiana, to cite another example, to date only one comprehensive center has qualified for construction funds under the Federal program. Eleven more centers are in the planning stage. We are informed by the Indiana Mental Health Association, a Division of the National Association, that the State of Indiana has programed $961,000 for comprehensive center construction this year, $1,370,000 in 1968, and another million in 1969—all with the anticipation that equal amounts of Federal matching funds will be available.

We also had a leter from the director of the Indiana Association the other day pointing out that the Indiana General Assembly in order to guarantee the implementation of the Federal program has just created a permanent dedicated source of funds to assist the communities in matching the Federal grants. This is a quarter of a cent of cigarette tax which will produce $3.37 million in the current biennium increasing to half a cent in the biennium in 1969 producing in the order of $6.7 million. That tax will be dedicated to community centers.

It should perhaps be made plain at this point that when we speak of a comprehensive community mental health center we do not necessarily mean a completely new building, built solely for the purpose of housing the essential services.

A most important feature of this program is its flexibility. The "center" concept does not require the housing of all the elements of service under one roof. On the contrary, so long as they are under a single administration, the various components may be separately housed.

We are informed that in only 5 percent of the centers for which construtcion grants have been awarded have the applicants requested funds for a single building to house all the services. The other 95 percent are taking advantage of the opportunity to achieve comprehensive community mental health services by requesting Federal grants to supplement existing services which are separately housed.

If you will pardon again the reference to my home State, the two centers I know most about are Oak Ridge and Knoxville. The Knoxville comprehensive center is being built on land adjoining the University of Tennessee Hospital in Knoxville. The land was con-

tributed by the university. The Oak Ridge Center is on land adjoining the Medical Arts Building and the hospital operated by the Methodist Church.

Mr. JARMAN. You plan six such centers?

Mr. BRANDT. We have three for which construction grants have been approved and three for which we hope to get the grants and two which are in the planning stage.

Mr. JARMAN. Eight?

Mr. BRANDT. Eight altogether, yes. The present State budget is contemplating only six, so somebody is going to have to scrounge around for more money.

We have 17 local clinics and of those 17 eight of them are going comprehensive.

Mr. Chairman, our State and local governments are earnestly and conscientiously trying to do their part. Some are well along and others are just now beginning to set up the ways and means for accomplishing this program. This is understandable when one considers the wide diversity among the States in population spread, finances, geography, and level of development of mental health services. The following examples will illustrate these points.

In Rhode Island a recommendation that the per capita ceiling on State aid for community mental health clinics be raised from 50 cents to $1.50 was made by the Governor's Council on Mental Health in its annual report to the Governor and State legislature.

A Rhode Island law enacted in 1962 places two limits on State aid for these programs. State grants cannot exceed 50 percent of total expenditures for allowed items and they cannot exceed a per capita of 50 cents in the population of the area served by a program.

Until recently, the council said—

> The 50 cents per capita sharing limit has been considered adequate to encourage communities to equally share the cost in providing local mental health programs. While some communities have not taken full advantage of matching the State's 50 cents per capita, other communities have enthusiastically responded. Overmatching by some local communities currently exists, in one community by as much as twice the amount received from the State.

The council said that the 50-cent limitation is no longer adequate and a substantial boost is needed to encourage the continued growth of the community health programs in Rhode Island.

The Illinois Association for Mental Health, a division of the National Association for Mental Health, informs us that Illinois has only just begun to avail itself of the Federal assistance which is crucial to the extension of mental health care throughout the State. Illinois has received only two construction grants and no staffing grants to date although, according to that State's plan for comprehensive mental health services, Illinois has been subdivided into 75 planning units each of which could reasonably be expected to maintain a community mental health center. We are informed by our Illinois division that:

> Illinois is just beginning to "tool up" to take advantage of these Federal funds. It took some time to educate communities as to the availability of Federal assistance and the requirements for eligibility. We have passed permissive legislation in Illinois which allows local governmental units to levy a one mill tax for mental health purposes. Eight counties and one village have successfully passed

this referendum and all, no doubt, are contemplating requests for Federal assistance now that they have a base for a source for matching funds. Three other referenda are scheduled for the month of April.

The State of Colorado has developed in recent years a statewide mental health program of real promise. Their State plan for an extension of comprehensive mental health services to all regions of Colorado has been formally approved. To date, Federal grants to aid in the construction and staffing of community mental health centers have been made to such populous areas as Denver, Boulder, Adams, Arapahoe and Jefferson Counties.

The Colorado Association for Mental Health, our affiliate, wrote us recently as follows:

> Our concern is for the less populous and less financially able regions of the State, where restrictions on the development of facilities imposed by scant budgets and problems of geography make it unlikely that plans for mental health centers can mature into reality without continued Federal assistance.
>
> For example, the first of the new centers in terms of priority is planned to serve Western Slope citizens from a site in Grand Junction. Without matching Federal funding it is doubtful that State and local resources can build and staff that center. On the other hand, with Federal aid for construction and initial staffing specific components of the Western Slope center and for other similar centers, their operation can be financed jointly until the expanding economy and population of Colorado make it possible to fund their operation from State and local revenues.

The foregoing are examples of progress that has been made to date—and progress anticipated in the future—under this farsighted program. It is important, I think, to consider some of the factors that have had the opposite effect, factors which have held us back, factors which explain why many communities are just now getting underway even though the program has been in effect for several years.

To begin with, no community will be given a construction grant or a staffing grant until it has proved to the satisfaction of NIMH that it can and will find the matching funds. This, of course, is essential. In some States, the State mental health authority, is able to help. In others, the centers are sponsored by county or municipal governments. In still others, non-governmental sources of funding predominate.

In my own State, the mix of State, county, city, community chest, patient fee, and private subscription sources of non-Federal funds varies from community to community. The broader the funding base, the longer it takes to round up the funds.

I would like to give as an example the Oak Ridge (Tenn.) Comprehensive Center's funding plan. This is their application for construction grant and it is 100 pages long and has been approved.

During the second year of operation, they expect a total operating budget of $478,000 of which Federal funds will amount to $142,000, State funds are $148,000, and county and municipal are $40,000. The Center will serve a five-county area. Two county courts and the city of Oak Ridge have agreed to put up some money; there are three counties which probably will not be able to contribute much. United Funds are $71,500 and patient fees are $124,000. Oak Ridge is very fortunate in that they have a fairly affluent population to draw on for patient fees. Then there is a balance of $5,000, for a total budget in the second year of $478,000.

So my point is the money comes from a variety of places and it takes time to line it up. Think how long it would take to get the governing

bodies of five rural counties to agree to put up $10,000 each toward the construction of a center. Yet I know a group of dedicated volunteers who have done just that.

I just learned from Dr. Winston, our State mental health commissioner, this morning in this hearing that not only have they agreed to put up the $10,000 each but the entire $50,000 is in the bank and drawing interest waiting for the Federal money.

It has taken them more than 2 years. They are now working on their application. They can't possibly get it approved by the June 30 deadline. My point is simply this: lining up local matching funds, whether you have got to get them out of your State legislature, your city council, your United Fund, or wherever, takes a long time.

Furthermore, there is just plain inertia to be overcome. It is one thing to promote a comprehensive center in a community that already has a mental health outpatient clinic or a State hospital or general hospital with a psychiatric wing and a core of mental health professionals in the area.

It is something else to go into virgin territory, such as in parts of Appalachia, where the closest contact they have with a mental health program of any kind is a remote State hospital, known to the community only by its outdated but prevailing popular reputation as a place where they lock up crazy people and you never see them again.

It is one thing to sell a comprehensive center in a community with a live-wire mental health chapter, with informed and dedicated volunteers who can and will take the time to do the spadework. It is something else to stir the people up where there is not even a local chapter of the mental health association.

Popular acceptance of local responsibility for ministering to the mentally ill takes a long, hard, persistent educational program.

The National Association for Mental Health knows, however, from its affiliated associations that more and more the people of this country want and are willing to support this program.

Now, a witness who preceded me this morning cited the Harris Poll taken just the other day, 2 days ago, in which 47 percent of the people asked by the poll favored expanding Federal aid to set up mental health clinics.

Mr. Chairman, may I insert this newspaper article in the record on the Harris Poll?

Mr. JARMAN. Yes.

Mr. BRANDT. Thank you.

(The information referred to follows:)

[From the New York Post, Apr. 3, 1967]

HARRIS ON THE GREAT SOCIETY: MOST STILL WANT PLANS KEPT

(By Louis Harris)

Public sentiment for cutting back President Johnson's Great Society programs has risen in the past year, but a majority of Americans still want to maintain or expand domestic programs despite the cost of waging war in Vietnam.

In-depth probing of the views of a carefully drawn cross-section of the adult population reveals a highly selective mood about which programs should be expanded, kept or cut back. The results reveal a new priority of domestic issues.

PUBLIC MANDATE ON DOMESTIC PROGRAMS

Expand

Program to curb air pollution
Program to curb water pollution
Aid to set up mental health clinics
Federal scholarships to needy college students
Federal aid to education
Medicare for the aged

Keep as is

Federal housing for low-income families
The Head-Start program
Federal aid in building highways
The war on poverty

Want cut back

Aid for welfare and relief payments
Aid to cities
Aid to provide for adequate commuter trains
The space program
Subsidy payments for farmers

The cutback list includes some new and some old sacred cows. The old New Deal standbys of aid for welfare and relief and subsidy payments to farmers have lost much of their luster. The new programs of aid to cities and commuter transportation simply do not yet command majority support. And the space program support appears to be fading.

In place of these areas the people lay heavy stress on resource and environment conservation (curbing air and water pollution), education (federal aid and an expanded college scholarship program) and health (more Medicare and mental health clinics).

In each of the six expansion areas the college-educated and higher-income people are far more in favor of expanding federal commitments than lower income, less-well-educated people.

A year ago and in the latest Harris Survey, cross-sections of the public were asked:

"In general, because of Vietnam, do you think President Johnson should or should not reduce the size of his programs at home, such as education, poverty and health?

GREAT SOCIETY PROGRAM AT HOME

[In percent]

	1967	1966
Don't reduce	54	72
Reduce	35	22
Not sure	11	6

The cross-section of people in 1,600 homes was asked:

"Besides providing for the military security of the country, the federal government conducts a number of programs in many different areas. For each, tell me if you think it should be expanded, kept as is or cut back."

In the following table, the key to the groupings of the areas is the relationship between the number wanting to expand or to cut back the program.

In analyzing this table the reader should keep in mind the direction of emphasis on the part of the public. In the case of air pollution there are over five times as many people who want to expand as want to cut back.

By the same token on the space program over three times as many people want to cut back spending on space as want to increase it. In contrast in the case of the Head Start program almost as many people want to cut it back as want to expand it, leaving the weight of opinion behind keeping the program as it is.

SPECIFIC DOMESTIC PROGRAMS

[In percent]

	Expand	Keep as is	Cut back	Not sure
Expand:				
Program to curb air pollution	50	31	9	10
Program to curb water pollution	50	35	5	10
Aid to set up mental health clinics	47	39	5	9
Federal scholarships for needy college students	47	38	9	6
Federal aid to education	45	42	10	3
Medicare for the aged	35	51	8	6
Keep as is:				
Federal housing for low-income families	25	48	19	8
The Headstart program	23	33	21	23
Federal aid in highway building	22	51	19	8
The war on poverty	23	37	31	9
Cut back:				
Aid for welfare and relief payments	16	46	31	7
Aid to cities	15	43	26	16
Aid to provide for adequate commuter trains	14	24	29	33
The space program	13	38	42	7
Subsidy payments for farmers	12	34	37	17

Mr. BRANDT. To allow the comprehensive community mental health grants program to die out with the existing authorization would be to deny its benefits, in many cases, to those communities which need it most, those where it takes the longest to get started and where they have the farthest to go.

In one sense, it would reward those places which were already so far along that they could take advantage of the Federal funds with but a little extra effort, and would penalize those which need help the most.

We strongly favor, as we have previously testified, this system which places on the local citizens the burden of initiating the program and, once the Federal support has been phased out, the ultimate responsibility for keeping it going. The grassroots approach always takes longer. But the results are worth it.

The National Association for Mental Health urges this committee to favorably report H.R. 6431.

Thank you.

(Mr. Brandt's prepared statement follows:)

STATEMENT OF SANDFORD F. BRANDT FOR THE NATIONAL ASSOCIATION FOR MENTAL HEALTH

I am Sandford F. Brandt, and I reside in Norris, Tenn. I am appearing today in behalf of the National Association for Mental Health. I serve on the legislative and public policy council of NAMH, and I am also first vice president and legislative chairman of the Tennessee Mental Health Association. In the past, I have served as board member and finance chairman of a community health center. I greatly appreciate the opportunity of presenting our views before this Subcommittee.

The National Association for Mental Health is a volunteer, non-profit organization with one million members and associated volunteers in 800 chapters throughout the United States. We speak for the more than one and a half million patients in mental hospitals, and for the uncounted other millions being treated as outpatients.

Mr. Chairman, it is our hope that by appearing here today we can, in some measure, alleviate the misery and suffering of the 1 in 10 of us who at one time or another in our lives fall prey to mental illness. I do not have to describe to this Committee the magnitude of the mental health problem in this country.

I would, however, like to submit for the record this fact sheet prepared by the National Association for Mental Health which more fully describes the problem.

The record shows the need for comprehensive mental health services, and I think the fact that the need has been translated into demand for services speaks to the effectiveness of the program which the Congresss inaugurated in 1963, and which you are now considering for extension.

The great demand for funds under this program continues. We anticipate that funds presently available will fall far short of the amounts ultimately required.

NAMH knows that hundreds of communities are now planning new community mental health centers in contemplation of federal support being available for their construction and/or staffing.

In may own state of Tennessee, Governor Ellington has asked the legislature to appropriate an additional $700,000 during the coming biennium to enable the Tennessee Department of Mental Health to help finance the operation of six comprehensive centers. This amount is in addition to the State's contribution to existing community mental health clinics and also is over and above local funds which, in Tennessee, constitute more than half the operating funds of the community clinics. The total Tennessee budget for state financial assistance to local clinics—just operations; not construction—will more than double during the three years ending June 30, 1969.

In Indiana, to cite another example, to date only one comprehensive center has qualified for construction funds under the Federal program. Eleven more centers are in the planning stage. We are informed that the State of Indiana has programmed $961,000 for comprehensive center construction this year, $1,370,000 in 1968, and another million in 1969—all with the anticipation that equal amounts of Federal matching funds will be available.

It should perhaps be made plain at this point that when we speak of comprehensive community mental health center we do not necessarily mean a completely new building, built solely for the purpose of housing the essential services.

A most important feature of this program is its flexibility. The "center" concept does not require the housing of all the elements of service under one roof. On the contrary, so long as they are under a single administration, the various components may be separately housed. We are informed that in only 5 percent of the centers for which construction grants have been awarded have the applicants requested funds for a single building to house all the services. The other 95 percent are taking advantage of the opportunity to achieve comprehensive community mental health services by requesting Federal grants to supplement existing services which are separately housed.

Mr. Chairman, our state and local governments are earnestly and conscientiously trying to do their part. Some are well along and others are just now beginning to set up the ways and means for accomplishing this. This is understandable when one considers the wide diversity among the states in population spread, finances, geography, and level of development of mental health services. The following examples will illustrate these points.

In Rhode Island a recommendation that the per capita ceiling on state aid for community mental health clinics be raised from 50 cents to $1.50 was made by the Governor's Council on Mental Health in its annual report to the governor and state legislature.

The council said the 50-cent limit is no longer adequate and a substantial boost is needed to encourage the continued growth of community mental health programs.

A Rhode Island law enacted in 1962 places two limits on state aid for these programs. State grants cannot exceed 50 percent of total expenditures for allowed items and they cannot exceed a per capita of 50 cents in the population of the area served by a program. "Until recently," the council said, "the 50 cents per capita sharing limit has been considered adequate to encourage communities to equally share the cost in providing local mental health programs. While some communities have not taken full advantage of matching the state's 50 cents per capita, other communities have enthusiastically responded. Overmatching by some local communities currently exists, in one community by as much as twice the amount received from the state."

The council said an increase in the state aid formula would "assist those communities who have reached the maximum and it would give an added incentive to the communities who have not."

Stressing that the mental health clinics not only provide direct services but also have an important preventive function, the report said:

"The availability of these services often prevents hospitalization of people needing assistance in the early phase of a mental or emotional problem. Such outpatient services are also valuable to patients discharged from hospitals to prevent re-hospitalization."

Six community mental health centers have been established in Rhode Island. Two of them, in Newport and Washington counties, provides services on a countywide basis. A third serves both Woonsocket and Burrillville. Clinics also are in operation in Warwick, East Providence and Pawtucket. Barrington purchases services for children with mental and emotional problems. Providence and Cranston have established mental health boards but have yet to set up clinics.

The report said that nearly $9 million was spent by state agencies in the past fiscal year for mental health services and that Blue Cross and Physicians Service paid out more than $1 million for the care and treatment of subscribers with mental and emotional problems.

"There is little question," the council said, "that the demand to increase existing services or implement new ones will increase mental health expenditures. This fact cannot be avoided."

The Illinois Association for Mental Health, a division of the National Association for Mental Health, informs us that Illinois has only just begun to avail itself of the Federal assistance which is crucial to the extension of mental health care throughout the state. Illinois has received only two construction grants and no staffing grants to date although, according to that state's plan for comprehensive mental health services, Illinois has been sub-divided into 75 planning units each of which could reasonably be expected to maintain a community mental health center. We are informed by our Illinois division that:

"Illinois is just beginning to 'tool up' to take advantage of these Federal funds. It took some time to educate communities as to the availability of Federal assistance and the Requirements for eligibility. We have passed permissive legislation in Illinois which allows local governmental units to levy a one mill tax for mental health purposes. Eight counties and one village have successfully passed this referendum and all, no doubt, are contemplating requests for Federal assistance now that they have a base for a source for matching funds. Three other referenda are scheduled for the month of April.

"In addition, state legislation has been proposed which would permit state funds to be used as matching funds against Federal construction funds, up to 30%. If enacted this law would go into effect this summer."

The state of Colorado has developed in recent years a statewide mental health program of real promise. Their state plan for an extension of comprehensive mental health services to all regions of Colorado has been formally approved. To date, Federal grants to aid in the construction and staffing of community mental health centers have been made to such populous areas as Denver, Boulder, Adams, Arapahoe and Jefferson Counties.

The Colorado Association for Mental Health, our affiliate, wrote us recently as follows:

"Our concern is for the less populous and less financially able regions of the state, where restrictions on the development of facilities imposed by scant budgets and problems of geography make it unlikely that plans for mental health centers can mature into reality without continued Federal assistance.

"For example, the first of the new centers in terms of priority is planned to serve Western Slope citizens from a site in Grand Junction. Without matching Federal funding it is doubtful that state and local resources can build and staff that center. On the other hand, with Federal aid for construction and initial staffing specific components of the Western Slope center and for other similar centers, their operation can be financed jointly until the expanding economy and population of Colorado make it possible to fund their operation from state and local revenues."

The foregoing are examples of progress that has been made to date—and progress anticipated in the future—under this farsighted program. It is important, I think, to consider some of the factors that have had the opposite effect, factors which have held us back, factors which explain why many communities are just now getting underway even though the program has been in effect for several years.

To begin with, no community will be given a construction grant or a staffing grant until it has proved to the satisfaction of NIMH that it can and will find the matching funds. This, of course, is essential. The pattern of local financing varies from state to state. In some states, the state mental health authority is able to help. In others, the centers are sponsored by county or municipal governments. In still others non-governmental sources predominate.

In my own state, the mix of state, county, city, community chest, patient fee, and private subscription sources of non-Federal funds varies from community to community. The broader the funding base, the longer it takes to round up the funds. Think how long it would take to get the governing bodies of five rural counties to agree to put up $10,000 each toward the construction of a center. Yet I know a group of dedicated volunteers who have done just that. It has taken them more than two years. They are now working on their application. They can't possibly get it approved by the June 30 deadline. My point is simply this: lining up local matching funds, whether you've got to get them out of your state legislature, your city council, your united fund, or wherever, takes time.

Furthermore, there is just plain inertia to be overcome. It is one thing to promote a comprehensive center in a community that already has a mental health outpatient clinic or a state hospital or general hospital with a psychiatric wing and a core of mental health professionals in the area. It is something else to go into virgin territory, such as in parts of Appalachia, where the closest contact they have with a mental health program of any kind is a remote state hospital, known to the community only by its outdated but prevailing popular reputation as a place where they lock up crazy people and you never see them again.

It is one thing to sell a comprehensive center in a community with a live-wire mental health chapter, with informed and dedicated volunteers who can and will take the time to do the spadework. It is something else to stir the people up where there is not even a local chapter of the mental health association.

Popular acceptance of local responsibility for ministering to the mentally ill takes a long, hard, persistent educational program.

The National Association for Mental Health knows, however, from its affiliated associations that more and more the people of this country want and are willing to support this program.

To allow the comprehensive community mental health grants program to die out with the existing authorization would be to deny its benefits, in many cases, to those communities which need it most, those where it takes the longest to get started and where they have the farthest to go. In one sense, it would reward those places which were already so far along that they could take advantage of the Federal funds with but a little extra effort, and would penalize those which need the help the most.

We strongly favor, as we have previously testified, this system which places on the local citizens the burden of initiating the program, and, once the Federal support has been phased out, the ultimate responsibility for keeping it going. The grass roots approach always takes longer. But the results are worth it.

We urge you not to penalize those communities which for one reason or another are just now beginning—or have yet to begin—to get this program moving.

The National Association for Mental Health urges this committee to favorably report HR 6431.

Thank you.

Mr. JARMAN. Mr. Brandt, in line with your testimony and your reference to the responsibility of local citizens, do you feel that somewhere down the line we can actually count on phasing out of Federal support and carrying this financial load by the States?

Mr. BRANDT. Mr. Chairman, I think so.

The evidence that I have seen personally is that the more the program goes, the more the local people get behind it. If I may cite my own State, since I am familiar with it, Dr. Winston pointed out this morning that the budget for his department in Tennessee for the coming biennum has increased more this year than any other time in the history of his department.

My personal observation is once you get started the people won't let it drop. My own family physician said he doesn't know how he got along without our mental health center before we had one.

Mr. JARMAN. You mentioned in your statement Illinois has been divided or subdivided into 75 planning units each of which could reasonably be expected to maintain a community mental health center.

Mr. BRANDT. That is under their State plan.

Mr. JARMAN. That will be a real and continuing responsibility for the communities and for States and I want to get your opinion?

Mr. BRANDT. I certainly think you can count on them. Get it started and they will follow through.

Mr. JARMAN. Mr. Nelsen.

Mr. NELSEN. No questions. Thank you for your statement.

Mr. JARMAN. Well, we thank you, and we appreciate your being with us very much.

Mr. BRANDT. Thank you.

Mr. JARMAN. Our next witness and our final witness in this hearing is Dr. Arthur Brayfield of the American Psychological Association.

I would like to say, Doctor, two bells indicate a rollcall on the floor of the House and when they ring again we will be under pressure to go over and vote but I did want to recognize you.

I understood you felt you could abbreviate your statement?

STATEMENT OF DR. ARTHUR BRAYFIELD, EXECUTIVE OFFICER, AMERICAN PSYCHOLOGICAL ASSOCIATION; ACCOMPANIED BY JOHN J. McMILLAN, ADMINISTRATIVE OFFICER FOR PROFESSIONAL AFFAIRS

Mr. BRAYFIELD. Yes, Mr. Chairman, I had been informed you probably would be needed very shortly before the House and I will try to move right along.

Mr. Chairman, I am Dr. Arthur H. Brayfield. I am executive officer of the American Psychological Association, the national organization of psychologists with 26,000 members, which has its headquarters at 1200 17th Street, NW., Washington, D.C.

I am accompanied by Dr. John J. McMillan, administrative officer for professional affairs. I welcome the opportunity to testify before this subcommittee today in support of H.R. 6431. Psychology and psychologists are deeply involved in mental health services and programs.

As a behavioral science discipline, phychology provides the fundamental basis for the work of all mental health professionals—psychiatrists, social workers, and nurses, as well as psychologists. As a behavorial science profession, psychology contributes a significant share of the manpower available to the field of mental health

Based on data from the National Register of Scientific and Professional Personnel and from NIMH studies, we estimate that in 1964 approximately 8,000 psychologists provided some 13 million man-hours per year of direct clinical services, primarily the diagnosis and treatment of mental disorders, and another 7,500 psychologists spent another 13 million man-hours per year of psychological effort, primarily teaching, and research, related to mental health.

This total of 26 million man-hours compares, for example, to an estimated 27 million man-hours per year contributed by psychiatrists.

The latter profession contributes a consderably higher proportion of its time to direct clinical service, particularly in private practice settings.

It is interesting and relevant to note that psychology is primarily a public service profession, for approximately 85 percent of all psychologists are employed in nonprofit organizations and only 5 or 6 percent are in private practice; the remaining 9 or 10 percent are employed in business and industry.

Thus psychologists are especially likely to be interested in community mental health center programs and, in keeping with their public service tradition, are likely to be a crucial source of manpower particularly if they have free and open access to positions of responsibility and leadership on the basis of individual competence equally with other mental health professions. We believe that manpower will be the critical element in mounting effective community mental health programs.

Mr. Chairman, along the line the questioning took this morning, that is, with respect to manpower, I would like for a minute to extend extemporaneously my remarks about the manpower problem. We in psychology believe this is the critical element. We believe this morning's questioning was highly relevant directly to the point.

The best discussion of this that I have seen is a brilliant and incisive analysis by Mike Gorman in a speech he made in Seattle in December of this past year entitled "Critical Need for Additional Mental Health Manpower," and with your permission I should like to enter it in the record at this point.

Mr. JARMAN. That will be done.

(The statement referred to follows:)

THE CRITICAL NEED FOR ADDITIONAL MENTAL HEALTH MANPOWER

(Speech at State of Washington Conference on Mental Health Training Needs, December 3, 1966, Seattle, Wash., by Mike Gorman, Washington, D.C., Executive Director, National Committee Against Mental Illness)

I want to emphasize here today that the severe shortages of all kinds of psychiatric personnel are the most serious roadblock in our determined efforts to bring intensive psychiatric care to all who need it. Last year, close to four million Americans received treatment for mental illness in state hospitals, general hospitals, outpatient clinics and in the offices of private practitioners, but another two million were turned away because we lacked the treatment personnel to handle them.

Despite the fact that the National Institute of Mental Health has supported the training of 30,000 professionals in the four core disciplines—psychiatry, psychology, social work and nursing—since 1948, we have never been able to catch up with the increasing demand for these people.

For example, approximately 25% of budgeted positions for staff psychiatrists in both state mental hospitals and schools for the mentally retarded still remain unfilled. Many of the filled positions are held by foreign doctors—in a number of states as high as 50% of the total psychiatric complement is made up of foreign born physicians.

According to a recent survey published by the National Institute of Mental Health, 21 state hospitals are without a single psychiatrist, and 91 state hospitals have only one to four psychiatrists.

In "Psychiatric News", the monthly publication of the American Psychiatric Association, an average of 150 positions for psychiatrists are offered each month. Some of these vacancies go unfilled for a year or more.

There is an increasing trend toward the opening of psychiatric units in general hospitals. Last year, a record number of 600,000 psychiatric patients were ad-

mitted to general hospitals. Despite this trend, a recent pilot study made by the NIMH staff disclosed that approximately half of the hospitalized patients in general hospitals have a primary or secondary diagnosis of mental illness, yet only six percent of all physicians and three percent of all nurses in these hospitals have had any psychiatric training.

The next few years will see a fantastic acceleration in the demand for psychiatric personnel.

The Medicare legislation, whose major provisions went into effect on July 1st of this year, authorizes psychiatric services for people over 65 in general hospitals, state hospitals, and private institutions; it also provides, under Part B of Title 18 of the Social Security Act, for psychiatric out-patient services up to $250 a year for the millions of elderly people who have already elected to participate in this phase of the program.

Labor, through the bargaining process, is winning sizeable psychiatric benefits for union members. For example, the contract negotiated by the United Auto Workers, which went into effect on September 1st of this year, covers two and a half million workers and their dependents in 77 major cities for extensive in-patient care and up to $400 a year in out-patient psychiatric services.

However, the greatest demand for mental health professionals is already manifesting itself as new community mental health centers are built under the 1963 Kennedy legislation. The announced goal of that legislation is 2,000 centers by 1975; this will generate a tremendous pressure for additional trained professionals in all disciplines.

A carefully documented 1965 NIMH survey indicates that we will need between 120,000 and 125,000 professionals in the four core disciplines by 1975. We have about 65,000 of these professionals now.

Those of us who were members of the Congressionally-appointed Joint Commission on Mental Illness and Health from 1955 to 1961, and those of us who had the privilege during the ensuing period of participating actively in the drafting of the Kennedy legislation, are absolutely determined that our nation will achieve the aforementioned goals.

Granted the overwhelming need for additional mental health manpower, what do we do about it?

Over the past decade and more, I have listened to scores of speeches and pored through a veritable cascade of articles dealing in the most general terms with the need for innovation and imagination in developing new minds of mental health personnel. I submit that the time for speech-making is over and that, in the words of the late Father Divine, we stop generalizing and begin to "tangibilitate."

Some of this hard thinking and planning has been going on within the various advisory training subcommitees of the National Institute of Mental Health since 1964. These efforts resulted in a document prepared in October of this year by a coordinating panel representing all the mental health training subcommittees which serve the National Institute of Mental Health. In the amount of time at my disposal I cannot present all of the thoughtful, practical recommendations of that panel, but I would like to highlight a few of them because they are highly relevant to the manpower situation here in the state of Washington.

1. There was a clear recognition on the part of the panel that resistances to any changes in current jurisdictional control over mental health manpower training were both fierce and formidible. It was the overwhelming consensus of the members of the NIMH panel that mental health professionals, most of whom are wedded to the status quo, offer little promise in developing and experimenting with new kinds of manpower. For example, leaders of the extant mental health professions frequently restrict their discussions to suggestions for additional categories of sub-professionals—in other words, lower forms of the human species who will be subservient to the professionals and who will, at the same time, increase the status of these professionals.

Noting that "a certain academic atmosphere of reprisal against change in discipline patterns for services and training existed", the coordinating panel recommended substantial research support to projects designed to delineate and propose solutions to the manifold barriers to innovation in training.

2. There was much discussion in the document of the feasibility of establishing a National Mental Health Training Service Center which would concentrate upon both the research necessary to define new manpower roles and upon the support of specific training projects for these people. It was suggested that this

center might be developed along the lines of the Foreign Service Academy, and that the setting of the center or institute might well be within a consortium arrangement of universities. In a further radical departure, the panel proposed that such a center train all categories of mental health personnel together, with the training programs geared to the broadest possible conceptualization of community mental health. In such an experimental, inter-disciplinary center, people in unions, housing, the poverty program, Alcoholics Anonymous, etc., would be brought together to learn and to exchange information as to ways in which people cope with severe stresses without professional help.

3. Support the work of, and do research on the job spectrum of selected individuals such as directors of small town community mental health centers in areas where very little orthodox professional help is available.

4. Integrate mental health training with such broad programs as Manpower Development and Training, Project Head Start, the Office of Economic Opportunity and countless others which are providing limited, directive training so that previously unskilled people can be of service to those in need.

5. Establish career development awards for outstanding individuals who would devote full time and attention to exploiting and exploring innovative ideas related to training.

6. Develop a procedure to promote innovation by establishing a flexible financial pool to provide risk capital for certain types of broad-scale innovation. This recommendation stemmed directly out of the panel's belief that the present rigid mechanisms of support tend to inhibit individuals with creative ideas from applying for grants. It was further suggested that a good deal of mental health training could be done outside of the university setting and that by doing so, one could bypass sterile curricula and academic jurisdictional empires.

At a meeting in November of this year, the National Advisory Mental Health Council devoted an entire day to a discussion of the crisis in mental health manpower, with particular emphasis upon the recommendations of the aforementioned coordinating panel on training. It appointed a subcommittee of three members, and since your own Dr. Charles Strother and I comprised two-thirds of the subcommittee, we came forth with a very strong policy declaration which the Council unanimously adopted:

"In light of the documented need and enormous demand for mental health services, and the momentum of the community mental health centers program, there also is an immediate requirement for strengthening and enlarging the mental health manpower pool through innovative and imaginative development of new manpower sources. This includes the possibility of new types of mental health workers, and the utilization of all educational resources including high schools, junior colleges, universities, technical schools, and graduate programs.

"In order to enlarge the manpower pool, emphasis must be placed on the following: (a) the definition and development of patterns of service that will make optimal use of new types of personnel; (b) the development and financial support of appropriate educational programs for such personnel; (c) the development of methods of supervision that will insure maintenance of adequate professional standards."

I am aware that you have been giving considerable attention to the mental health manpower situation here in Washington. I have recently re-read the texts of the papers of your November, 1963 Discussion in Depth Conference on Mental Health Manpower; I am more impressed today than I was a couple of years ago with the pioneering nature of the thinking at that conference. For example, Dr. Robert Hewitt, then Director of the Western Interstate Commission on Higher Education mental health program, pegged his whole presentation around the point that the existing mental health disciplines excluded thousands of people who could be trained to work with the mentally ill. He proposed a new personnel yardstick: "What are the vital things to do to restore people to the community"? He suggested that we develop new job descriptions which would conform to these realistic needs rather than to an academic delineation of professional and sub-professional roles.

Even more radical and innovative in its thinking was the paper delivered by Dr. Garrett Heyns, then your distinguished Director of the Department of Institutions and now the Executive Director of the Joint Commission on Correctional Manpower and Training. Appropriately entitled "Training for What?", the

Heyns presentation pointed out a number of mental health areas where no training curriculum existed. As as example, he cited the fact that no college curriculum existed to prepare students to function as full time directors of volunteers in either hospital or other mental health settings. In the burgeoning field of industrial therapy, he noted the existence of only one college curriculum, and for recreational leaders only six college curricula. Stressing the vital role of in-service manpower education, he wondered "why there has not been the development of curricula in graduate programs which would more specifically prepare persons to work as directors and instructors in inservice education programs."

Concluding his talk, he suggested that university faculties come out of the ivory tower, visit mental health institutions and agencies to find out what kinds of people were needed, and then work with these agencies in formulating job descriptions and in developing new training curricula.

I am fully aware of the fact that there are a few places in the country where new kinds of personnel are being trained and used quite effectively. In Washington, D.C., where I live, we are using trained housewives whose own children have completed school in key roles in well baby clinics, in our Children's Hospital, etc. In several states in the country—notably Illinois, Indiana and Kansas—child care workers who have had a formal junior college course, or merely intensive on-the-job training, are being used with great success. In New York City, expediters are being used as a personnel bridge between a mental hospital, several neighborhood mental health centers and the ethnic minorities served by these facilities. Arizona is about to launch a program under which it will place hospital-community respresentatives in various parts of the state to serve as a bridge between its one mental hospital and the patients and their families. Several state hospitals are beginning to train and use expediters who will be assigned a specific number of ward patients and will be responsible for interpreting their treatment and other needs to the now remote central administration of the hospital.

These state and local efforts are heartening, but I submit that there is a broad need for a national effort in planning for the recruitment, training and utilization of many new kinds of mental health personnel. At this point in time, very little thinking has gone into this staggering but exciting challenge. However, the Southern Regional Education Board, a compact of 15 Southern states, has not only held an exciting conference on the cooperative regional training of new kinds of mental health personnel, but is also developing hard data on the people being served in the various components of the community mental health program, what specific jobs the helping professions carry out in these centers, and what additional kinds of people are needed to serve present and future patient needs. Later this month, the SREB will hold a conference on the role of the community mental health center in teaching people how to work in community mental health.

In concluding this paper, I would like to share with you some of the challenging new ideas and suggestions which have been developed out of these various conferences within the past year.

The most heartening development has been the formulation of an increasingly precise articulation of what we are looking for when we talk of new kinds of mental health personnel. There is a growing recognition that individuals possessing less than complete professional training can serve an important role in helping persons who are experiencing emotional distress or mental disabilities. In other words, individuals with differing levels of training can provide important services to people in need of help.

At the aforementioned SREB conference, a fairly sophisticated group of more than 60 people involved in training generally agreed that what we are looking for is a middle level mental health worker who can perform many of the tasks now done by professionals. It was pointed out that the concept of the middle level worker had been accepted quite widely in the field of physical medicine over the past decade; the associate nurse, the practical nurse, medical and dental technicians, office assistants, X-ray technicians and other para-medical workers were cited as examples.

Three broad categories of mental health workers were identified by the conference delegates:

1. Innovative roles and functions, i.e. new occupations.
2. Generalists ("Human Services Technicians" was suggested as a possible definition.)
3. Sub-professional.

The designation "sub-professional" is perjorative and condescending in its status implications, and I am most happy that the SREB conference delegates concentrated their major hopes upon the innovative and generalist areas. The fact that these two types of workers are not identified with any single professional group is, to my way of thinking, an enormous virture. Innovation is always difficult; I am fully aware that job descriptions for new types of middle level mental health workers will require a lot of work and experimentation. But, as one conference delegate pointed out, we are not engaged in formulating a description of an all-purpose mental health worker, but rather designing specifications for particular kinds of workers—child care specialists, therapy workers, counsellors of alcoholics, interviewers, data gatherers, nursery school aides, research assistants, and so on.

We are not exactly walking in the wilderness in this area. A questionnaire sent to Mental Health Workers in Florida, VISTA full time workers in West Virginia and assorted workers in other mental health programs revealed the kinds of mental health duties actually being performed now by people who think of themselves as community mental health workers. The training of these people ranges from a high school diploma only to a Master's Degree in a specialty. It is illustrative to list some of the tasks these workers currently perform:

1. Does individual counselling.
2. Does group counselling.
3. Carries out pre- and post-hospital care visits.
4. Makes home visits to families during hospitalization, to patients and families after hospitalization.
5. Leads returned mental patients' group.
6. Assists patients in making financial and other arrangements for transportation to clinics, for living needs, for medication, etc.
7. Assists patients to find living accommodations, homemaker services, etc.
8. Assists patients with legal restoration procedures.
9. Makes case investigations for county judge.
10. Serves as liaison with physicians and county health officers regarding admissions and releases.
11. Does home investigations for hospital staff.
12. Serves as liaison with ministers, welfare officers, employers, vocational counsellors regarding restoration of patients.
13. Works with school staffs—teachers, principals, guidance counsellors—regarding problem children.
14. Serves as liaison between clinic and outlying counties, other agencies, etc.

During the past year, there has been much discussion of the role of the junior or community college in providing training for middle level mental health workers. There are approximately 500 junior colleges in the country now, with a total enrollment of a million and a quarter students. The junior college movement is growing so rapidly that by 1972 it is predicted that more than two million students will be enrolled in these colleges. Furthermore, many junior colleges are adding a wide variety of occupational training programs to their curricula. For example, 180 colleges now offer a two-year Associate Degree in Nursing program; thousands of graduates have already been placed in hospitals throughout the country.

Providing the training is only the first step in this massive effort. A number of training directors at the SREB conference pointed out that until mental health agencies provided positions with sufficient status and adequate salaries, recruitment would continue to be difficult. For example, Dr. John E. True, Associate Director of the Purdue University experimental two-year program for mental health workers, pointed out that his program had not been flooded with applicants.

A number of conference delegates emphasized the necessity for a more aggressive recruitment program among married women, domestic workers, the unskilled and the educational drop-outs. Poverty and juvenile delinquency programs in various parts of the nation use many of these people to excellent advantage, but the mental health field is still too rigid and stuffy to seek converts from these groups.

Finally, for the purpose of further discussion at this meeting, I submit for your attention a shopping list of steps which must be taken in the next few years if we are to recruit the thousands of mental health workers we need in our vastly expanding mental health programs:

1. A more incisive analysis of the total personnel needs in mental health is required for a clearer understanding of the specific contributions which can be made by middle level mental health workers.

2. A great deal of further work is needed in sharpening the role definition and specific competencies of the mental health worker. This is particularly necessary for the generalist, or "people worker", as he was described at the SREB conference.

3. The problem of establishing uniform standards of training and licensing or certification of the graduate must be squarely faced. Rigid Civil Service and personnel standards must be opened to new job classifications.

4. A major task involves improving the image of the mental health worker. Dr. Norman C. Harris, Professor of Technical Education at the University of Michigan, remarked recently that despite the great national need for semi-professional and technical workers, these occupations were still down-graded in our society. As he said:

"This lack of status exacerbates the problem and even where community colleges have provided excellent facilities and instrumental programs, enrollments are seldom up to expectations."

It has been suggested that voluntary agencies such as the National Association for Mental Health take steps to correct the distorted and out-dated images the general public has of people working in a mental health setting. One specific proposal which deserves serious consideration is that a sampling survey of high school students and their families be made to determine their attitudes toward these potential mental health worker jobs.

Accomplishing the aforementioned bill of particulars will not be easy, but it can and it *must* be done. Dr. Kenneth Skaggs, a specialist in occupational curriculums with the American Association of Junior Colleges, summed up our present position and our future potential very nicely in a recent address to training leaders:

"We have no place to go but forward. We cannot go back and I think that we all need to realize that as the needs of society begin to crystallize, somebody is going to do the job, and God forbit that inappropriate people do the job. And unless we in the professions and we in education, the appropriate people do it, somebody else will and we will probably not like the results. We have no place to go but in the positive implementation of these things we have been talking about."

Mr. BRAYFIELD. Mr. Gorman, in that speech, set out the dimensions of the problem and recommended fundamental changes in approach. One of the things that interested us most was that he was critical, highly critical, I might say, in the matter of conservative professional leadership. He pointed to jurisdictional disputes and pointed to the fact that training programs in universities had been slow to change and in general he said that the professions were not meeting adequately their responsibilities.

We were so impressed by the statement we sent it out to more than 200 graduate departments of psychology. There have been jurisdictional disputes. In 1963, for example, it was necessary for psychologists to wrestle with NIMH over regulations for the 1963 legislation because they did not make possible for other nonpsychiatric mental health professionals to have leadership responsibilities in that program.

Fortunately, the picture is changing and the 1965 legislation in its legislative history explicitly recognized that positions of leadership should be filled on the basis of competence, not the basis of professional discipline.

I was interested in Dr. Donohue's presentation because he and I have had the pleasure of working together over the last several years. I remember our first exchange after serving on a committee for some time, he said, "You don't talk like a psychiatrist." I was pleased to be able to say to him, "You don't talk like a psychiatrist."

This is a development that is taking place.

I also note that staffing patterns advocated by Mr. Jones on behalf of HEW in 1963 in the hearing record of that time have gone by the boards as some of the testimony today indicated. But manpower is indeed in its conventional dimensions a critical problem. Psychologists, for example. We produce about 1,000 Ph. D's a year. Over the next 10 years our best estimate is it will require all of these Ph. D. psychologists simply to staff the teaching and research positions in the institutions of higher education.

This certainly means that in psychology we may not be able to make the kind of contribution that we will be expected to make. Community mental health centers do not present the only mental health professional personnel service needs. For example, the VA needs about 100 or 200 psychologists each year and the State hospitals are miserably staffed in the sense of having adequate numbers, and special clinics report the same thing, and I think the important thing to note, as questioning by Mr. Brown indicated earlier, is that there are other areas of human service that are draining off manpower.

I was down in Texas recently and the State education authority there had just issued a call for one year for 1,200 school psychologists to be added in that State. School psychology is the most rapidly growing area of psychology. You can't begin to fill the needs.

Correctional psychology, work with children, the recent Gibbon's bill calling for training of 50,000 additional child development school personnel, all indicate to us that as far as psychology is concerned we do indeed have a major manpower problem which would lead me to recommend that the NIMH training support stipend program in psychology be increased by at least a factor of five, and this is on the basis of some considered study of their present program and needs for the future.

We have an interest in new programs. In Florida, for example, Dr. Louis Cohen at the University of Florida has recently started a program for the training of mental health workers with bachelor's degrees. We have also coming up this month a jointly sponsored conference with the National Association of Social Workers which is devoted entirely to use of nonprofessional indigenous personnel in mental health capacities.

Our concern with the community mental health program has been evidenced, for example, by the adoption of the association's official position paper entitled, "The Community and the Community Mental Health Center," which is widely distributed and attracts great public interest and which I thought, in preparing this testimony, was perhaps quite relevant to the legislation under consideration and after hearing the questions of the last 2 days I would say not only is it relevant but extremely important because we have really been hearing about a quite conservatively oriented community health program and I am pleased to say I believe our approach is considerably more progressive than what is represented to date.

With your permission, Mr. Chairman, I would respectfully request that our paper be made a part of the official hearing record.

(The material referred to follows:)

The Community and the Community Mental Health Center

By M. Brewster Smith [1] and Nicholas Hobbs [2]

(This statement was adopted on March 12, 1966, by the Council of Representatives as an official position paper of the American Psychological Association)

Throughout the country, state and communities are readying themselves to try the "bold new approach" called for by President John F. Kennedy to help the mentally ill and, hopefully, to reduce frequency of mental disorders. The core of the plan is this: to move the care and treatment of the mentally ill back into the community so as to avoid the needless disruption of normal patterns of living, and the estrangement from these patterns, that often come from distant and prolonged hospitalization; to make the full range of help that the community has to offer readily available to the person in trouble; to increase the likelihood that trouble can be spotted and help provide early when it can do the most good; and to strengthen the resources of the community for the prevention of mental disorder.

The community-based approach to mental illness and health attracted national attention as a result of the findings of the Joint Commission on Mental Illness and Health that was established by Congress under the Mental Health Study Act of 1955. After 5 years of careful study of the nation's problems of mental illness, the Commission recommended that an end be put to the construction of large mental hospitals and that a flexible array of services be provided for the mentally ill in settings that disrupt as little as possible the patient's social relations in his community. The idea of the comprehensive community mental health center was a logical sequel.

In 1962, Congress appropriated funds to assist states in studying their needs and resources as a basis for developing comprehensive plans for mental health programs. Subsequently, in 1963, it authorized a a substantial Federal contribution toward the cost of constructing community mental health centers proposed within the framework of state mental health plans. It appropriated $35 million for use during fiscal year 1965. The authorization for 1966 is $50 million and for 1967, $65 million. Recently, in 1965, it passed legislation to pay part of the cost of staffing the centers for an initial period of 5 years. In the meantime, 50 states and three territories have been drafting programs to meet the challenge of this imaginative sequence of Federal legislation.

In all the states and territories, psychologists have joined with other professionals, and with nonprofessional people concerned with mental health, to work out plans that hold promise of mitigating the serious national problems in the area of human well-being and effectiveness. In their participation in this planning, psychologists have contributed to the medley of ideas and proposals for translating the concept of comprehensive community mental health centers into specific programs. Some of the proposals seem likely to repeat past mistakes. Others are fresh, creative, stimulating innovations that exemplify the "bold new approach" that is needed.

Since the meaning of a comprehensive community mental health center is far from self-evident, the responsible citizen needs some guidelines or principles to help him assess the adequacy of the planning that may be under way in his own community, and in which he may perhaps participate. The guidelines and discussion that are offered here are addressed to community leaders who face the problem of deciding how their communities should respond to the opportunities that are opened by the new Federal and state programs. In drafting what follows, many sources have been drawn upon: the monographs and final report of the Joint Commission, testimony presented to Congress during the consideration of relevant legislation, official brochures of the National Institute of Mental Health, publications of the American Psychiatric Association, and recommenda-

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tions from members of the American Psychological Association who have been involved in planning at local, state, and national levels.

The community mental health center, 1966 model, cannot be looked to for a unique or final solution to mental health problems: varied patterns will need to be tried, plans revised in the light of evaluated experience, rigidities avoided. Even as plans are being drawn for the first comprehensive centers under the present Federal legislation, still other bold approaches to the fostering of human effectiveness are being promulgated under the aegis of education and of economic opportunity programs. A single blueprint is bound to be inadequate and out of date at the moment it is sketched. The general approach underlying these guidelines may, it is hoped, have somewhat more enduring relevance.

Throughout, the comprehensive community mental health center is considered from the point of view of members of a community who are seeking good programs and are ultimately responsible for the kind of programs they get. The mental health professions are not to be regarded as guardians of mental health, but as agents of the community—among others—in developing and conserving its human resources and in restoring to more effective functioning people whose performance has been impaired. Professional people are valuable allies in the community's quest for the health and well-being of its members, but the responsibility for setting goals and major policies cannot be wisely delegated.

COMMUNITY INVOLVEMENT AND COMMUNITY CONTROL

For the comprehensive community mental health center to become an effective agency of the community, community control of center policy is essential. The comprehensive community mental health center represents a fundamental shift in strategy in handling mental disorders. Historically, and still too much today, the preferred solution has been to separate the mentally ill person from society, to put him out of sight and mind, until, if he is lucky, he is restored to normal functioning. According to the old way, the community abandoned its responsibility for the mental patient to the distant mental hospital. According to the new way, the community accepts responsibility to come to the aid of the citizen who is in trouble. In the proposed new pattern, the person would remain in his own community, often not even leaving his home, close to family, to friends, and to the array of professional people he needs to help him. Nor would the center wait for serious psychological problems to develop and be referred. Its program of prevention, detection, and early intervention would involve it in many aspects of community life and in many institutions not normally considered as mental health agencies: the schools, churches, playgrounds, welfare agencies, the police, industry, the courts, and community councils.

This spread of professional commitment reflects in part a new conception of what constitutes mental illness. The new concept questions the appropriateness of the term "illness" in this context, in spite of recognition that much was gained from a humanitarian viewpoint in adopting the term. Mental disorders are in significant ways different from physical illnesses. Certainly mental disorder is not the private misery of an individual; it often grows out of and usually contributes to the breakdown of normal sources of social support and understanding, especially the family. It is not just an individual who has faltered; the social systems in which he is embedded through family, school, or job, through religious affiliation or through friendship, have failed to sustain him as an effective participant.

From this view of mental disorder as rooted in the social systems in which the troubled person participates, it follows that the objective of the center staff should be to help the various social systems of which the community is composed to function in ways that develop and sustain the effectiveness of the individuals who take part in them, and to help these community systems regroup their forces to support the person who runs into trouble. The community is not just a catchment area from which patients are drawn; the task of a community mental health center goes far beyond that of purveying professional services to disordered people on a local basis.

The more closely the proposed centers become integrated with the life and institutions of their communities, the less the community can afford to turn over to mental health professionals its responsibility for guiding the center's policies. Professional standards need to be established for the centers by Federal and state authorities, but goals and basic policies are a matter for local control. A broadly based responsible board of informed leaders should help to ensure that the center serves in deed, not just in name, as a focus of the Com-

munity's varied efforts on behalf of the gerater effectiveness and fulfillment of all its residents.

RANGE OF SERVICES

The community mental health center is "comprehensive" in the sense that it offers, probably not under one roof, a wide range of services, including both direct care of troubled people and consultative, educational, and preventive services to the community. According to the administrative regulations issued by the United States Public Health Service, a center must offer five essential services to qualify for Federal funds under the Community Mental Health Centers Act of 1963: (*a*) *inpatient care* for people who need intensive care or treatment around the clock; (*b*) *outpatient care* for adults, children, and families; (*c*) *partial hospitalization:* at least day care and treatment for patients able to return home evenings and weekends; perhaps also night care for patients able to work but needing limited support or lacking suitable home arrangement; (*d*) *emergency care* on a 24-hour basis by one of the three services just listed; and (*e*) *consultation and education* to community agencies and professional personnel. The regulations also specify five additional services which, together with the five essential ones, "complete" the comprehensive community mental health program: (*f*) *diagnostic service;* (*g*) *rehabilitative service* including both social and vocational rehabilitation; (*h*) *precare and aftercare,* including screening of patients prior to hospital admission and home visiting or halfway houses after hospitalization; (*i*) *training* for all types of mental health personnel; and (*j*) *research and evaluation* concerning the effectivenes of programs and the problems of mental illness and its treatment.

That the five essential services revolve around the medically traditional inpatient-outpatient core may emphasize the more traditional component of the comprehensive center idea somewhat at the expense of full justice to the new conceptions of what is crucial in community mental health. Partial hospitalization and emergency care represent highly desirable, indeed essential, extensions of the traditional clinical services in the direction of greater flexibility and less disruption in patterns of living. Yet the newer approach to community mental health through the social systems in which people are embedded (family, school, neighborhood, factory, etc.) has further implications. For the disturbed person, the goal of community mental health programs should be to help him and the social systems of which he is a member to function together as harmoniously and productively as possible. Such a goal is more practical, and more readily specified, than the elusive concept of cure, which misses the point that for much mental disorder the trouble lies not within the skin of the individual but in the interpersonal systems through which he is related to others. The emphasis in the regulations upon consultation and public education goes beyond the extension of direct patient services to open wide vistas for imaginatve experimentation.

The vanguard of the community approach to mental health seeks ways in which aspects of people's social environment can be changed in order to improve mental health significantly through impact on large groups. Just as a modern police or fire department tries to prevent the problems it must cure, so a good mental health center would look for ways of reducing the strains and troubles out of which much disorder arises. The center might conduct surveys and studies to locate the sources of these strains; it might conduct training programs for managers, for teachers, for ministers to help them deal with the problems that come to light. By providing consultation on mental health to the governing agencies of the community, to schools, courts, churches, to business and industry, the staff of the center can bring their special knowledge to bear in improving the quality of community and family life for all citizens. Consultation can also be provided to the state mental hospitals to which the community sends patients, to assist these relics of the older dispensation in finding a constructive place in the new approach to mental health. Preferably, revitalized state hospitals will become integral parts of the comprehensive service to nearby communities.

In performing this important and difficult consultative role, the mental health professionals of the center staff do not make the presumptuous and foolish claim that they know best how the institutions of a community should operate. Rather, they contribute a special perspective and special competencies that can help the agencies and institutions of community life—the agencies and institutions through which people normally sustain and realize themselves—find ways in which to perform their functions more adequately. In this endeavor, the center staff needs to work in close cooperation with other key agencies that share a concern

with community betterment but from different vantage points: councils of social agencies, poverty program councils, labor groups, business organizations, and the like. To promote coordination, representatives of such groups should normally be included in the board responsible for the center's policies.

Communities may find that they want and need to provide for a variety of services not specifically listed among the additional services in the regulations issued by the United States Public Health Service: for example, a special service for the aged, or a camping program, or, unfortunately, residences for people who do not respond to the best we can do for them. The regulations are permissive with respect to additional services, and communities will have to give close and realistic attention to their own needs and priorities. For many rural areas, on the other hand, and for communities in which existing mental health services are so grossly inadequate that the components of a comprehensive program must be assembled from scratch, the present regulations in regard to "essential services" may prove unduly restrictive. Communities without traditions of strong mental health services may need to start with something short of the full, prescribed package. So long as their plan provides for both direct and indirect services, goes beyond the traditional inpatient-outpatient facility, and involves commitment to movement in the direction of greater comprehensiveness, the intent of the legislation might be regarded as fulfilled.

Many of the services that are relevant to mental health will naturally be developed under auspices other than the comprehensive center. That is desirable. Even the most comprehensive center will have a program that is more narrowly circumscribed than the community's full effort to promote human effectiveness. What is important is that the staff of the center be in good communication with related community efforts and plan the center's own undertakings so as to strengthen the totality of the community's investments in the human effectiveness of its members.

FACILITIES

Facilities should be planned to fit a program and not vice versa. The comprehensive community mental health center should not be thought of as a place, building, or collection of buildings—an easy misconception—but as a people-serving organization. New physical facilities will necessarily be required, but the mistake of constructing large, congregate institutions should not be repeated. The danger here is that new treatment facilities established in medical centers may only shift the old mental hospital from country to town, its architecture changed from stone and brick to glass and steel. New conceptions are needed even more than new facilities.

Small units of diverse design reflecting specific functions and located near users or near other services (such as a school or community center) might be indicated and can often be constructed at a lesser cost than a centralized unit linked to a hospital. For example, most emotionally disturbed children who require residential treatment can be effectively served in small residential units in a neighborhood setting removed from the hospital center. Indeed, there is the possibility that the hospital with its tense and antiseptic atmosphere may confirm the child's worst fears about himself and set his deviant behavior.

Each community should work out the pattern of services and related facilities that reflects its own problems, resources, and solutions. The needs and resources of rural areas will differ radically from those of urban ones. Every state in the nation has its huge mental hospitals—grim monuments to what was once the latest word in treatment of the mentally ill, and a major force in shaping treatment programs ever since. It should not be necessary to build new monuments.

CONTINUITY OF CONCERN

Effective community action for mental health requires continuity of concern for the troubled individual in his involvements with society, regardless of awkward jurisdictional boundaries of agencies, institutions, and professions. A major barrier to effective mental health programing is the historical precedent of separating mental health services from other people-serving agencies—schools, courts, welfare agencies, recreational programs, etc. This is partly a product of the way of thinking that follows from defining the problem as one of illness and thus establishing the place of treatment and the professional qualifications required to treat it. There are thus immense gaps in responsibility for giving help to people in trouble. Agencies tend to work in ignorance of each other's pro-

grams, or at cross purposes. For example, hospital programs for emotionally disturbed children often are operated with little contact with the child's school; a destitute alcoholic who would be hospitalized by one community agent is jailed by another.

Current recommendations that a person in trouble be admitted to the total mental health system and not to only one component of it fall short of coming to grips with the problem. The laudable aim of these recommendations is to facilitate movement of a person from one component to another—from hospital to outpatient clinic, for example, within minimum red-tape and maximum communication among the professional people involved. Such freedom of movement and of communication within the mental health system is much to be desired. But freedom of movement and of communication between systems is quite as important as it is within a system.

No one system can comprise the range of mental health concerns to which we are committed in America, extending from serious neurological disorders to include the whole fabric of human experience from which serious—and not so serious—disorders of living may spring. Mental health is everyone's business, and no profession or family of professions has sufficient competence to deal with it whole. Nor can a mental health center, however comprehensive, encompass it. The center staff can and should engage in joint programing with the various other systems with whom "patients" and people on the verge of trouble are significantly involved—school, welfare, industry, justice and the rest. For such joint programing to reflect the continuity of concern for the individual that is needed, information must flow freely among all agencies and systems. The staff of the center can play a crucial role in monitoring this flow to see to it that the walls that typically restrict communication between social agencies are broken down.

REACHING THOSE WHO MOST NEED HELP

Programs must be designed to reach the people who are hardly touched by our best current efforts, for it is actually these who present the major problems of mental health in America. The programs of comprehensive community mental health centers must be deliberately designed to reach all of the people who need them. Yet the forces generated by professional orthodoxies and by the balance of public initiative or apathy in different segments of the community—forces that have shaped current model community mental health programs—will tend unless strenuously counteracted to restrict services to a favored few in the community. The poor, the dispossessed, the uneducated, the poor treatment risk, will get less service—and less appropriate service—than their representation in the community warrants, and much, much less service than their disproportionate contribution to the bedrock problem of serious mental illness would demand.

The more advanced mental health services have tended to be a middle-class luxury; chronic mental hospital custody a lower-class horror. The relationship between the mental health helper and the helped has been governed by an affinity of the clean for the clean, the educated for the educated, the affluent for the affluent. Most of our therapeutic talent, often trained at public expense, has been invested not in solving our hard-core mental health problem—the psychotic of marginal competence and social status—but in treating the relatively well-to-do educated neurotic, usually in an urban center. Research has shown that if a person is poor, he is given some form of brief, mechanical, or chemical treatment; if his social, economic, and educational position is more favored, he is given long-term conversational psychotherapy. This disturbing state of affairs exists whether the patient is treated privately or in a community facility, or by a psychiatrist, psychologist, or other professional person. If the community representatives who take responsibility for policy in the new community mental health centers are indignant at this inequity, their indignation would seem to be justified on the reasonable assumption that mental health services provided at public expense ought to reach the people who most need help. Although regulations stipulate that people will not be barred from service because of inability to pay, the greatest threat to the integrity and usefulness of the proposed comprehensive centers is that they will nonetheless neglect the poor and disadvantaged, and that they will simply provide at public expense services that are now privately available to people of means.

Yet indignation and good will backed with power to set policy will not in themselves suffice to bring about a just apportionment of mental health services. In-

ventiveness and research will also be indispensable. Even when special efforts are made to bring psychotherapy to the disturbed poor, it appears that they tend not to understand it, to want it, or to benefit from it. They tend no to conceive of their difficulties in psychological terms or to realize that talk can be a "treatment" that can help. Vigorous experimentation is needed to discover ways of reaching the people whose mental health problems are most serious. Present indications suggest that methods hold most promise which emphasize actions rather than words, deal directly with the problems of living rather than with fantasies, and meet emergencies when they arise without interposing a waiting list. Much more attention should also be given to the development of nonprofessional roles for selected "indigenous" persons who in numerous ways could help to bridge the gulf between the world of the mental health professional and that of the poor and uneducated where help is particularly needed.

INNOVATION

Since current patterns of mental health service are intrinsically and logistically inadequate to the task, responsible programming for the comprehensive community mental health center must emphasize and reward innovation. What can the mental health specialist do to help people who are in trouble? A recent survey of 11 most advanced mental health centers, chosen to suggest what centers-in-planning might become, reveals that the treatment of choice remains individual psychotherapy, the 50-minute hour on a one-to-one basis. Yet 3 minutes with a sharp pencil will show that this cannot conceivably provide a realistic basis for a national mental health program. There simply are not enough therapists—nor will there ever be—to go around, nor are there enough hours, nor is the method suited to the people who consistute the bulk of the problem—the uneducated, the inarticulate. Given the bias of existing facilities toward serving a middle-class clientele, stubborn adherence to individual psychotherapy when a community could find and afford the staff to do it would still be understandable if there were clear-cut evidence of the superior effectiveness of the method with those who find it attractive or acceptable. But such evidence does not exist. The habits and traditons of the mental health professions are not a good enough reason for the prominence of one-to-one psychotherapy, whether by psychiatrists, psychologists, or social workers, in current practice and programing.

Innovations are clearly required. One possibility with which there has been considerable experience is group therapy; here the therapist multiplies his talents by a factor of six or eight. Another is crisis consultation: a few hours spent in active intervention when a person reaches the end of his own resources and the normal sources of support run out. A particularly imaginative instance of crisis consultation in which psychologists have pioneered is the suicide-prevention facility. Another very promising innovation is the use under professional direction of people without professional training to provide needed interpersonal contact and communication. Still other innovations, more radical in departure from the individual clinical approach, will be required if the major institutional settings of youth and adult life—school and job—are to be modified in ways that promote the constructive handling of life stresses on the part of large numbers of people.

Innovation will flourish when we accept the character of our national mental health problem and when lay and professional people recognize and reward creative attempts to solve it. Responsible encouragement of innovation, of course, implies commitment to and investment in evaluation and research to appraise the merit of new practices.

CHILDREN

In contrast with current practice, major emphasis in the new comprehensive centers should go to services for children. Mental health programs tend to neglect children, and the first plans submitted by states were conspicuous in their failure to provide a range of services to children. The 11 present community programs described as models were largely adult-oriented. A recent (1965) conference to review progress in planning touched occasionally and lightly on problems of children. The Joint Commission on Mental Illness and Health bypassed the issue; currently a new Joint Commission on Mental Health of Children is about to embark upon its studies under Congressional auspices.

Most psychiatric and psychological training programs concentrate on adults,

Individual psychotherapy through talk—the favored method in most mental health programs—is best suited to adults. What to do with an enraged child on a playground is not normally included in curricula for training mental health specialists. It would seem that our plans and programs are shaped more by our methods and predilections than by the problems to be solved.

Yet an analysis of the age profile of most communities—in conjunction with this relative neglect—would call for a radically different allocation of money, facilities, and mental health professionals. We do not know that early intervention with childhood problems can reduce later mental disorder, but it is a reasonable hypothesis, and we do know that the problems of children are receiving scant attention. Sound strategy would concentrate our innovative efforts upon the young, in programs for children and youth, for parents, and for teachers and others who work directly with children.

The less than encouraging experience of the child guidance clinic movement a generation and more ago should be a stimulus to new effort, not an occasion for turning away from services to children. The old clinics were small ventures, middle-class oriented, suffering from most of the deficiencies of therapeutic approach and out-reach that have been touched upon above. A fresh approach to the problems of children is urgently needed.

We feel that fully half of our mental health resources—money, facilities, people—should be invested in programs for children and youth, for parents of young children, and for teachers and others who work directly with children. This would be the preferable course even if the remaining 50% would permit only a holding action with respect to problems of adults. But our resources are such that, if we care enough, we can move forward on both fronts simultaneously.

The proposal to place the major investment of our mental health resources in programs for children will be resisted, however much sense it may make, for it will require a thoroughgoing reorientation of the mental health establishment. New facilities, new skills, new kinds of professional people, new patterns for the development of manpower will be required. And new and more effective ways must be found to reach and help children where they are—in families and schools—and to assist these critically important social systems in fostering the good development of children and in coming to the child's support when the developmental course goes astray. This is one reason why community leaders and other nonprofessionals concerned with the welfare and development of people should be centrally involved in establishing the goals of community mental health centers. They can and should demand that the character of the new centers be determined not by the present habits and skills of professional people but by the nature of the problem to be solved and the full range of resources available for its solution.

PLANNING FOR PROBLEM GROUPS THAT NOBODY WANTS

As a focus for community planning for mental health, the comprehensive center should assure that provision is made to deal with the mental health component in the problems of various difficult groups that are likely to fall between the stools of current programs. Just as good community programming for mental health requires continuity of concern for the troubled individual across the many agencies and services that are involved with him, so good programing also requires that no problem groups be excluded from attention just because their problems do not fit neatly into prevalent categories of professional interest, or because they are hard to treat.

There are a number of such groups of people, among whom problems of human ineffectiveness are obivous, yet whose difficulties cannot accurately or helpfully be described as mainly psychological: for example, addicts, alcoholics, the aging, delinquents, the mentally retarded. It would be presumptuous folly for mental health professionals to claim responsibility for solving the difficult social and biological problems that are implicated in these types of ineffectiveness. But it would also be irresponsible on the part of persons who are planning community mental health programs not to give explicit attention to the adequacy of services being provided to these difficult groups and to the adequacy of the attack that the community is making on those aspects of their problems that are accessible to community action.

Recently, and belatedly, national attention has been focussed on the mentally retarded. This substantial handicapped group is likely to be provided for outside the framework of the mental health program as such, but a good community

mental health plan should assure that adequate provision is in fact made for them, and the comprehensive center should accept responsibility for serving the mental health needs of the retarded and their families.

Some of the other problem groups just mentioned—e.g., the addicts and alcoholics—tend to get left out partly because treatment by psychiatric or psychological methods has been relatively unproductive. Naturally, the comprehensive center cannot be expected to achieve magical solutions where other agencies have failed. But if it takes the approach advocated here—that of focusing on the social systems in which problem behavior is embedded—it has an opportunity to contribute toward a rational attack on these problems. The skills that are required may be more those of the social scientist and community change agent than those of the clinician or therapist.

In planning its role with respect to such difficult groups, the staff of the center might bear two considerations in mind: in the network of community agencies, is humanly decent care being provided under one or another set of auspices? and does the system-focused approach of the center have a distinctive contribution to make toward collaborative community action on the underlying problems?

MANPOWER

The present and future shortage of trained mental health professionals requires experimentation with new approaches to mental health services and with new divisions of labor in providing these services. The national effort to improve the quality of life for every individual—to alleviate poverty, to improve educational opportunities, to combat mental disorders—will tax our resources of professional manpower to the limit. In spite of expanded training efforts, mental health programs will face growing shortages of social workers, nurses, psychiatrists, psychologists, and other specialists. The new legislation to provide Federal assistance for the staffing of community mental health centers will not increase the supply of manpower but perhaps may result in some minor redistribution of personnel. If adequate pay and opportunities for part-time participation are provided, it is possible that some psychiatrists and psychologists now in private practice may join the public effort, adding to the services available to people without reference to their economic resources.

The manpower shortage must be faced realistically and with readiness for invention, for creative solutions. Officially recommended staffing patterns for community mental health centers (which projected nationally would require far more professionals than are being trained) should not be taken as setting rigid limitations. Pediatricians, general medical practitioners, social workers other than psychiatric ones, and psychological and other technicians at nondoctoral levels should be drawn into the work of the center. Specific tasks sometimes assigned to highly trained professionals (such as administrative duties, follow-up contacts, or tutoring for a disturbed child) may be assigned to carefully selected adults with little or no technical training. Effective communication across barriers of education, social class, and race can be aided by the creation of new roles for specially talented members of deprived groups. New and important roles must be found for teachers, recreation workers, lawyers, clergymen. Consultation, in-service training, staff conferences, and supervision are all devices that can be used to extend resources without sacrificing the quality of service.

Mental health centers should find ways of using responsible, paid volunteers, with limited or extended periods of service. There is a great reservoir of human talent among educated Americans who want to contribute their time and efforts to a significant enterprise. The Peace Corps, the Vista program, Project Head-Start have demonstrated to a previously skeptical public that high level, dependable service can be rendered by this new-style volunteer. The contributions of unpaid volunteers—students, housewives, the retired—can be put to effective use as well.

PROFESSIONAL RESPONSIBILITY

Responsibility in the comprehensive community mental health center should depend upon competence in the jobs to be done. The issue of who is to be responsible for mental health programs is complex and is not to be solved in the context of professional rivalries. The broad conception of mental health to which we have committed ourselves in America requires that responsibility for mental health programs be broadly shared. With good will, intelligence, and

a willingness to minimize presumed prerogatives, professional people and lay board members can find ways of distributing responsibility that will substantially increase the effectiveness of a center's program. The tradition, of course, is that the director of a mental health center must be a psychiatrist. This is often the best solution, but other solutions may often be equally sensible or more so. A social worker, a psychologist, a pediatrician, a nurse, a public health administrator might be a more competent director for a particular center.

The issue of clinical responsibility is more complex but the principle is the same: competence rather than professional identification should be the governing concern. The administration of drugs is clearly a competence-linked responsibility of a physician. Diagnostic testing is normally a competence-linked responsibility of a psychologist; however, there may be situations in which a psychiatrist or a social worker may have the competence to get the job done well. Responsibility for psychotherapy may be assumed by a social worker, psychiatrist, psychologist, or other trained person. The director of training or of research could reasonably come from one of a number of disciplines. The responsible community member, to whom these guidelines are addressed, should assure himself that there is a functional relationship in each instance between individual competence and the job to be done.

This issue has been given explicit and responsible attention by the Congress of the United States in its debates and hearings on the bill that authorizes funds for staffing community mental health centers. The intent of Congress is clear. As the Senate Committee on Labor and Public Welfare states in its report on the bill (Rept. No. 366, to accompany H.R. 2985, submitted June 24, 1965):

> There is no intent in any way in this bill to discriminate against any mental health professional group from carrying out its full potential within the realm of its recognized competence. Even further it is hoped that new and innovative tasks and roles will evolve from the broadly based concept of the community mental health services. Specifically, overall leadership of a community mental health center program may be carried out by any one of the major mental health professions. Many professions have vital roles to play in the prevention, treatment and rehabilitation of patients with mental illnesses.

Similar legislative intent was established in the debate on the measure in the House of Representatives.

Community members responsible for mental health centers should not countenance absentee directorships by which the fiction of responsibility is sustained while actual responsibility and initiative are dissipated. This is a device for the serving of professions, not of people.

TRAINING

The comprehensive community mental health center should provide a formal training program. The need for centers to innovate in the development or reallocation of professional and subprofessional roles, which has been stressed above in line with Congressional intent, requires in every center an active and imaginative training program in which staff members can gain competence in their new roles. The larger centers will also have the self-interested obligation to participate in the training of other professionals. Well-supervised professional trainees not only contribute to the services of a center; their presence and the center's training responsibilities to them promote a desirable atmosphere of self-examination and openness to new ideas.

There should be a director of training who would be responsible for: (a) in-service training of the staff of the center, in the minimum case; and, in the larger centers, (b) center-sponsored training programs for a range of professional groups, including internships, field placements, postdoctoral fellowships, and partial or complete residency programs; and (c) university-sponsored training programs that require the facilities of the center to give their students practical experience. Between 5% and 10% of the center's budget should be explicitly allocated to training.

PROGRAM EVALUATION AND RESEARCH

The comprehensive community mental health center should devote an explicit portion of its less budget to program evaluation. All centers should inculcate in their staff attention to and respect for research findings; the larger centers have

an obligation to set a high priority on basic research and to give formal recognition to research as a legitimate part of the duties of staff members. In the 11 "model" community programs that have been cited previously, both program evaluation and basic research are rarities; staff members are commonly overburdened by their service obligations. That their mental health services continue to emphasize one-to-one psychotherapy with middle-class adults may partly result from the small attention that their programs give to the evaluative study of program effectiveness. The programs of social agencies are seldom evaluated systematically and tend to continue in operation simply because they exist and no one has data to demonstrate whether they are useful or not. In this respect the model programs seem to be no better.

The whole burden of the preceding recommendations, with their emphasis on innovation and experimentation, cries out for substantial investment in program evaluation. Only through explicit appraisal of program effects can worthy approaches be retained and refined, ineffective ones dropped. Evaluative monitoring of program achievements may vary, of course, from the relatively informal to the systematic and quantitative, depending on the importance of the issue, the availability of resources, and the willingness of those responsible to take the risks of substituting informed judgment for evidence.

One approach to program evaluation that has been much neglected is hardheaded cost analysis. Alternative programs should be compared not only in terms of their effects, but of what they cost. Since almost any approach to service is likely to produce some good effects, mental health professionals may be too prone to use methods that they find most satisfying rather than those that yield the greatest return per dollar.

All community mental health centers need to plan for program evaluation; the larger ones should also engage in basic research on the nature and causes of mental disorder and on the processes of diagnosis, treatment, and prevention. The center that is fully integrated with its community setting will have unique opportunities to study aspects of these problems that elude investigaion in traditional clinic and hospital settings. That a major investment be made in basic research on mental health problems was the recommendation to which the Joint Commission on Mental Illness and Health gave topmost priority.

The demands of service and of research are bound to be competitive. Because research skills, too, are scarce, it is not realistic to expect every community mental health center to have a staff equipped to undertake basic research. At the very least, however, the leadership in each center should incorporate in its training program an attitude of attentiveness to research findings and of readiness to use them to innovate and change the center's practices.

The larger centers, especially those that can establish affiliation with universities, have an obligation to contribute to fundamental knowledge in the area of their program operations. Such centers will normally have a director of research and a substantial budget allocation in support of research, to be supplemented by grants from foundations and governmental agencies. By encouraging their staff members to engage in basic studies (and they must be sedulously protected from encroaching service obligations if they are to do so), these centers can make an appropriate return to the common fund of scientific and professional knowledge upon which they draw; they also serve their own more immediate interests in attracting and retaining top-quality staff and in maintaining an atmosphere in which creativeness can thrive. As a rough yardstick, every center should devote between 5% and 10% of its budget to program evaluation and research.

VARIETY, FLEXIBILITY, AND REALISM

Since the plan for a comprehensive community mental health center must allocate scarce resources according to carefully considered priorities tailored to the unique situation of the particular community, wide variation among plans is to be expected and is desirable. Since decisions are fallible and community needs and oportunities change, provision should be made for flexibility and change in programs, including periodic review of policies and operations. In spite of the stress in these guidelines on ideal requirements as touchstones against which particular plans can be appraised, no single comprehensive center can be all things to all men. Planning must be done in a realistic context of limited resources and imperfect human talent as well as of carefully evaluated community needs, and many hard decisions will have to be made in setting priorities.

In rural areas, especially, major alterations in the current blueprint would seem to be called for if needed services are to be provided. As a result, the comprehensive community mental health centers that emerge should be as unique as the communities to whose needs and opportunities they are responsive. This is all to the good, for as it has been repeatedly emphasized, there is no well-tested and prefabricated model to put into automatic operation. Variety among centers is required for suitability to local situations; it is desirable also for the richer experience that it should yield for the guidance of future programing.

The need for innovation has been stressed; the other side of the same coin is the need for adaptability to the lessons of experience and to changing requirements of the community. Flexibility and adaptiveness as a characteristic of social agencies does not just happen; it must be planned for. The natural course of events is for organizations to maintain themselves with as little change as possible, and there is no one more conservative than the proponent of an established, once-radical departure. Plans for the new centers should therefore provide for the periodic self-review of policies and operations, with participation by staff at all levels, and by outside consultants if possible. To the extent that active program evaluation is built intrinsically into the functioning of the center, the review process should be facilitated, and intelligent flexibility of policy promoted. Self-review by the center staff should feed into general review by the responsible board of community leaders, in which the board satisfies itself concerning the adequacy with which the policies that it has set have been carried out.

This final recommendation returns once more to the theme, introduced at the outset, that has been implicit in the entire discussion: the responsibility of the community for the quality and adequacy of the mental health services that it gets. The opportunities are now open for communities to employ the mechanism of the comprehensive mental health center to take major strides toward more intelligent, humane, and effective provision for their people. If communities rise to this opportunity, the implications for the national problem of mental health and for the quality of American life are immense.

Mr. JARMAN. Doctor, we are going to have to halt.

Mr. BRAYFIELD. Let me terminate my testimony right now and thank you very much for the opportunity, and I will file my additional remarks for the record tomorrow.

Mr. JARMAN. We appreciate your statement very much and appreciate your being with us.

I am sorry about the time element.

Mr. BRAYFIELD. I appreciate that, you can't help it.

Mr. JARMAN. You can add to your testimony in the record and certainly we will be studying it before the committee acts.

Mr. BRAYFIELD. Thank you, Mr. Chairman.

(Dr. Brayfield's prepared statement follows:)

STATEMENT OF DR. ARTHUR H. BRAYFIELD, EXECUTIVE OFFICER, AMERICAN PSYCHOLOGICAL ASSOCIATION

Mr. Chairman and Members of the Subcommittee: My name is Dr. Arthur H. Brayfield. I am Executive Officer of the American Psychological Association, the national organization of psychologists with 26,000 members, which has its headquarters at 1200 17th Street, N.W., Washington, D.C. I am accompanied by Dr. John J. McMillan, Administrative Officer for Professional Affairs. I welcome the opportunity to testify before this Subcommittee today in support of H.R. 6431. Psychology and psychologists are deeply involved in mental health services and programs. As a behavioral science discipline, psychology provides the fundamental basis for the work of all mental health professionals—psychiatrists, social workers and nurses, as well as psychologists. As a behavioral science profession, psychology contributes a significant share of the manpower available to the field of mental health. Based on data from the National Register of Scientific and Professional Personnel and from NIMH studies, we estimate that in 1964 approximately 8,000 psychologists provided some 13 million man-hours per year of direct clinical services, primarily the diagnosis and treatment of mental disorders, and another 7,500 psychologists spent another

13 million man-hours per year of psychological effort, primarily teaching and research, related to mental health. This total of 26 million man-hours compares, for example, to an estimated 27 million man-hours per year contributed by psychiatrists. The latter contribute a considerably higher proportion of their time to direct clinical service, particularly in private practice settings.

It is interesting and relevant to note that psychology is primarily a public service profession for approximately 85 percent of all psychologists are employed in non-profit organizations and only 5 or 6 percent are in private practice; the remaining 9 or 10 percent are employed in business and industry. Thus psychologists are especially likely to be interested in community mental health center programs and, in keeping with their public service tradition, are likely to be a crucial source of manpower particularly if they have free and open access to positions of responsibility and leadership on the basis of individual competence equally with other mental health professions. We believe that manpower will be the critical element in mounting effective community health programs.

In March 1966, the American Psychological Association adopted an official position paper titled "The Community and the Community Mental Health Center" offering guidelines and discussion addressed to "community leaders who face the problem of deciding how their communities should respond to the opportunities that are opened by the new Federal and state programs". Because of the widespread public interest this paper has attracted and because of its relevance to the legislation, H.R. 6431, which is the subject of these hearings, I respectfully request that it be made a part of the official hearings record.

As it did in formal testimony in 1963 and again in 1965, the American Psychological Association supports the goals of the community mental health centers legislation.

The first priority of the community mental health centers program is to make hospital beds and care readily available in settings close to home to people whose disturbed behavior either incapacitates them or causes concern to themselves, their family, their friends and employers, and the community at large. Thus the basic care facilities of the formerly geographically-remote state mental hospital are now in the process of being located in local and regional population centers. More beds and, hopefully, more care will become available as this program develops. The psychotic and the acutely disturbed members of the community will find help near at hand. The achievement of this limited but important objective will be a considerable accomplishment.

The community mental health centers program seeks also to make more readily available in communities throughout the nation forms of care and treatment which heretofore have been tried out on a more limited basis or in a relatively few places. Thus provisions are being made to incorporate day care programs, halfway houses, suicide centers, emergency or "walk-in" services, and the like into the community center programs. These already existing practices and procedures for dealing with the acutely and severely disturbed may thus become more generally available.

However, the most significant and exciting challenge and opportunity for the community mental health centers program does not revolve around this medically traditional inpatient-outpatient care program. The boldness and the promise of the enabling and supporting legislation passed by the Congress in 1963 and 1965, resides in its potential for obtaining a breadth and depth of local community involvement that would *get to the crux of behavior disorder*. For mental disorder is neither the private misery of the individual nor a personal problem solely of his making; it frequently has its roots, as well as its effects, in the social relationships and the social settings or systems of which the individual is a part.

On this view, the community mental health center's major undertaking will be to strengthen the totality of the community's investment in the human effectiveness of its members. The schools, the courts, the churches, business and industry are among the major social arenas in which the special perspective and special competencies of the center should find expression. For the disturbed or troubled person, the goal of community mental health programs should be to help him and the social systems of which he is a member to function together as harmoniously and productively as possible. And as we gain new knowledge bearing on the design of human environments for effective human functioning we *eventually* will be able to come to terms with the basic problem of prevention. But, beyond that, our ultimate goal, in a viable democracy, must be no less than to provide for the discovery, development, and wise utilization of all our human resources. Meet-

ing the immediate needs of the severely disturbed is prologue to the achievement of this national goal.

The other great opportunity and challenge is to devote a necessary and substantial share of the total community mental health effort to children and youth. They are our resources for the future—our potentially productive contributors to the quality of American life—our major responsibility for the present. They must not be overlooked.

If we settle simply for a "mopping-up" or "picking up the pieces" operation in our community mental health programs, we settle for too little.

So it is the promise and the prospect, the anticipation of things to come, that especially commands our interest and mobilizes our efforts as psychologists. The beginning has been made, the effort is underway. To sustain its gathering momentum, we endorse and support the provisions of H.R. 6431.

Thank you for the opportunity to appear here today.

(Additional material submitted by the American Psychological Association may be found in the committee files.)

Mr. JARMAN. This concludes our hearings on the bill and we appreciate all of you appearing before us.

Thank you.

(The following material was submitted for the record:)

THE AMERICAN PUBLIC HEALTH ASSOCIATION, INC.,
New York, N.Y., April 7, 1967.

HON. HARLEY O. STAGGERS,
Chairman, House Committee on Interstate and Foreign Commerce,
Rayburn Office Building,
Washington, D.C.

DEAR MR. CHAIRMAN: The American Public Health Association is privileged to support the principles and objectives included in *H.R. 6431*, which you have introduced, and which would extend the authority of the Community Mental Health Centers Act. As stated in our testimony to your Committee in 1963, the motives and objectives of this Act, which at that time was a legislative proposal, merited the full support of everyone who was interested in or concerned about the problems of mental health. We stated then that the proportions and scope of the problems involved in the treatment and cure of mental disorders made it apparent that there is a continuing need for a redirection of efforts relative to the control of mental disorders. We are convinced that effective treatment of the mentally ill is facilitated when patients are removed from the huge and impersonal mental hospital. Mental health services should be made a part of the total medical capabilities of communities.

The bill H.R. 6431 is basically an extension of the authority originally granted. Those features of the bill which are administrative in nature we will not comment upon. Is is our considered judgment that experience since the enactment of the Community Mental Health Centers Act has provided ample evidence of the validity of this endeavor. The progress to date, as might well be expected, is not as comprehensive nor far-reaching as could be hoped but it most certainly is headed in the proper direction. This this nation in an enilghtened age could not continue to countenance a system of treatment that was medieval in concept has been proven, even if to a limited degree, during the few short years of experience under the Community Mental Health Centers Act. We are convinced that even greater potentials remains to be realized. The statement of your Committee contained in the Committee's report dated August 21, 1963, which related to the previously accepted method of providing what had been termed as "care for the mentally ill," was most eloquent. In this context the report stated, "Either we must develop the quantity and quality of community services which will ultimately replace these institutions, or we will have to undertake a massive program to strengthen State mental hospitals." It was further stated that your Committee was of the opinion that there was a need to develop new methods of treatment, that there was a lessening in our disposition to reject and isolate the sufferers of mental illness, and that all of these factors argued strongly for the

treatment of mental illness in the community. Evidence that this would require a major effort seemed apparent; for example, only $1 was being spent on Community Mental Health Services for every $10 being spent for care in State institutions.

The American Public Health Association was and is in complete agreement with your Committee's conviction that there must be established for the citizen who needs it the capability to obtain through a single point of contact the full range of diagnostic, therapeutic and rehabilitative services, whether in-patient or out-patient, for the mental illness from which he may suffer. We are not convinced, however, that this concept has been accepted by some involved in programs of mental health. We hope your Committee will continue every effort to bring about the desired change of emphasis from the large institutionalized facility to the community-centered mental health program.

We urge, therefore, that the basic elements of the Community Mental Health Services Act be extended as is proposed in H.R. 6431. Would you please make this statement a part of the record of hearings on H.R. 6431?

Sincerely yours,

BERWYN F. MATTISON, M.D.,
Executive Director.

AMERICAN HOSPITAL ASSOCIATION,
Washington, D.C., April 6, 1967.

Hon. JOHN JARMAN,
Chairman, Subcommittee on Health, Interstate and Foreign Commerce Committee, Rayburn House Office Building, Washington, D.C.

DEAR CONGRESSMAN JARMAN: This statement is sent to you to express the views of the American Hospital Association in respect to H.R. 6431, a bill "to amend the public health laws relating to mental health to extend, expand, and improve them, and for other purposes."

The American Hospital Association strongly supported the legislation developed in 1963 which resulted in the Community Mental Health Centers Act. We further supported the amendments to the Act developed in 1965 which had the primary purpose of providing assistance in meeting certain costs of professional and technical personnel utilized within comprehensive mental health centers.

At the time the Congress was considering the professional and technical personnel assistance amendments of 1965, we stressed our belief that the costs involved in mental health care were such that the government would likely have to be involved on a continuing basis. We further strongly urged that the matter of such financing be approached on a long range basis. We suggested that such a continuing financing program to be sound should require more than short-term federal monies but should provide a basis for continuing grants with state and local participation.

It was our belief that once a mental health center was developed and in operation, there was no evidence to substantiate any decreasing need for financial support. As we have observed the program in its development, our beliefs have been confirmed by reports we have received from throughout the field. A good many hospitals have not undertaken to participate in the program because of the uncertainties of continued financial support. Boards of trustees are fearful of becoming involved in major mental health developments when they can foresee no continuing assurances as to their ability to finance the projects.

Therefore, we urge once again that this committee approach the problem on a long-range basis and amend the law so as to require continued federal financing with state and local participation.

We wish to comment also on the over-all operation of the mental health program. On the basis of all evidence then available, we expressed our beliefs at the time the legislation was being developed that basically it was essential to develop the program so that mental health care would be developed within the main stream of the communities' over-all health programs. One obvious means for such an accomplishment was to utilize fully the potential of community general hospitals and, of course, the medical staffs of such hospitals.

We are concerned that the program in its development to date is failing to utilize the full potential of existing health facilities throughout the country.

We have had repeated statements from around the country that a basic problem is the rigidity with which the state mental health commissioners have administered the program. By and large, it is our impression that they have had too little interest in seeing community general hospitals participate; and, in fact, the statements are made that attempts on the part of general hospitals to participate are often frustrated.

It is the contention of general hospitals that there is real danger of mental health moving back into the old pattern of its devolpment outside the general medical care community and within separate mental care institutions. We believe this would be an unfortunate continuation of past practices and policies.

As we have viewed these problems it has seemed to us that in part the present total emphasis on the comprehensiveness of the program may be at fault. There are undoubtedly large medical complexes where it is entirely fitting that a truly comprehensive approach to mental health be developed. However, it is obvious that such situations are relatively few in number when we view the country as a whole. It is strongly suggested that this legislation should be amended so as to make possible the full contribution of general hospitals and the medical care community without the necessity of in every instance insisting that only a totally comprehensive program will be approved.

It is our feeling that this desirable result could be accomplished by amending the law so as to permit the Surgeon General to approve less than totally comprehensive programs in areas of the country where it is demonstrated that such comprehensiveness is not feasible and yet where it can be demonstrated that an important service can be provided on less than a comprehensive basis and in such a way that we are thus taking advantage of all potential resources.

Another hindering aspect of the present mental health program is the high priority given to patients residing in what is defined as "catchment" areas. This suggests a geographic approach to the definition of areas which can be served. Such a definition is totally contrary to the concept of the normal health service areas. The larger community hospitals, and particularly all those which are teaching hospitals, do not draw patients from any specific geographic area. Patients come from widely divergent areas not circumscribed by any set boundaries. We suggest that mentally ill patients can best be served by developing programs for those patients who are normally attracted to a given medical center. This appears especially necessary since it will be a very long period of time before the country is likely to be blanketed by community mental health programs.

The hospitals of the nation as represented by this Association are keenly aware of the enormity of the problems involved in developing adequate health care programs for the mentally ill. We applaud the demonstrated desire of the federal government to stimulate and encourage local community action. This statement is in no wise intended to be simply critical of the past performance of the program. On the contrary, we express our strong belief that it is essential that the full potential of individual communities and the nation's health resources be utilized in an approach to the problems involved. We are fearful that at the present time we are failing to develop programs in such a way as to maximize such full potential and so that such a result will be achieved.

We appreciate the opportunity of expressing these views and request the statement be made a part of the published record of the hearings.

Sincerely yours,

KENNETH WILLIAMSON,
Associate Director.

AMERICAN NURSES' ASSOCIATION, INC.,
New York, N.Y., April 3, 1967.

Hon. HARLEY O. STAGGERS,
Chairman, Committee on Interstate and Foreign Commerce,
U.S. House of Representatives, Washington, D.C.

DEAR MR. STAGGERS: The American Nurses' Association, the professional organization of registered nurses, wishes to record its support of H.R. 6431, which proposes to extend, expand and improve the public health laws relating to mental health.

The American Nurses' Association supported enactment of Public Law 88–164 which provided assistance for construction of mental health centers and Public

Law 89–105, which authorized financial assistance to help the centers meet the cost of professional and technical personnel.

We supported the legislation because we were aware that the treatment of the mentally ill in state hospitals was handicapped because of the size, location and staffing patterns of these institutions. Too frequently care has been custodial rather than therapeutic largely due to the lack of professional personnel. This resulted in frequent, long, or permanent hospitalizations. Additionally, the isolated location of most state hospitals deprived patients of close, supportive contacts with family, friends, and community life. This situation also made recruitment of qualified personnel more difficult.

The establishment of community mental health centers is a relatively new approach to the prevention and treatment of the mentally ill. Many communities already have available diagnostic and treatment facilities, inpatient and outpatient psychiatric services, and provisions for emergency care and rehabilitation. In most instances these are not coordinated to the extent that continuing supervision of patients is provided from the onset of symptoms through to complete rehabilitation. One important function of the community mental health center was to stimulate coordinating of these various efforts to improve services to patients and families.

The availability of services in localities where people live can result in early recognition of illness and intervention at a time when treatment is likely to be more successful and lastng. For patients who may still require hospitalization away from their homes, the community mental health center is a resource for providing follow-up care and rehabilitative services. The hospital stay would, therefore, be shorter enabling the individual more quickly to resume his proper role in society.

In addition to providing direct services to patients and families, the mental health center also has an educational function in the community. Because of lack of knowledge and understanding of the pathological process by members of the family and community, the mentally ill were all too frequently rejected. The support and understanding of relatives is vital to full recovery. Because hospitals for the mentally ill are generally in isolated areas, an effective sustained plan for interpreting mental illness and 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 too have a responsibility in prevention, in follow-up care, and in rehabilitation. The staff of the community mental health center becomes a resource for helping these allied professional groups broaden their understanding and knowledge of mental health and therefore, provide more effective service. The centers provide clinical facilities where doctors, nurses, psychologists and social workers can gain first hand experience in working with psychiatric patients and their families. In addition, consultant service is made available to those coping with the behavior problems of the child and adolescent.

The success of programs to combat mental illness depends in large measure on the availability of well-qualified professional manpower. We have stated repeatedly that buildings alone cannot constitute a program. They provide only facilities for treatment. The provision of treatment and the quality of care is dependent on personnel. We, therefore, urge your Committee to approve the extension of the provision for meeting the costs for staffing mental health centers.

Your bill H.R. 6431 will continue the assistance to states to help them deal effectively with the problem of mental illness and further relieve them of the tremendous financial burden they carried so long. Establishment of the mental health centers is providing a means, not only for helping patients in their own communities, but also for developing new types of programs that are less costly than the traditional confinement in a longterm institution.

We urge the favorable consideration of H.R. 6431 and request that this communication be made a part of your Committee's record of hearings.

Sincerely yours,

JUDITH G. WHITAKER, R.N.,
Executive Director.

NATIONAL ASSOCIATION OF SOCIAL WORKERS, INC.,
Washington, D.C., April 6, 1967.

Hon. HARLEY O. STAGGERS,
Chairman, House Interstate and Foreign Commerce Committee,
House Office Building, Washington, D.C.

DEAR MR. STAGGERS: In behalf of the 47,000 members of the National Association of Social Workers, may I express support for H.R. 6431—the Mental Health Amendments of 1967.

Our organization supported this legislation when it was enacted. Our many members who are involved in the carrying out of the programs have told us of the changing patterns of services meaning more effective care which are now possible.

In most communities the programs are really just getting under way and not only continued but increased appropriations are needed to sustain the effectiveness of the community mental health approach.

We should like to make a final comment in support of Section 5 of H.R. 6431—establishing a contingency fund. We see this as insurance for sustaining important programs which otherwise might become bogged down or cut off because of unforeseeable administrative complexities.

Sincerely,

MELVIN A. GLASSER, *Chairman, Social Action Commission.*

(Whereupon, at 2:25 p.m., the subcommittee adjourned, subject to the call of the Chair.)

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