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**COMMUNITY MENTAL HEALTH CENTERS
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HEARINGS
BEFORE THE
SUBCOMMITTEE ON
PUBLIC HEALTH AND WELFARE
OF THE
COMMITTEE ON
INTERSTATE AND FOREIGN COMMERCE
HOUSE OF REPRESENTATIVES

NINETY-FIRST CONGRESS

FIRST SESSION

ON

H.R. 14617, H.R. 13163, H.R. 13609,
and H.R. 14086

**BILLS TO EXTEND THE PROGRAM OF MATCHING GRANTS
FOR CONSTRUCTION AND STAFFING OF COMMUNITY MEN-
TAL HEALTH CENTERS AND OF FACILITIES FOR THE
CARE AND TREATMENT OF ALCOHOLICS AND NARCOTICS
ADDICTS**

NOVEMBER 18, 19, AND 20, 1969

Serial No. 91-35

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Committee on Interstate and Foreign Commerce



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HEARINGS

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 Smedley, Lawrence, assistant director, social security department.
- American Psychiatric Association, Dr. James N. Sussex.
- American Psychological Association:
 Edgerton, J. Wilbert, Ph. D., associate professor of psychology, University of North Carolina.
- McMillan, Dr. John J.
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- Miller, Dr. Morton, Acting Associate Director, National Institute of Mental Health.
- Yolles, Dr. Stanley, Director, National Institute of Mental Health.
- Multi-County Comprehensive Mental Health Center, Tullahoma, Tenn., John B. Carver, director.
- National Association for Mental Health:
 Chase, Irving, chairman, council on legislation and public policy.
 Freeland, Michael E., associate director.
- National Association of State Mental Health Program Directors:
 Schnibbe, Harry C., executive director.
 Schumacher, Dr. William E.
- National Committee Against Mental Illness, Mike Gorman, executive director.
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- Morrison, Dr. Donald, director, Northern Wyoming Mental Health Center, Sheridan, Wyo.
- Portz, Dr. Alex T., director, Appalachian Mental Health Center, Elkins, W. Va.
- Ramirez, Raymond, director, Mental Health Authority for West Central Illinois, Quincy, Ill.
- Weston, Dr. W. Donald, associate professor of psychiatry and human development, Michigan State University.
- National Council on Alcoholism:
 Gorman, Mike, legislative representative.
- Knott, Dr. David H., medical director, Alcoholic Rehabilitation Unit, Tennessee Psychiatric Hospital.
- New York City Mental Health and Mental Retardation Services, Dr. J. Herbert Fill, commissioner.
- University Research Corp., Sheldon S. Steinberg, executive vice president and member of the board of directors.

COMMUNITY MENTAL HEALTH CENTERS ACT EXTENSION

TUESDAY, NOVEMBER 18, 1969

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

The subcommittee met at 10 a.m., pursuant to notice, in room 2128, 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. 14617, introduced at the request of the administration by Chairman Staggers for himself and Mr. Springer, and other bills having a similar purpose, proposing to extend the program of matching grants for construction and staffing of community mental health centers and of facilities for the care and treatment of alcoholics and narcotics addicts.

The bills in general would extend the existing program for 3 fiscal years; would provide increased matching for facilities in urban or rural poverty areas; would provide grants for initiation and development of mental health centers and other facilities; would provide for training and evaluation of alcoholism programs; and would provide increased Federal matching for the costs of staffing of these facilities through stretching out the period of such matching, and increasing the Federal percentage in certain cases.

At this point there will be printed in the record the text of the bills and the agency reports thereon.

(The text of H.R. 14617, H.R. 13163, H.R. 13609, and H.R. 14086, and departmental reports thereon, follow:)

[H.R. 14617, 91st Cong., 1st Sess., introduced by Mr. Staggers (for himself and Mr. Springer) on October 30, 1969]

A BILL To amend the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 to extend and improve the provisions relating to the construction and operation of community mental health facilities, and of specialized facilities for alcoholics and narcotic addicts, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Community Mental Health Centers Amendments of 1969".

MENTAL HEALTH CENTERS CONSTRUCTION GRANTS; EXTENSION OF DURATION

Authorization of Appropriations

SEC. 2. (a) (1) Section 201 of the Community Mental Health Centers Act (42 U.S.C. 2681) is amended by striking out "and" before "\$70,000,000" and by inserting before the period at the end thereof "and such sums as may be necessary for each of the next three fiscal years".

(1)

(2) Section 207 of such Act (42 U.S.C. 2687) is amended by striking out "1970" and inserting in lieu thereof "1973".

Allotments to States; Inclusion of Trust Territory

(b) (1) The first sentence of subsection (a) of section 202 of such Act (42 U.S.C. 2682) is amended by inserting "80 per centum of" before "the sums appropriated under section 201".

(2) The first sentence of such subsection (a) is further amended by striking out "and Guam," and inserting in lieu thereof "Guam, and the Trust Territory of the Pacific Islands,".

(3) The second sentence of such subsection (a) is amended by inserting after "State" the first time it appears, ", other than the Virgin Islands, American Samoa, Guam, and the Trust Territory of the Pacific Islands,".

(4) Such subsection (a) is further amended by adding at the end thereof the following new sentence: "Sums so allotted to the Virgin Islands, American Samoa, Guam, or the Trust Territory of the Pacific Islands for a fiscal year and remaining unobligated at the end of such year shall remain available to it for such purpose for the next two fiscal years (and for such years only), in addition to the sums allotted to it for such purpose for each of such next two fiscal years."

(5) The amendments made by this subsection shall be effective with respect to allotments under section 202 from funds appropriated for fiscal years beginning after June 30, 1970.

Special Project Grants

(c) Part A of the Community Mental Health Centers Act (42 U.S.C. 2681 et seq.) is amended by redesignating sections 203, 204, 205, 206, and 207, as 204, 205, 206, 207, and 208, respectively, and by adding after section 202 the following new section:

"DIRECT GRANTS FOR PROJECTS OF SPECIAL SIGNIFICANCE

"SEC. 203. (a) Of the sums appropriated pursuant to section 201 for any fiscal year after June 30, 1970, 20 per centum shall be available for grants by the Secretary to pay up to 90 per centum of the cost of construction of community mental health centers which in his judgment are of special significance because they will provide mental health services for persons in an area designated by the Secretary as an urban or rural poverty area, or demonstrate new or particularly effective or efficient methods of delivery of mental health services.

"(b) No such grant may be made for projects in any State if the State mental health agency designated in accordance with section 205(a)(1); after giving an opportunity for review and comment to any appropriate areawide health planning agency which has developed the comprehensive regional, metropolitan area, or other local area plan or plans referred to in section 314(b) of the Public Health Service Act covering the area in which such project is to be located or, if there is none, to such other public or nonprofit private agency or organization (if any) which performs, as determined in accordance with criteria included in regulations, similar functions, but in no event later than sixty days after such application has been referred to such State agency, notifies the Secretary that it disapproves of such application.

"(c) Grants under this section may be paid in advance or by way of reimbursement, and in such installments, and on such conditions, as the Secretary may determine."

State Plans

(d) Effective with respect to construction projects approved after June 30, 1970, under part A of the Community Mental Health Centers Act, subsection (a) of that section redesignated as section 205 by subsection (c) hereof, is amended by striking out "and" after clause (a)(9), by striking out the period at the end of clause (10), and inserting "; and" in lieu thereof, and by adding after clause (10) the following new clause:

"(11) be approved by the State agency of such State designated or established pursuant to section 314(a)(2)(A) of the Public Health Service Act."

Approval of Projects

(e) Effective with respect to applications for construction projects approved after June 30, 1970 under part A, the fourth sentence of subsection (a) of that section of the Community Mental Health Centers Act, redesignated as section 206 by subsection (c) hereof, is amended by striking out "State agency and" in clause (E), and inserting in lieu thereof "State agency, after submission of such application for review, and comment within sixty days of such submission, to the public or nonprofit private agency or organization which has developed the comprehensive regional, metropolitan area, or local area plan or plans referred to in section 314(b) of the Public Health Service Act covering the area in which such project is to be located or, if there is none, to such other public or nonprofit private agency or organization (if any) which performs, as determined in accordance with criteria included in regulations, similar functions, and the application is for a project which".

INITIAL STAFFING

Higher Federal Share Payable for Two Years; Higher Federal Share for Disadvantaged Areas

SEC. 3. (a) Effective with respect to costs of operation of any center, for any period beginning after June 30, 1970, for which a grant has been or is made under subsection (b) of section 220 of the Community Mental Health Centers Act (42 U.S.C. 2688), such subsection is amended to read as follows:

"(b) Grants for such costs for any center under this part may not exceed—

"(1) except as provided in clause (2), 75 per centum of such costs for the first two years after the first day of the first month for which such a grant is made with respect to such center, 60 per centum of such costs for the third year after such first day, 50 per centum of such costs for the fourth year after such first day, 40 per centum of such costs for the fifth year after such first day, 30 per centum of such costs for the sixth year after such first day, 20 per centum of such costs for the seventh year after such first day; and 10 per centum of such costs for the eighth year after such first day; or

"(2) in the case of any such center providing services for persons in an area designated by the Secretary as an urban or rural poverty area, 90 per centum of such costs for the first two years after the first day of the first month for which such a grant is made with respect to such center, 80 per centum of such costs for the third year after such first day, 70 per centum of such costs for the fourth year after such first day, 60 per centum of such costs for the fifth year after such first day, 50 per centum of the costs for the sixth year after such first day, 40 per centum of the costs for the seventh year after such first day, 30 per centum of such costs for the eighth year after such first day, 20 per centum of such costs for the ninth year after such first day, and 10 per centum of such costs for the tenth year after such first day.

In no event may such grants under clause (1) with respect to any center be made for any period of time which is later than the last year referred to in clause (1), or such grants under clause (2) be made for any period of time which is later than the last year referred to in clause (2)."

Maintenance of Effort

(b) Section 221(a)(4) of the Community Mental Health Centers Act (42 U.S.C. 2688a) is amended to read as follows:

"(4) the Secretary determines that there is satisfactory assurance that (A) the services to be provided will constitute an addition to, or a significant improvement in quality (as determined in accordance with criteria of the Secretary) in, services that would otherwise be provided, and (B) Federal funds made available under this part of any period will be so used as to supplement and, to the extent practical, increase the level of State, local, and other non-Federal funds, including third party health insurance payments, that would in the absence of such Federal funds be made available for the program described in paragraph (2) of this subsection; and".

Extension of Duration

(c) (1) Section 221(b) of such Act (42 U.S.C. 2688a) is amended by striking out "1970" each time it appears therein and inserting in lieu thereof "1973".

(2) The first sentence of section 224 of such Act (42 U.S.C. 2688d) is amended by striking out "and" before "\$32,000,000" and by inserting "and such sums as may be necessary for each of the next three fiscal years," after "1970,".

(3) The second sentence of section 224 of such Act is amended by striking out "seven" and inserting in lieu thereof "fifteen".

Cost of Compensation of Staff

(d) Effective with respect to costs of operation of any center, for any period beginning after June 30, 1970, for which a grant has been or is made under subsection (a) of section 220 of the Community Mental Health Centers Act (42 U.S.C. 2688), such subsection is amended by striking out "a portion of the costs (determined pursuant to regulations under section 223) of compensation of professional and technical personnel for the initial operation" and inserting in lieu thereof "a portion of the costs (determined pursuant to regulations under section 223) of operation, staffing, and maintenance".

Initiation and Development Grants

(e) Effective with respect to amounts appropriated for initial staffing grants after June 30, 1970 under part B of the Community Mental Health Centers Act, such part B is amended by adding after section 224 the following new section:

"GRANTS FOR INITIATION AND DEVELOPMENT OF COMMUNITY MENTAL HEALTH CENTERS

"SEC. 225. Not to exceed 5 per centum of the amount appropriated for new grants pursuant to section 224 for any fiscal year beginning after June 30, 1970, shall be available to the Secretary to make grants to public or nonprofit private organizations to cover part or all of the costs of projects, in areas designated by the Secretary as urban or rural poverty areas, for assessing needs for mental health services, designing mental health services programs, obtaining local financial and professional assistance and support for community mental health services, and fostering community involvement in initiating and developing community mental health services for persons residing in such areas. In no case shall any grant under this section exceed \$50,000, or be for a period in excess of one year."

(f) The heading of part B of such Act (42 U.S.C. 2688 et seq.) is amended to read:

"GRANTS FOR INITIAL COSTS OF OPERATION OF CENTERS"; ALCOHOLISM AND NARCOTIC ADDICT REHABILITATION

Extension of Duration

SEC. 4. (a) (1) Effective with respect to projects approved under part C or part D of the Community Mental Health Centers Act, section 261(a) of such Act is amended by striking out "and" before "\$25,000,000" in the first sentence thereof and inserting after "the next fiscal year" in the same sentence the words ", and such sums as may be necessary for the next three fiscal years,".

(2) Subsection (a) of such section is further amended by inserting before the period at the end of the first sentence "and section 246."

(3) Subsection (b) of such section 261 is amended by striking out "1971" and inserting in lieu thereof "1974," by striking out "three fiscal years" and inserting in lieu thereof "seven fiscal years", and by striking out everything before the period at the end of the section beginning with "for the fiscal year ending June 30, 1969".

Construction Grants; Alcoholism

(b) Effective with respect to the cost of construction of any facility, for any period beginning after June 30, 1970, for which a grant from appropriations under section 261 of such Act has been or is made, subsection (b) of section 241 of such Act is amended by striking out "66 $\frac{2}{3}$ " and inserting in lieu thereof "90".

Staffing Grants; Alcoholism

(c) (1) Effective with respect to the costs of operation of any facility, for any period after June 30, 1970, for which a grant from appropriations under section 261 of such Act has been or is made, subsection (a) of section 242 of such

Act is amended by striking out "a portion of the costs (determined pursuant to regulations of the Secretary) of compensation of professional and technical personnel for the initial operation" and inserting in lieu thereof "a portion of the costs (determined pursuant to regulations of the Secretary) for operation, staffing, and maintenance".

(2) Subsection (b) of such section 242 is amended to read as follows:

"(b) Grants for such costs for any facility under this section may not exceed 90 per centum of such costs for the first two years after the first day of the first month for which such a grant is made with respect to such facility, 80 per centum of such costs for the third year after such first day, 70 per centum of such costs for the fourth year after such first day, 60 per centum of such costs for the fifth year after such first day, 50 per centum of such costs for the sixth year after such first day, 40 per centum of such costs for the seventh year after such first day, 30 per centum of such costs for the eighth year after such first day, 20 per centum of such costs for the ninth year after such first day, and 10 per centum of such costs for the tenth year after such first day."

Specialized Facilities

(d) Effective with respect to the cost of construction or operation of any facility, for any period beginning after June 30, 1970, for which a grant from appropriations under section 261 of such Act has been or is made:

(1) Subsection (a) of section 243 of such Act is amended by striking out "compensation of professional and technical personnel" and inserting in lieu thereof "operation, staffing, and maintenance".

(2) Subsection (c) of such section is amended by striking out "compensation of professional and technical personnel" and inserting in lieu thereof "operation, staffing, and maintenance".

(3) Subsection (d) of such section is amended by striking out "66 $\frac{2}{3}$ " and inserting in lieu thereof "90".

TRAINING AND EVALUATION; ALCOHOLISM

(e) Part C of the Community Mental Health Centers Act is amended by redesignating section 246 as section 247, and adding after section 245 a new section 246 to read as follows:

"TRAINING AND EVALUATION

"Sec. 246. The Secretary is authorized during the period beginning July 1, 1970 and ending June 30, 1973, to make grants to any public or nonprofit private agency or organization to cover part or all of the cost of (A) developing specialized training programs or materials relating to the provision of public health services for the prevention or treatment of alcoholism, or developing in-service training or short-term or refresher courses with respect to the provision of such services; (B) training personnel to operate, supervise, and administer such services; and (C) conducting surveys and field trials, to evaluate the adequacy of the programs for the prevention and treatment of alcoholism within the several States with a view to determining ways and means of improving, extending, and expanding such programs."

Construction Grants, Narcotic Addict Rehabilitation

(f) Effective with respect to the cost of construction of any facility for any period beginning after June 30, 1970, for which a grant from appropriations under section 261 of such Act has been or is made, subsection (b) of section 251 of such Act is amended by striking out "66 $\frac{2}{3}$ " and inserting in lieu thereof "90".

Staffing Grants; Narcotic Addict Rehabilitation

(g) (1) Effective with respect to the costs of operation of any facility, for any period beginning after June 30, 1970, for which a grant from appropriations under section 261 of such Act has been or is made, subsection (a) of section 251 of such Act is amended by striking out "the costs, determined pursuant to regulations of the Secretary, of compensation of professional and technical personnel for the initial operation" and inserting in lieu thereof "the costs, determined pursuant to regulations of the Secretary, for the staffing, operation, and maintenance".

(2) Subsection (c) of such section 251 is amended by striking out "Grants made under subsection (a) for the cost of compensation of professional and technical personnel" and inserting in lieu thereof "Grants made under subsection (a) for the costs of operating such facilities".

AMENDMENTS TO GENERAL PROVISIONS

Trust Territory of the Pacific Islands Included in Definition of State

SEC. 5. (a) Effective with respect to allotments under part C of title I or part A of title II of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 made from funds appropriated for fiscal years beginning after June 30, 1970, paragraph (a) of section 401 thereof (42 U.S.C. 2691) is amended by inserting "the Trust Territory of the Pacific Islands," after "the Virgin Islands,".

Cost of Land Included in Cost of Construction

(b) Effective with respect to projects approved under part C of title I or under title II of such Act, so much of paragraph (e) of such section 401 as follows the semicolon is amended to read "including architect's fees and the cost of the acquisition of land, but excluding the cost of off-site improvements."

Federal Share To Be Maximum; Higher Share for Disadvantaged Areas

(e) Effective with respect to projects approved under part C of title I, or under title II of such Act after June 30, 1970, section 402 of such Act (42 U.S.C. 2692) is repealed and paragraph (h) of such section 401 is amended to read as follows:

"(h) (1) The term 'Federal share' with respect to any project means the portion of the cost of construction of such project to be paid by the Federal Government under part C of title I or under part A of title II.

"(2) The Federal share with respect to any project in the State shall be the amount determined by the State agency designated in the State plan but, except as provided in paragraph (3), not more than 66 $\frac{2}{3}$ per centum or the State's Federal percentage, whichever is the lower. Prior to the approval of the first such project in the State during any fiscal year such State agency shall give the Secretary written notification of the maximum Federal share established pursuant to this paragraph for such projects in such State to be approved by the Secretary during such fiscal year and the method for determining the actual Federal share to be paid with respect to such project; and such maximum Federal share and such method of determination for such projects in such State approved during such fiscal year shall not be changed after such approval.

"(3) In the case of any facility or center which provides or will, upon completion of the project for which application has been made under part C of title I or under part A of title II, provide services for persons in an area designated by the Secretary as an urban or rural poverty area or demonstrate new or particularly efficient methods of delivery of mental health services, the maximum Federal share determined under paragraph (3) may be such higher percentage, not in excess of 90 per centum, as the State may determine."

PERIOD FOR PROMULGATING FEDERAL PERCENTAGES

(d) Paragraph (j) (1) of such section 401 is amended by striking out "August 31" and inserting in lieu thereof "September 30".

(e) Effective with respect to expenditures referred to in paragraph (1) of subsection (e) of section 403 of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 made after June 30, 1970, such paragraph (42 U.S.C. 2693) is amended by striking out "2 per centum" and inserting in lieu thereof "5 per centum".

CONFORMING AMENDMENTS

SEC. 6. (a) That section of the Mental Retardation and Community Mental Health Centers Construction Act of 1963 redesignated as section 205 by section 2(c) hereof is amended by striking out "203(1)" and "203(4)" in clause (4) of subsection (a) and inserting in lieu thereof "204(1)" and "204(4)"; and

by striking out "203(2)" in clause (5) of such subsection and inserting in lieu thereof "204(2)".

(b) That section of such Act redesignated as section 206 by section 2(c) hereof is amended by striking out "203(2)" in clause (2) of subsection (a) and inserting in lieu thereof "204(2)"; by striking out in the second paragraph of such subsection "203" in clause (B), "204" and "203(4)" in clause (C), and "203(2)" in clause (E), and inserting in lieu thereof "204", "205", "204(4)", and "204(2)", respectively.

(c) That section of the Community Mental Health Centers Act redesignated as section 207 by section 2(c) hereof is amended by striking out "204(a) (1)", "204" in clause (1), and "205" in each instance in clauses (5) and (6), and inserting in lieu thereof "205(a) (1)", "205", and "206", respectively.

(d) Section 241(a) of such Act is amended by striking out "205(a)" in the first sentence thereof and inserting in lieu thereof "206(a)"; by striking out "204(a) (1)" in clause (C) and inserting in lieu thereof "205(a) (1)"; and by striking out "203(4)" in clause (E) and inserting in lieu thereof "204(4)".

(e) Section 243(d) of such Act is amended by striking out "205(a) (5)" and inserting in lieu thereof "206(a) (5)".

(f) Section 251(b) of such Act is amended by striking out "205(a) (5)" and inserting in lieu thereof "206(a) (5)".

(g) (1) Section 403(a) of such Act is amended by striking out "204" and inserting in lieu thereof "205"; and by striking out "206" and inserting in lieu thereof "207".

(2) Subsection (b) of such section is amended by striking out "205" and inserting in lieu thereof "206".

(h) The first sentence of section 404 of such Act is amended by striking out "205" and inserting in lieu thereof "206"; and striking out "204(b)" and inserting in lieu thereof "205(b)"; and by striking out "206" and inserting in lieu thereof "207".

(i) Section 405 is amended by striking out "205" in clause (1)(A) and inserting in lieu thereof "206"; and by striking out "204" in clause (1)(B) and inserting in lieu thereof "205".

[H.R. 13163, and H.R. 13609, 91st Cong., 1st Sess., introduced by Mr. Staggers on July 29, 1969, and Mr. Corman on September 4, 1969, respectively, are identical as follows:]

A BILL To amend the Community Mental Health Centers Act to extend the program of assistance under that Act for community mental health centers and facilities for the treatment of alcoholics and narcotic addicts, to establish programs for mental health of children, and for other purposes

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

SHORT TITLE

SECTION 1. This Act may be cited as the "Community Mental Health Centers Amendments of 1969".

TITLE I—GRANTS FOR CONSTRUCTION OF COMMUNITY MENTAL HEALTH CENTERS AND FACILITIES FOR ALCOHOLICS AND NARCOTIC ADDICTS

EXTENSION OF PROGRAM FOR COMMUNITY MENTAL HEALTH CENTERS

SEC. 101. (a) Section 201 of the Community Mental Health Centers Act (42 U.S.C. 2681) is amended by striking out the period at the end and inserting in lieu thereof a comma and the following: "and for each of the next three fiscal years."

(b) Section 207 of such Act (42 U.S.C. 2687) is amended by striking out "1970" and inserting in lieu thereof "1973".

EXTENSION OF PROGRAMS FOR FACILITIES FOR ALCOHOLICS AND NARCOTIC ADDICTS

SEC. 102. (a) Section 261(a) of such Act (42 U.S.C. 2688a) is amended by striking out "and \$25,000,000 for the next fiscal year" and inserting in lieu

thereof "\$15,000,000 for the fiscal year ending June 30, 1970, \$20,000,000 for the fiscal year ending June 30, 1971, \$25,000,000 for the fiscal year ending June 30, 1972, and \$30,000,000 for the fiscal year ending June 30, 1973".

(b) Section 261(b) of such Act is amended by striking out "the next three" and inserting in lieu thereof "the next thirteen", and by striking out "for the fiscal year ending June 30, 1969, or the fiscal year ending June 30, 1970" and inserting in lieu thereof "for any fiscal year ending before July 1, 1973".

PERCENTAGE OF ALLOTMENTS AVAILABLE FOR STATE PLAN ADMINISTRATION

SEC. 103. (a) Section 403(c)(1) of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (42 U.S.C. 2693) is amended by striking out "such part" and inserting in lieu thereof "title II"; and section 403(c)(2) of such Act is amended by striking out "such part A" and inserting in lieu thereof "title II".

TRAINING AND EVALUATION OF PROGRAMS FOR ALCOHOLISM

SEC. 104. Part C of the Community Mental Health Centers Act is amended by redesignating section 245 as section 246, and by inserting after section 244 the following:

"TRAINING AND EVALUATION

"SEC. 245. The Secretary is authorized to make grants to any public or nonprofit private agencies and organizations to cover part or all of the cost of (A) developing specialized training programs or materials relating to the provision of public health services for the prevention and treatment of alcoholism, or developing inservice training or short-term or refresher courses with respect to the provision of such services; (B) training personnel to operate, supervise, and administer such services; and (C) conducting surveys and field trials to evaluate the adequacy of the programs for the prevention and treatment of alcoholism within the several States with a view to determining ways and means of improving, extending, and expanding such programs."

TITLE II—GRANTS FOR STAFFING OF COMMUNITY MENTAL HEALTH CENTERS AND FACILITIES FOR ALCOHOLICS AND NARCOTIC ADDICTS

FEDERAL SHARE

SEC. 201. (a) (1) Effective with respect to costs of development and operation of any center for any period after June 30, 1970, for which a grant has been or is made under subsection (a) of section 220 of the Community Mental Health Centers Act (42 U.S.C. 2688), subsection (b) of such section is amended to read as follows:

"(b) Grants for such costs for any center under this part may not exceed—

"(1) except as provided in paragraphs (2) and (3), 75 per centum of the costs for each of the first two years after the first day of the first month for which such grant is made with respect to such center, 60 per centum of such costs for the third year after such first day, 45 per centum of such costs for the fourth year after such first day, and 30 per centum of such costs for each of the next six years after such first day;

"(2) in the case of grants to any center which provides services for persons in an area designated by the Secretary as an urban or rural poverty area, 90 per centum of such costs for each of the first two years after the first day of the first month for which such grant is made with respect to such center, and 75 per centum of such costs for each of the next 8 years after such first day; and

"(3) in the case of a grant which undertakes to initiate and develop a program for delivery of community mental health center services for persons in an area designated by the Secretary as an urban or rural poverty area, 100 per centum of the costs (or \$50,000, whichever is less) attributable to the initiation and development of such program for the one-year period beginning with the first day of the first month for which such grant is made for such purpose.

No grant shall be made under this section, in the case of any center referred to in paragraph (1), for any period of time which is later than the last year referred to in paragraph (1), or, in the case of any center referred to in paragraph (2),

for any period of time which is later than the last year referred to in paragraph (2)."

(2) Effective with respect to costs of development and operation of any facility for any period after June 30, 1970, for which a grant has been or is made under subsection (a) of section 242 or 251 of the Community Mental Health Centers Act (42 U.S.C. 2688g, 2688k), subsection (b) of section 242 of such Act is amended to read as follows:

"(b) Grants for such costs for any facility under this section may not exceed—

"(1) except as provided in paragraphs (2) and (3), 75 per centum of the costs for each of the first two years after the first day of the first month for which such grant is made with respect to such facility, 60 per centum of such costs for the third year after such first day, 45 per centum of such costs for the fourth year after such first day, and 30 per centum of such costs for each of the next six years after such first day;

"(2) in the case of grants to any facility which provides services for persons in an area designated by the Secretary as an urban or rural poverty area, 90 per centum of such costs for each of the first two years after the first day of the first month for which such grant is made with respect to such facility, and 75 per centum of such costs for each of the next eight years after such first day; and

"(3) in the case of a grant which undertakes to initiate and develop a program for delivery of services for persons in an area designated by the Secretary as an urban or rural poverty area, 100 per centum of the costs (or \$50,000, whichever is less) attributable to the initiation and development of such program for the one-year period beginning with the first day of the first month for which such grant is made for such purpose.

No grant shall be made under this section, in the case of any facility referred to in paragraph (1), for any period of time which is later than the last year referred to in paragraph (1), or, in the case of any facility referred to in paragraph (2), for any period of time which is later than the last year referred to in paragraph (2)."

(b) In the case of a community mental health center, a facility for the prevention and treatment of alcoholism, or a treatment facility for narcotic addicts, for which a staffing Mental Health Centers Act before July 1, 1970, the applicable provisions of subsection (b) (1) of section 220 or 242 of such Act (as added by subsection (a) of this section) shall apply to the same extent as if such subsection (b) (1) had been in effect on the date a staffing grant for such center or facility was initially made, except that the maximum percentage of such costs shall not exceed the percentage of staffing costs payable with respect to such center or facility as of June 30, 1970.

APPLICATIONS AND CONDITIONS FOR APPROVAL

SEC. 202. Section 221(a) of such Act (42 U.S.C. 2688a) is amended (1) by striking out "and" at the end of paragraph (4), (2) by striking out the period at the end of paragraph (5) and inserting in lieu thereof "; and", and (3) by adding after paragraph (5) the following new paragraph:

"(6) in the case of a grant (as referred to in section 220(b) (3) for costs attributable to initiation and development and staffing of a program for delivery of community mental health services to persons in an urban or rural poverty area, the Secretary is satisfied, upon the basis of evidence supplied by the applicant, that persons broadly representative of all elements of the persons broadly representative of all elements of the population of such area will be given an opportunity to participate in the development of such program."

EXTENSION OF DURATION

SEC. 203. Section 221(b) of such Act (42 U.S.C. 2688a) is amended by striking out "1970" each place it appears therein and inserting in lieu thereof "1973".

AUTHORIZATION OF APPROPRIATIONS

SEC. 204. (a) The first sentence of section 224 of such Act (42 U.S.C. 2688d) is amended by striking out "and \$32,000,000 for the fiscal year ending June 30, 1970" and inserting in lieu thereof "\$26,000,000 for the fiscal year ending June 30, 1970, \$32,000,000 for the fiscal year ending June 30, 1971, \$40,000,000 for the fiscal year ending June 30, 1972, and \$48,000,000 for the fiscal year ending June 30, 1973".

(b) Such section 224 is further amended by adding immediately after the first sentence thereof the following: "For the purposes of assessing local mental health needs, developing necessary resources, and involving local citizens in the development of mental health programs, up to a maximum of 5 per centum of the appropriation authorized for each fiscal year under this section shall be available to the Secretary for grants to local public or private nonprofit agencies or organizations to cover up to 100 per centum of the costs, but in no case to exceed \$50,000, for initiation and development of a program for delivery of community mental health center services, for one year only running from the first day of the first month for which such a grant is made with respect to such a local public or private nonprofit agency or organization. In no event may such grants under clause (3) of section 220(b) or 242(b) with respect to any local public or private nonprofit agency or organization be made for any period after such one year."

(c) The second sentence of such section 224 is amended by striking out "seven" and inserting in lieu thereof "seventeen".

TITLE III—AMENDMENTS RELATING TO COMMUNITY MENTAL HEALTH CENTERS AND FACILITIES FOR THE MENTALLY RETARDED AND NARCOTIC ADDICTS

FEDERAL SHARE TO BE MAXIMUM; HIGHER SHARE FOR DISADVANTAGED AREAS

SEC. 301. (a) Effective with respect to projects approved after June 30, 1970, under part C of title I or part A of title II of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, section 402 of such Act (42 U.S.C. 2692) is repealed, and section 401(h) of such Act is amended to read as follows:

"(h) (1) The term 'Federal share' with respect to any project means the portion of the cost of construction of such project to be paid by the Federal Government under part C of title I or part A of title II.

"(2) The Federal share with respect to any project in the State shall, except as provided in paragraph (3), be an amount equal to 66 $\frac{2}{3}$ per centum of the Federal percentage for the State, or, if lower, the amount determined by the State agency designated in the State plan. Prior to the approval of the first such project in the State during any fiscal year, such State agency shall give the Secretary written notification of the maximum Federal share established pursuant to this paragraph for such projects in such State to be approved by the Secretary during such fiscal year and the method of determining the actual Federal share to be paid with respect to such projects; and such maximum Federal share and such method of determining the actual Federal share for such projects in such State approved during such fiscal year shall not be changed after such written approval has been given.

"(3) In the case of any facility or center which provides or will, upon completion of the project for which application has been made under part C of title I or part A of title II, provide services for persons in an area designated by the Secretary as an urban or rural poverty area, the maximum Federal share shall be equal to such per centum of the costs of the construction of the project as may be determined by the State, except that such per centum shall not exceed 90 per centum."

(b) Section 251(b) of such Act (42 U.S.C. 2688k) is amended by inserting immediately after "66 $\frac{2}{3}$ per centum" the following: "(or 90 per centum in the case of a facility providing services for persons in an area designated by the Secretary as an urban or rural poverty area)".

PERIOD FOR PROMULGATING FEDERAL PERCENTAGES

SEC. 302. Section 401(j) (1) of such Act is amended by striking out "August 31" and inserting in lieu thereof "September 30".

TITLE IV—MENTAL HEALTH OF CHILDREN

CONSTRUCTION AND STAFFING OF TREATMENT FACILITIES

SEC. 401. The Community Mental Health Centers Act is amended by adding at the end thereof the following:

"PART F—MENTAL HEALTH OF CHILDREN

"GRANTS FOR TREATMENT FACILITIES

"Sec. 271. (a) Grants from appropriations under subsection () may be made to public or nonprofit private agencies and organizations to assist them in meeting the costs of construction of facilities for mental health of children within the States, and to assist them in meeting the cost, determined pursuant to regulations by the Secretary, of staffing of such facilities constructed with grants made under part A of this part, or of new services in existing facilities for mental health of children.

"(b) The grant program for construction of facilities authorized by subsection (a) shall be carried out consistently with the grant program under part A except to the extent, in the judgment of the Secretary, special considerations make differences appropriate; but (1) before the Secretary may make a grant under such subsection for the construction of a facility for mental health of children he must find that the application for such grant meets the requirement of section 205(a)(5) (relating to the payment of prevailing wages), and (2) the amount of any such grant with respect to any project shall be such percentage of the cost thereof, but not in excess of 66 $\frac{2}{3}$ per centum (or 90 per centum in the cost of a facility providing services for persons in an area designated by the Secretary as an urban or rural poverty area), as the Secretary may determine.

"(c) Grants made under subsection (a) for the costs of staffing may not exceed the percentages of such costs, and may be made only for the periods, prescribed for grants for such costs under section 242.

"(d) (1) There are authorized to be appropriated \$6,000,000 for the fiscal year ending June 30, 1971, \$10,000,000 for the fiscal year ending June 30, 1972, and \$15,000,000 for the fiscal year ending June 30, 1973, for construction and staffing grants under this part.

"(2) There are also authorized to be appropriated for the fiscal year ending June 30, 1971, and each of the next thirteen fiscal years such sums as may be necessary to continue to make grants with respect to any project under this part for which a staffing grant was made under the above section for any fiscal year ending before June 30, 1973.

"(e) For purposes of this section, the term 'staffing' means salaries, fringe benefits, and travel allowances for professional and technical personnel needed to provide services to administer, evaluate, and operate the programs of a center for mental health of children.

"TRAINING AND EVALUATION

"Sec. 272. (a) The Secretary is authorized, during the period beginning July 1, 1971, and ending with the close of June 30, 1973, to make grants to any public or nonprofit private agencies and organizations to cover part or all of the cost of (A) developing specialized training programs or materials relating to the provision of services for the mental health of children or developing inservice training of short-term or refresher courses with respect to the provision of such services; (B) training personnel to operate, supervise, and administer such services; and (C) conducting surveys and field trials to evaluate the adequacy of the programs for the mental health of children within the several States with a view to determining ways and means of improving, extending, and expanding such programs.

"(b) There are hereby authorized to be appropriated for carrying out the provisions of this section, \$2,000,000 for the fiscal year ending June 30, 1971, \$4,000,000 for the fiscal year ending June 30, 1972, and \$4,000,000 for the fiscal year ending June 30, 1972."

[H.R. 14086, 91st Cong., 1st Sess., introduced by Mr. Rogers of Florida (for himself, Mr. Jarman, Mr. Nelsen, Mr. Satterfield, Mr. Carter, Mr. Kyros, Mr. Skubitz, Mr. Preyer of North Carolina, and Mr. Hastings) on September 30, 1969]

A BILL To amend the Community Mental Health Centers Act to extend the program of assistance under that Act for community mental health centers and facilities for the treatment of alcoholics and narcotic addicts, and for other purposes

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

SHORT TITLE

SECTION. 1. This Act may be cited as the "Community Mental Health Centers Amendments of 1969".

TITLE I—GRANTS FOR CONSTRUCTION OF COMMUNITY MENTAL HEALTH CENTERS AND FACILITIES FOR ALCOHOLICS AND NARCOTIC ADDICTS

EXTENSION OF PROGRAM FOR COMMUNITY MENTAL HEALTH CENTERS

SEC. 101. (a) Section 201 of the Community Mental Health Centers Act (42 U.S.C. 2681) is amended by striking out the period at the end and inserting in lieu thereof a comma and the following: "and for each of the next three fiscal years."

(b) Section 207 of such Act (42 U.S.C. 2687) is amended by striking out "1970" and inserting in lieu thereof "1973".

EXTENSION OF PROGRAMS FOR FACILITIES FOR ALCOHOLICS AND NARCOTIC ADDICTS

SEC. 102. (a) Section 261(a) of such Act (42 U.S.C. 2688a) is amended by striking out "and \$25,000,000 for the next fiscal year" and inserting in lieu thereof "\$15,000,000 for the fiscal year ending June 30, 1970, \$20,000,000 for the fiscal year ending June 30, 1969, or the fiscal year ending June 30, 1970" and inserting in lieu thereof "for any fiscal year ending before July 1, 1973".

(b) Section 261(b) of such Act is amended by striking out "the next three" and inserting in lieu thereof "the next eight", and by striking out "for the fiscal year ending June 30, 1969, or the fiscal year ending June 30, 1970" and inserting in lieu thereof "for any fiscal year ending before July 1, 1973".

PERCENTAGE OF ALLOTMENTS AVAILABLE FOR STATE PLAN ADMINISTRATION

SEC. 103. (a) Section 403(c) (1) of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (42 U.S.C. 2693) is amended by striking out "such part" and inserting in lieu thereof "title II"; and section 403(c) (2) of such Act is amended by striking out "such part A" and inserting in lieu thereof "title II".

TRAINING AND EVALUATION OF PROGRAMS FOR ALCOHOLISM

SEC. 104. Part C of the Community Mental Health Centers Act is amended by redesignating sections 245 and 246 as sections 246 and 247, respectively, and by inserting after section 244 the following:

"TRAINING AND EVALUATION

"SEC. 245. The Secretary is authorized to make grants to any public or non-profit private agencies and organizations to cover part or all of the cost of (1) developing specialized training programs or materials relating to the provision of public health services for the prevention and treatment of alcoholism, or developing inservice training or short-term or refresher courses with respect to the provision of such services; (2) training personnel to operate, supervise, and administer such services; and (3) conducting surveys and field trials to evaluate the adequacy of the programs for the prevention and treatment of alcoholism within the several States with a view to determining ways and means of improving, extending, and expanding such programs."

TITLE II—GRANTS FOR STAFFING OF COMMUNITY MENTAL HEALTH CENTERS AND FACILITIES FOR ALCOHOLICS AND NARCOTIC ADDICTS

FEDERAL SHARE

SEC. 201. (a) (1) Effective with respect to costs of development and operation of any community mental health center for any period after June 30, 1970, for which a grant has been or is made under subsection (a) of section 220 of the Community Mental Health Centers Act (42 U.S.C. 2688), subsection (b) of such section is amended to read as follows:

"(b) Grants under this part for such costs for any center may not exceed 75 per centum of the costs for the first fifteen months after the first day of the first month for which such grant is made with respect to such center, 60 per centum of such costs for the first year thereafter, 45 per centum of such costs for the second year thereafter, and 30 per centum of such costs for each of the next three years thereafter. No grant shall be made under this section for any period of time which is later than the last year referred to in the preceding sentence."

(2) Effective with respect to costs of development and operation of any alcoholism prevention and treatment facility, specialized facility for alcoholics, or treatment facility for narcotic addicts for any period after June 30, 1970, for which a grant has been or is made under subsection (a) of section 242 or 251 of the Community Mental Health Centers Act (42 U.S.C. 2688g, 2688k), subsection (b) of section 242 of such Act is amended to read as follows:

"(b) Grants under this section for such costs for any facility may not exceed 75 per centum of the costs for the first fifteen months after the first day of the first month for which such grant is made with respect to such facility, 60 per centum of such costs for the first year thereafter, 45 per centum of such costs for the second year thereafter, and 30 per centum of such costs for each of the next three years thereafter. No grant shall be made under this section for any period of time which is later than the last year referred to in the preceding sentence."

(b) In the case of any community mental health center, alcoholism prevention and treatment facility, specialized facility for alcoholics, or treatment facility for narcotic addicts, for which a staffing grant was made under section 220, 242, or 251 of the Community Mental Health Centers Act before July 1, 1970, the applicable provisions of subsection (b) of section 220 or 242 of such Act (as added by subsection (a) of this section) shall apply to the same extent as if such subsection (b) had been in effect on the date a staffing grant for such center or facility was initially made, except that the maximum percentage of such costs shall not exceed the percentage of staffing costs payable with respect to such center or facility as of June 30, 1970.

EXTENSION OF DURATION

SEC. 202. Section 221(b) of such Act (42 U.S.C. 2688a) is amended by striking out "1970" each place it appears therein and inserting in lieu thereof "1973".

AUTHORIZATION OF APPROPRIATIONS

SEC. 203. (a) The first sentence of section 224 of such Act (42 U.S.C. 2688d) is amended by striking out "and \$32,000,000 for the fiscal year ending June 30, 1970" and inserting in lieu thereof "\$26,000,000 for the fiscal year ending June 30, 1970, \$32,000,000 for the fiscal year ending June 30, 1971, \$40,000,000 for the fiscal year ending June 30, 1972, and \$48,000,000 for the fiscal year ending June 30, 1973".

(b) Such section 224 is further amended by adding immediately after the first sentence thereof the following: "For the purposes of assessing local mental health needs, developing necessary resources, and involving local citizens in the development of mental health programs, up to a maximum of 5 per centum of the appropriation authorized for each fiscal year under this section shall be available to the Secretary for grants to local public or private nonprofit agencies or organizations to cover up to 100 per centum of the costs, but in no case to exceed \$50,000, for initiation and development of a program for delivery of community mental health center services, for one year only running from the first day of the first month for which such a grant is made with respect to such a local public or private nonprofit agency or organization."

(c) The last sentence of such section 224 is amended by striking out "seven" and inserting in lieu thereof "twelve".

TITLE III—AMENDMENTS RELATING TO COMMUNITY MENTAL HEALTH CENTERS AND FACILITIES FOR THE MENTALLY RETARDED AND NARCOTIC ADDICTS

FEDERAL SHARE TO BE MAXIMUM; HIGHER SHARE FOR DISADVANTAGED AREAS

SEC. 301. Effective with respect to projects approved after June 30, 1970, under part C of title I or part A of title II of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, section 402

of such Act (42 U.S.C. 2692) is repealed, and section 401(h) of such Act is amended to read as follows:

"(h) (1) The term 'Federal share' with respect to any project means the portion of the cost of construction of such project to be paid by the Federal Government under part C of title I or part A of title II.

"(2) The Federal share with respect to any project in the State shall, except as provided in paragraph (3), be an amount equal to 66⅔ per centum of the Federal percentage for the State, or, if lower, the amount determined by the State agency designated in the State plan. Prior to the approval of the first such project in the State during any fiscal year, such State agency shall give the Secretary written notification of the maximum Federal share established pursuant to this paragraph for such projects in such State to be approved by the Secretary during such fiscal year and the method of determining the actual Federal share to be paid with respect to such projects; and such maximum Federal share and such method of determining the actual Federal share for such projects in such State approved during such fiscal year shall not be changed after such written approval has been given.

"(3) In the case of any facility or center which provides or will, upon completion of the project for which application has been made under part C of title I or part A of title II, provide services for persons in an area designated by the Secretary as an urban or rural poverty area, the maximum Federal share shall be equal to such per centum of the costs of the construction of the project as may be determined by the State, except that such per centum shall not exceed 90 per centum."

PERIOD FOR PROMULGATING FEDERAL PERCENTAGES

SEC. 302. Section 401(j) (1) of such Act is amended by striking out "August 31" and inserting in lieu thereof "September 30".

EXECUTIVE OFFICE OF THE PRESIDENT,
BUREAU OF THE BUDGET,
Washington, D.C., November 13, 1969.

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 requests for the views of the Bureau of the Budget on H.R. 13163, H.R. 14086, and H.R. 14617, bills cited as the "Community Mental Health Centers Amendments of 1969."

The Department of Health, Education, and Welfare on October 30, 1969 submitted to the Congress legislation to extend and improve the provisions of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 relating to mental health, alcoholism, and narcotic addiction. This legislation, introduced as H.R. 14617, would enable continuing Federal support for the development of community facilities for the prevention and treatment of mental illness, alcoholism, and narcotic addiction. In addition, it would provide special incentives to encourage the development of such facilities in those areas having the most critical need.

We recommend favorable consideration of H.R. 14617, in lieu of H.R. 13163 or H.R. 14086. The enactment of H.R. 14617 would be consistent with the Administration's objectives.

Sincerely yours,

WILFRED H. ROMMEL,
Assistant Director for Legislative Reference.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., December 1, 1969.

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

DEAR MR. CHAIRMAN: This is in reply to your request of November 3, 1969, for our views on H.R. 14617, a bill "To amend the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 to extend and improve the provisions relating to the construction and operation of community

mental health facilities, and of specialized facilities for alcoholics and narcotic addicts, and for other purposes".

This bill embodies the provisions of a draft bill submitted to the Speaker of the House of Representatives by this Department on October 30, 1969. The details of the bill are explained in a letter of the same date to the Speaker, a copy of which is enclosed for your convenience.

For the reasons stated in the enclosed letter, we urge enactment of the bill.

The Bureau of the Budget advises that enactment of this bill would be consistent with the Administration's objectives.

Sincerely,

ROBERT H. FINCH, *Secretary.*

Enclosure.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,

Washington, D.C., October 30, 1969.

Hon. JOHN W. McCORMACK,

The Speaker of the House of Representatives,
Washington, D.C.

DEAR MR. SPEAKER: Enclosed herewith for consideration of the Congress is a draft bill, "To amend the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 to extend and improve the provisions relating to the construction and operation of community mental health facilities, and of specialized facilities for alcoholics and narcotic addicts, and for other purposes."

This proposal would assure the continuing support of the Federal Government in the development of facilities to meet community needs in the prevention and treatment of mental illness, alcoholism, and narcotic addiction, and would provide special incentives to encourage the development of such facilities in those areas having the most critical need.

The Community Mental Health Centers Program makes comprehensive mental health services accessible to the individual in his home community. It has been demonstrated that recovery from mental illness can be very rapid if during treatment emergency services, partial hospitalization, and outpatient treatment are readily available along with inpatient care. In community mental health centers, all of these services are available without disruption in care as the patient moves from one stage of recovery to the next.

The proposed amendments would extend for an additional three years the program of grants to the States for the construction of community mental health centers. The bill provides, however, that 20 percent of the grant funds appropriated by Congress shall be reserved for direct project grants by the Secretary to cover up to 90 percent of the cost of community mental health centers which, in his judgment, are of special significance by virtue of their meeting the special needs of the disadvantaged for mental health services or by demonstrating new or particularly effective or efficient methods of delivery of mental health services.

In addition, in line with our desire to provide more coordination and encourage greater efficiency in our health system, the draft bill would add the requirements that the State plan for construction of community mental health centers must be approved by the State comprehensive health planning agency created under the provisions of Section 314(a) of the Public Health Service Act, and that applications for construction grants be reviewed and commented on by the appropriate areawide health planning agency created under the provisions of Section 314(b) of the Act.

The bill would extend the period of Federal support of staffing of community mental health centers from the present four and one-third years to eight years for all centers, and to ten years in the case of those centers providing services for persons in an area designated by the Secretary as an urban or rural poverty area. Staffing grants would support a share of all the costs of operation, staff, and maintenance of the centers, rather than being limited to support of the costs of professional and technical personnel as presently authorized. The present arrangement of supporting a portion of the costs of only professional and technical personnel has proved inadequate. We feel support of a portion of initial costs of operation, staffing, and maintenance should be provided in order to assure a more reasonable level of financial assistance in the developmental years and bring about substantial administrative simplification.

The draft bill would also authorize the use of up to 5 percent of the funds appropriated for new staffing grants for support of project grants to assess

the need, develop, and initiate mental health services in communities designated by the Secretary as urban or rural poverty areas.

Drug abuse and alcoholism programs require strong and continued Federal support. Preferential matching and a longer period of support will be necessary. To meet these objectives, the proposal would extend for 3 additional years the program of grants for the construction and staffing of facilities for the prevention and treatment of alcoholism and narcotics addiction. The maximum Federal share of the costs of construction would be increased from 66⅔ percent to 90 percent. Existing Federal support of professional and technical personnel would be expanded to include a portion of the initial costs of operation, staffing, and maintenance. The period of support would be increased from 4½ years to 10 years, and the maximum level of support would be increased.

A new program of grants for the development of specialized training programs or materials relating to the provision of services for the prevention or treatment of alcoholism and for the evaluation of such programs is added by the proposed bill. This grant program is similar to the program already authorized for the rehabilitation of narcotic addicts.

Appropriations authorizations are requested for three years for such sums as may be necessary.

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

The Bureau of the Budget advises that enactment of this bill would be consistent with the Administration's objectives.

Sincerely,

ROBERT H. FINCH, *Secretary.*

DEPARTMENT OF JUSTICE,
OFFICE OF THE DEPUTY ATTORNEY GENERAL,
Washington, D.C., December 2, 1969.

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 requests for the views of the Department of Justice on H.R. 13163, H.R. 14086 and H.R. 14617, bills to amend the Community Mental Health Centers Act to extend the program of assistance under that Act for community mental health centers and facilities for the treatment of alcoholics and narcotic addicts. H.R. 13163 would also establish programs for mental health of children.

All three bills, which bear the title "Community Mental Health Centers Amendments of 1969", would amend the Mental Retardation Facilities and Community Mental Health Centers Construction Act, 77 Stat. 284 as amended (42 U.S.C. 2661 *et seq.*) in several respects. They would extend the appropriation authorizations for construction of community mental health centers, for staffing of community mental health centers, for construction and staffing of alcoholism treatment centers, and for construction and staffing of narcotic addict treatment facilities. The bills would expand the authorization for federal payment of administrative costs of programs and would authorize new training grants for the prevention and treatment of alcoholism. And they would revise present provisions on the determination of the federal share of grants and would increase the federal share in rural or urban poverty areas. In addition, H.R. 13163 would add to existing law a provision authorizing grants for construction and staffing of facilities for mental health of children, and H.R. 14617 would make the Trust Territories of the Pacific Islands eligible to receive grants under the Act.

Whether this legislation should be enacted involves questions as to which the Department of Justice defers to the Department of Health, Education and Welfare.

The Bureau of the Budget has advised that there is no objection to the submission of this report from the standpoint of the Administration's program, and that enactment of H.R. 14617 would be consistent with that program.

Sincerely,

RICHARD G. KLEINDIENST,
Deputy Attorney General.

Mr. JARMAN. Our first witness this morning will be Mr. Creed C. Black, Assistant Secretary for Legislation of the Department of Health, Education, and Welfare.

Mr. Black, we welcome you to the subcommittee as a lead-off witness on this important legislation and would appreciate the introduction of your associates.

STATEMENT OF CREED C. BLACK, ASSISTANT SECRETARY FOR LEGISLATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY IRVING J. LEWIS, DEPUTY ADMINISTRATOR, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION; DR. STANLEY YOLLES, DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH; DR. SAMUEL L. BUKER, ACTING CHIEF, DIVISION OF MENTAL HEALTH SERVICES PROGRAMS, NIMH; AND DR. MORTON MILLER, ACTING ASSOCIATE DIRECTOR, NIMH

Mr. BLACK. Thank you, Mr. Chairman.

We are glad to be here to testify on the administration bill which you mentioned, H.R. 14617, and also the two other bills, H.R. 13163, introduced by your distinguished chairman, Mr. Staggers, and H.R. 14086, introduced by Mr. Rogers of your subcommittee.

With me this morning on my right is Mr. Irving J. Lewis, Deputy Administrator of the Health Services and Mental Health Administration; on my immediate left is Dr. Stanley Yolles, Director of the National Institute of Mental Health; and next to him is Dr. Samuel L. Buker, Acting Chief, Division of Mental Health Services Programs, NIMH; and on his left Dr. Morton Miller, Acting Associate Director of the NIMH.

In the short span of less than 5 years, the community mental health centers program has succeeded in bringing mental health services to thousands upon thousands of Americans, many of whom had no access to such services before. When the present authorization expires on June 30, 1970, almost 500 centers will have been funded, in areas ranging from the very poorest counties in Appalachia to the affluent urban-suburban fringes of our major cities. These services will be within the reach of more than 75 million of our citizens.

In addition to making needed services available, the program has reaped other real benefits.

Communities across the Nation, for example, have had an opportunity to demonstrate their interest in shouldering program and fiscal responsibility at the local level for development of services fitted to the specific mental health needs of their citizens.

Additionally, many communities have become increasingly aware of the special priority needs of their people, such as those concerned with the severity of mental health problems of the poor, with alcoholism, and with drug abuse. They have come to realize that these critical problems of our national life demand specialized, long-range programs of high quality.

In the community mental health centers program we also see the development of innovative models of prevention and ambulatory mental health care which have reduced the need for more expensive hospitalization and custodial care.

These programs have also been instrumental in helping to channel scarce mental health manpower into communities which have lacked

this resource. The centers have become training settings for professional and auxiliary health manpower, increasing the total pool of mental health manpower available to serve the country's needs. The better utilization of manpower and other community resources is, indeed, an outstanding feature of the centers program that is enhancing the effectiveness and efficiency of mental health care.

All in all, the centers represent a Federal partnership with State and local resources—both public and private—which justifies the conclusion that we have taken a major step toward development of a network of health services which will have a significant impact on the quality of life in our country.

The community mental health centers program is thus a major element in HEW's effort to alter the Nation's traditional pattern of organization and delivery of health services. This administration is committed to its continuation.

The experience to date, however, has suggested that some changes are needed in the legislation to meet problems which have been encountered in these early years.

Across the Nation, many communities which are aware of their needs, and have clearly expressed their readiness and motivation to do something about those needs, have either abandoned steps initiated, or have not even begun to go ahead with programs, because they doubt that they can marshal the necessary local resources within the period of initial Federal support now existing.

Other communities which have developed center programs, particularly those in the fourth year of support, and facing a fifth year (when Federal staffing support is limited to only 30 percent of costs for 3 months), are experiencing serious difficulty. It appears clear that a number of these programs will have to retrench, cutting back to a portion of direct services which they find fiscally feasible. Should this occur, it will be at the cost of those preventive services most needed to solve the present severe problems. These are the educational and preventive efforts that are the outstanding hallmarks of these programs in that they make the most of vital collaboration with other health and welfare resources.

Optimistic expectations for the progressive development of funding resources unfortunately have not materialized as rapidly as necessary to replace the reduction in Federal support available for participation in the initial funding of staff for new services in community mental health centers.

There is already much evidence that the original estimates of the extent and duration of Federal financial participation required for the initial implementation period were too low. One factor has been that congressional leaders and program administrators have been overly optimistic in estimates of the rate of development of related regional and national public and private assistance programs that would become part of the financial base available to the community for the program. Social security, private insurance resources, and other third-party payments have not developed at the pace and to the extent anticipated.

Also underestimated was the task and time involved in organization of the community for assessment of its needs, achieving a public mandate, and marshaling its public and private resources for taking fiscal

and program responsibility to achieve a quality, stable, effective program. The extent of the resources and the time required are only now becoming evident.

Meanwhile, States and communities throughout the Nation have repeatedly emphasized the need for greater outside support both in terms of length of support and levels of support.

Some State officials indicate that centers in their States will be in financial difficulty if Federal funds for staffing decline in accord with existing rates because there will not have been sufficient time to develop adequate local and State support. State and regional officials note similar problems in both rural areas and in centers serving metropolitan areas. Some States are currently making up the funding deficits of local centers, but predict this will not be possible as the number of centers continues to increase in the State.

The administration recognizes, therefore, that the continuation and development of the community mental health centers program now requires revisions in Federal grant support. It is clear that the present 51-month period of Federal funding of mental health centers is inadequate. All of the proposed bills acknowledge the problem of inadequate funding and increase the duration and rate of Federal staffing assistance, although H.R. 14086 provides a rather limited extension of only 2 years.

In connection with the administration's review of the program, we have examined very closely the need for strengthening this assistance, and believe that Federal aid should be extended to all operating costs. The current arrangement limits aid to the cost of professional and technical personnel. We view this not only as unsound administratively, but as inadequate coverage to sustain the life of the centers. Only the administration bill broadens the definition of initial staffing operation to cover all personnel, operation and maintenance costs.

The administration is also cognizant of the urgent need for even more extended assistance for services to urban and rural poverty areas. It has been noted repeatedly that the areas designated by the States as those of highest priority, based on an assessment of community need, are not among the first to initiate centers. This is partially due to the difficulty in developing resources to meet the matching requirements because of the low economic status of the community. Thus, we have had to face the fact that those in greatest need of community-based mental health services, the urban and rural poor, have been the least able to effectively organize, plan, and raise sufficient funds to compete successfully for Federal grant support.

All of the proposals acknowledge this problem and provide special assistance to urban and rural poverty areas by raising the level of the Federal share of construction costs for centers serving these areas. The administration bill also provides for the reservation of 20 percent of construction grant appropriations for direct project grants by the Secretary for the construction of centers of "special significance"—which specifically include centers providing services for persons in urban or rural poverty areas. In addition, the administration bill provides preferential matching for the operation of centers in these disadvantaged areas.

In other Federal programs designed to deal with social conditions in poverty areas, preferential matching and other special incentives

have been found necessary. Relatively few organizations or institutions which serve the disadvantaged and are potential applicants for community mental health center funds have professional staff with the necessary experience for effective mental health program development. This barrier has been overcome elsewhere by the use of a developmental grant, for example, in the model cities program and in the neighborhood health center program. We have proposed grants for the initiation and development of community mental health programs which serve urban and rural poverty areas. These grants will ease the task of assessing local mental health needs, designing sound programs, and developing the resources required to support mental health center programs serving poverty areas.

Before turning to two major mental health programs—alcoholism and drug abuse—which require strong and continued Federal support and are therefore the object of preferential funding in the administration bill, permit me to place my statement in a larger setting within which the centers program, and others, have been reviewed by this administration.

As you know, the President has instructed that a number of significant reviews of ongoing Federal programs be conducted to be sure that the programs reflect not only social needs but also the requirements of effective operation and responsiveness to the varied needs of States and localities. A major objective of these reviews is to reform the grant-in-aid system under which so many Federal programs are conducted. As a beginning effort to cope with the necessity to rationalize the grant-in-aid system, the President has proposed a Grant Consolidation Act, which would permit, with congressional approval, the merger of overlapping Federal grant-in-aid programs.

I should like to emphasize that these reviews derive from a fundamental concern of this administration not only for efficiency and economy but for the necessity of improving the delivery of health and social services to the people. A principal need today is to improve our delivery system: to insure that the intended services actually reach the intended recipients.

The administration has introduced its proposals for extension of the community mental health centers programs in the context not only of the needs of the program itself, but also the larger administration legislative program.

In regard to the planning of centers, for example, the administration's bill provides for improved planning coordination. We recommend that each construction project application be submitted for review and comment to the appropriate areawide health planning agency established under section 314(b) of the Public Health Service Act. In addition we propose that construction plans be reviewed and approved by the State's comprehensive health planning agency established under section 314(a). We firmly believe that these provisions should be made in the extension of the community mental health centers program.

To make the most effective use of public and private resources in the development of the centers program, it is necessary to insure that health planning on a State, interstate, and local level be taken into account. In addition, it is essential that we strengthen the capacity of each community to develop integrated health services.

While all three bills before this committee seek to help the States defray administrative expenses in connection with centers plans, the administration's proposal raises to a realistic level the percentage of funds which can be used for this purpose.

A basic point I would like to make, Mr. Chairman, is that the administration is committed not only to the continuation of the community mental health centers program, but to strengthening the quality of the centers which have been funded or can be in the future.

We also want to move toward greater integration of community mental health efforts with comprehensive health care at the community level.

We will continue to attempt to meet the goals as fast as fiscal constraints will permit. As these constraints force choices among alternatives, the administration would prefer to have fewer centers, better funded, firmly in place, with a sound, stable organizational and programmatic base, than to have more centers in more communities at funding levels inadequate to assure continuity and stability.

Health insurance now accounts for only a small percentage of the income which supports mental health services. Encouraging the expansion of insurance coverage to a point where it will eventually make a major financial contribution to the support of high-quality community mental health programs is a goal of this administration. By providing extensive consultation to the health insurance industry and funding feasibility and evaluation studies, the Department has taken specific measures to foster this development as rapidly as possible. Indeed, some of these efforts are directly related to the increase in private health insurance coverage which has occurred, for example, in trade union programs and in Federal employee health benefits programs.

In the long run, we look to improvements in health care payment mechanisms to cover a larger share of the costs of services in new modes of delivery of health care, such as the community mental health centers. Here I would note that Secretary Finch's report of July 10 calls upon the health insurance industry to mobilize to expand coverage to additional groups, to provide broader and more effective coverage, to encourage preventive services and to provide incentives to keep people out of hospitals and high-cost facilities. Response by the health insurance industry to the challenge of the Secretary is essential if we are, in the long run, to achieve the full benefits of our health programs.

As for the nationwide problems of alcoholism and drug abuse to which I have referred, the administration is in complete accord with the need to develop special programs for dealing with these afflictions. We are firmly convinced that special services must continue and that Federal support should be, as at present, provided as an integral part of the network of community mental health services.

We would be opposed to legislation that would depart from the present concept of integration of services. Preventive and curative services for drug abusers and for alcoholics must be part of a comprehensive mental health system and should not lead to separate facilities and services. The mental health center model is an ideal one in which to integrate facilities and services for alcoholism and drug abuse. Centers are structured to respond to the needs of their respective communities—the place where persons suffering from these disorders live

and to which they will return. The coordination of mental health and social services in the centers provides treatment which can be tailored to fit patients' needs and allows for natural progression through inpatient treatment, gradual return to the community by partial care systems, and long-term, followup services.

We are equally of the view, Mr. Chairman, that, for a number of reasons, services for alcoholics and narcotic addicts at the community level will require very special efforts and incentives. As I pointed out earlier, few communities are initially able or willing to devote limited resources to these two problems. Professional interest, too, needs to be stimulated. We believe, therefore, that preferential matching and a period of support longer than 51 months is necessary. While the administration bill and H.R. 13163 both provide preferential matching for staffing these programs, H.R. 14086 does not. Moreover, the latter extends each staffing grant only 2 years, compared to the 5-year, 9-month extension in the others. In addition, the administration's proposal provides preferential matching for construction of alcoholism facilities as well as facilities for treating narcotic addicts.

Finally, Mr. Chairman, I want to point out that this administration has identified the health needs of children as an area of high priority. As you know, the community mental health centers program we have been discussing today provides services to children as well as adults. The Department is now carrying on evaluation studies of the centers program to determine additional ways in which the program can be strengthened, including improvements in the provision of mental health services for children. In addition, we are reviewing a number of recommendations which deal with the provision of services for children, including the report of the Joint Commission on the Mental Health of Children which was established by the Congress and has recently completed a 3-year study of this area. This evaluation and review will provide a basis for further development of mental health programs for children and for our future recommendations in this area.

Mr. Chairman, I have appreciated this opportunity to present to the committee our views with respect to amendments to the Community Mental Health Centers Act. The extension of community mental health services into every area of the country and the strengthening of these services are vital if the mental health needs of this Nation are to be met.

Thank you. We will be happy to answer any questions you might have.

Mr. JARMAN. Thank you, Mr. Black, for a comprehensive statement on this important subject.

Let me ask you a couple of questions about the financial side of the program and the recommendation of the administration. The committee needs as specific information as we can get on what the money needs of the program will be. Can you give us specific recommendations for appropriation authorizations for each of the fiscal years covered by the administration's bill?

Mr. BLACK. No, Mr. Chairman. As you know, our bill provides for the appropriation of such sums as may be necessary. Our present funding levels and our 1970 recommendations are known, of course. Our 1971 recommendations are now before the Bureau of the Budget; I

don't think we could give you specific figures for these 3 years. I just simply say that as pointed out in my testimony, there are some fiscal constraints affecting all of our programs. Our position is that we would rather, in the framework of whatever the Congress sees fit to appropriate, concentrate on strengthening the centers that are now in existence, which are the ones we will fund, rather than continuing to fund a much larger number at a lower level.

Mr. JARMAN. Do you feel you will be in a position to recommend something specific to the committee prior to our executive session on the bill and consideration of the bill in the committee and taking the bill to the floor of the House?

Mr. BLACK. Well, that will depend in part on the timing; I would think, at least as far as 1971 is concerned. As you know, the program is not now being funded at anything close to the present authorization level. I think it would be unrealistic to believe that in this period of fiscal constraints the program could be funded at these present authorization levels. (See letter dated Dec. 3, 1969, p. 61.)

Mr. JARMAN. Well, because the program is not being funded at authorization levels I think is another reason why the committee needs specific recommendations as to exactly what you feel is necessary from the financial side. We have always had in the committee a real reluctance to vote into law open end authorizations and in this subcommittee we intend to be as specific as possible in trying to anticipate the needs in a particular health field. So it certainly would be helpful to this committee if something definite can be suggested to us to cover the program that the administration proposes.

Mr. BLACK. As I said, Mr. Chairman, certainly as far as 1971 is concerned, we can probably, depending again on the time, give you an indication fairly soon as to what our budget request will be and then we could give you an idea of what kind of funding we are thinking of. I am sure you understand we are in no position to do that now because our proposals are before the Bureau of the Budget and we do not have their reaction to them yet.

Mr. JARMAN. Yes, but one real problem we are having here on Capitol Hill is that we are now near the end of the year and must deal with the necessity of continuing these programs that are in being. The Congress has waited on many of these programs for specific recommendations from the administration. If we are to legislate and write new law, we need the recommendations now.

Mr. BLACK. Well, Mr. Chairman, I think that we have before you our recommendations, which are quite complete and comprehensive as far as the structure of the program is concerned. The only things missing are the specific figures on what authorization levels the committee might adopt, and as a matter of policy we have at this point simply said that we think we prefer to see it on this "such sums as may be necessary" basis. I do not know that we would be able to give you specific figures on that before the committee acts. I point out again that I think we can give you some indication of the funding level that we think will be realistic for this program. I am sure you know that this is only one of many programs in which there is a big gap between what the authorizing committee and the appropriations committee think the figures should be.

Mr. JARMAN. Yes, that certainly is true but we as the authorizing committee have to start with a recommended figure of what the administration and the Congress decide will cover the plans for the future. The Department is aware of the fact that the phrasing "such sums as may be needed" has never been acceptable to the committee. Our position is consistent. I will say again we think that is the responsibility of the Department and that specific recommendations should come to this committee.

In connection with the money problem let me ask you about the first paragraph on page 9 of H.R. 14671, lines 1 through 8. "The administration bill proposes to broaden the costs covered by Federal matching." Is it intended that all costs of these centers be covered by this proposal exclusive of construction which is covered elsewhere?

Mr. BLACK. Yes. Our proposal is that all operating costs be included. As I indicated in my statement, we think that this would be administratively sound. It would be a much simpler arrangement than the one that exists now where we are separating not simply personnel costs from other costs but even one portion of the personnel costs. We think it would simplify the administration of the program a great deal, based on the experience to date, and that, further, it would help provide the initial support that our experience indicates the centers need.

Mr. JARMAN. Let me ask also, what amounts are contained in the appropriation bill for the Department of Health, Education, and Welfare for this program for each of the following: construction, staffing, and alcoholic and narcotic addict facilities?

Mr. BLACK. For 1970?

Mr. JARMAN. Yes.

Mr. BLACK. The appropriation for construction for 1970 is \$29,200,000; for staffing, \$51,300,000; for narcotic, \$8 million; and for alcoholism no appropriation was requested.

Mr. JARMAN. Are these amounts, Mr. Black, the same as requested in the budget?

Mr. BLACK. Those are the budget requests, yes, sir.

Mr. ROGERS. I think the House put in \$4 million, did it not?

Mr. BLACK. The House put in \$4 million for alcoholism.

Mr. ROGERS. Even though it was not requested.

Mr. BLACK. That is right. Our figures were for our request. We had no request for alcoholism and the House did add \$4 million.

Mr. JARMAN. Thank you very much.

Mr. ROGERS.

Mr. ROGERS. Thank you, Mr. Chairman.

Mr. Secretary, it is good to see you and your associates.

How many centers do we presently have functioning?

Mr. BLACK. We presently have operational—as of June 30, we had 175.

Incidentally, we have a couple of other things here which might be useful. We have a brief summary of our bill and then a group of charts and tables, which the NIMH staff has put together. On page 3, Mr. Rogers, you see more figures on where we stand with the program today: 376 funded, as of June 30; 175 were operational.

(The material referred to follows:)

SUMMARY—COMMUNITY MENTAL HEALTH CENTERS AMENDMENTS OF 1969

CONSTRUCTION GRANTS

1. Extends for 3 years (FY 1971-1973) the duration of the program of allotments to States for grants for construction of community mental health facilities, without specifying any appropriation ceiling.
2. Permits allotments for such construction grants to the Virgin Islands, American Samoa, Guam, and the Trust Territory of the Pacific Islands to be carried over for 2 years beyond the end of the fiscal year for which the allotments are made.
3. Increases from the lesser of 2 per cent or \$50,000 to 5 per cent or \$50,000, the portion of the State allotment which may be used to pay up to $\frac{1}{2}$ of the cost of the administration of the State plan.
4. Requires that the State plan for construction of community mental health centers must be approved by the State comprehensive health planning agency established under section 314(a) of the PHS Act, and that applications for construction grants should be reviewed and commented on by the appropriate areawide health planning agency created under 314(b) of the same Act, or if there is none any appropriate agency performing similar functions.
5. Reserves 20 per cent of the grant funds for direct project grants by the Secretary to cover up to 90 per cent of the cost of community mental health centers which, in his judgment, are of special significance by virtue of their meeting the special needs of the disadvantaged or by demonstrating new or particularly effective or efficient methods of delivery of mental health services.

INITIAL STAFFING GRANTS

1. Extends for 3 years (FY 1971-1973) the duration of the program without any appropriation ceiling.
2. Provides for financial participation in the cost of operation, staffing, and maintenance for the initial operation of community mental health centers instead of only in the cost of compensation of professional and technical personnel for such initial operation.
3. Increases, from the first 15 months of operation to first two years thereof, the period during which 75 per cent of the cost of initial operation of a community mental health center will be payable.
4. Provides higher Federal share (90 per cent for the first 2 years, and declining percentages for the next 8 years) of cost of operation for projects in poverty areas.
5. Provides that the Secretary, in determining maintenance of effort on the part of a center, will receive assurance that Federal funds will supplement and, to the extent practicable, increase the level of non-Federal funds, including third party health insurance payments.
6. Reserves 5 per cent of the amount appropriated for staffing grants for grants to initiate and to develop projects for the delivery of mental health services.

ALCOHOLISM AND NARCOTIC ADDICT REHABILITATION

1. Extends for three years (FY 1971-1973) the duration of the program of construction and staffing grants for community mental health centers for alcoholism and narcotic addict rehabilitation.
2. Increases to 90 per cent the maximum Federal share for construction grants for these programs.
3. Provides for financial participation in operation, staffing, and maintenance instead of professional and technical personnel, and provides a higher Federal share (90 per cent for the first 2 years, plus declining percentages over the next 8 years) for cost of operation of such projects.
4. Authorizes the Secretary to make grants for training programs for alcoholism, and evaluation of programs already in operation.

MISCELLANEOUS AMENDMENTS APPLICABLE TO BOTH

1. Makes the Trust Territory of the Pacific Islands eligible.
2. Authorizes Federal participation in the cost of acquisition of land as well as in the cost of construction of facilities thereon.

3. Changes Federal share from the percentage of the cost of construction to be paid by the Federal Government to the maximum on the percentage of cost to be paid. Eliminates minimum Federal share of 33 $\frac{1}{3}$ per cent; provides higher maximum (90 per cent—instead of 66 $\frac{2}{3}$ per cent or the State's Federal percentage, whichever is lower) for poverty areas.

ESSENTIAL AND COMPREHENSIVE SERVICES—COMMUNITY MENTAL HEALTH CENTERS

ESSENTIAL SERVICES

The services and programs of the mental health center must include five essential elements of community mental health services:

1. *Inpatient services*: A unit to provide 24-hour care for treatment of acute disorders.

2. *Outpatient services*: All forms of outpatient mental health treatment will be provided.

3. *Partial hospitalization services*: Space and facilities will be provided for treatment during the day of patients able to return to their homes and families in the evenings and weekends. Also space and facilities for treatment and overnight accommodations for patients able to work but needing further care or having an unsuitable home situation.

4. *Emergency services* provided 24 hours per day must be available within at least one of the first three services listed above.

5. *Consultation and education services* available to community agencies and professional personnel: This will include consultative and diagnostic assistance to private practitioners and to community agencies such as schools, courts, and welfare departments concerning emotional problems of the individuals with whom they deal.

COMPREHENSIVE SERVICES

For a program adequately responsive to community needs, additional services such as the following are desirable and are eligible for Federal support.

1. *Diagnostic services*, ranging from testing of mentally retarded and emotionally disturbed persons, to screening of patients prior to admission to the appropriate service within the center.

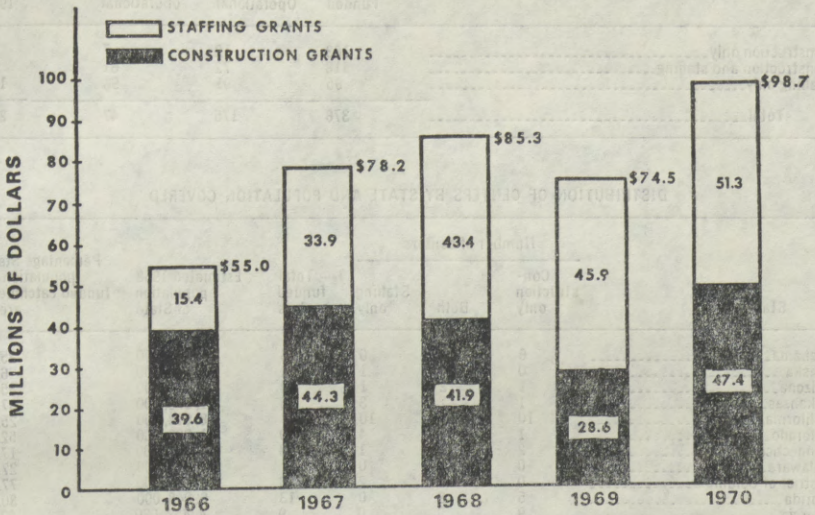
2. *Rehabilitative services*, including vocational and educational programs: These services would be coordinated with existing facilities and would also be an extension of the day or partial hospitalization program.

3. *Precare and aftercare services* in the community, including foster home placement, home visiting, and halfway houses.

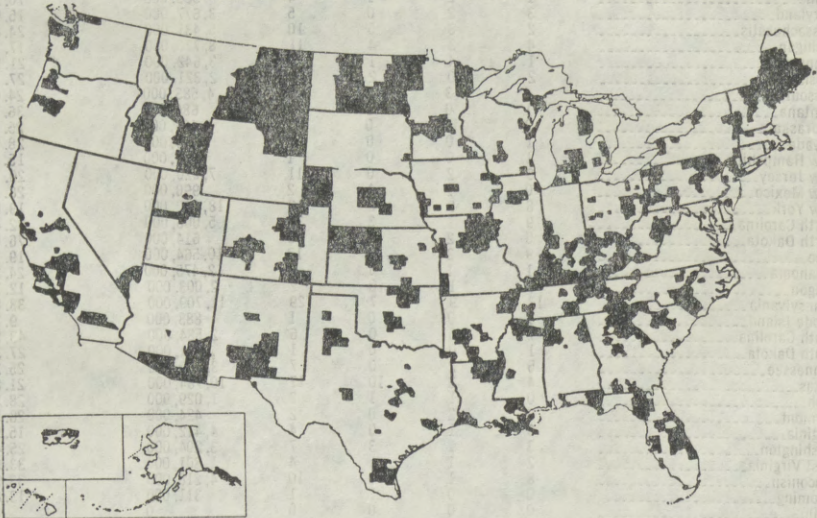
4. *Training programs* in community mental health practices: The center should provide facilities for the training of all personnel directly involved in the care and treatment of the mentally ill, including ministers, nursing home operators, probation officers, teachers, and volunteers.

5. A *research and evaluation program*: The center will serve as a base for research in mental illness, epidemiological studies of incidence and distribution of mental illness in the community, and evaluation of the treatment procedures and programming of the center.

OBLIGATIONS BY YEAR FOR CONSTRUCTION AND STAFFING OF COMMUNITY MENTAL HEALTH CENTERS



COMMUNITY MENTAL HEALTH CENTERS CATCHMENT AREAS AS OF JULY 1, 1969



NUMBER OF CENTERS FUNDED AND OPERATIONAL

	As of June 30, 1969			Estimated, as of June 30, 1970
	Funded	Operational	Percent operational	
Construction only.....	163	12	7	18
Construction and staffing.....	118	72	61	92
Staffing only.....	95	91	96	115
Total.....	376	175	47	225

DISTRIBUTION OF CENTERS BY STATE AND POPULATION COVERED

State	Number of centers			Total funded centers	Estimated 1968 population of State	Percentage State population in funded catchment areas
	Construction only	Both	Staffing only			
Alabama.....	6	0	0	6	3,522,000	25.0
Alaska.....	0	0	1	1	241,000	6.7
Arizona.....	1	2	1	4	1,631,000	35.9
Arkansas.....	1	2	3	6	1,976,000	37.0
California.....	10	14	10	34	18,918,000	25.4
Colorado.....	1	4	4	9	1,986,000	52.5
Connecticut.....	2	0	1	3	2,951,000	17.2
Delaware.....	0	1	0	1	525,000	27.4
District of Columbia.....	0	1	2	3	790,000	77.3
Florida.....	5	8	0	13	6,048,000	30.0
Georgia.....	9	0	0	9	4,452,000	27.9
Hawaii.....	1	1	0	2	727,000	30.9
Idaho.....	0	2	1	3	699,000	41.1
Illinois.....	6	1	0	7	10,934,000	11.1
Indiana.....	6	1	0	4	5,051,000	24.4
Iowa.....	3	2	1	6	2,771,000	13.5
Kansas.....	0	9	1	10	2,262,000	35.5
Kentucky.....	9	2	12	21	3,160,000	92.4
Louisiana.....	1	2	1	4	3,678,000	35.9
Maine.....	3	2	0	5	963,000	70.3
Maryland.....	2	3	5	10	3,677,000	15.9
Massachusetts.....	4	3	4	11	5,431,000	24.8
Michigan.....	1	4	1	6	8,720,000	17.1
Minnesota.....	2	0	2	4	3,642,000	21.8
Mississippi.....	4	3	1	8	2,321,000	27.1
Missouri.....	1	0	1	2	4,583,000	24.6
Montana.....	2	1	0	3	686,000	36.7
Nebraska.....	1	0	0	1	1,424,000	25.1
Nevada.....	1	0	0	1	699,000	28.9
New Hampshire.....	9	2	0	11	7,020,000	15.5
New Jersey.....	0	1	1	2	990,000	20.7
New Mexico.....	8	9	2	19	18,040,000	26.1
New York.....	9	1	3	13	5,006,000	19.0
North Carolina.....	0	2	3	5	5,006,000	32.4
North Dakota.....	9	3	1	13	614,000	76.0
Ohio.....	1	1	1	3	10,564,000	19.1
Oklahoma.....	1	1	0	2	2,475,000	24.3
Oregon.....	1	1	0	2	2,003,000	12.7
Pennsylvania.....	13	9	7	29	11,709,000	38.8
Rhode Island.....	1	0	0	1	883,000	9.2
South Carolina.....	1	5	0	6	2,584,000	43.5
South Dakota.....	1	0	0	1	651,000	27.3
Tennessee.....	5	2	0	7	3,940,000	25.2
Texas.....	4	3	10	17	10,784,000	21.8
Utah.....	0	1	1	2	1,029,000	28.5
Vermont.....	0	2	0	2	424,000	28.5
Virginia.....	3	1	0	4	4,412,000	15.9
Washington.....	3	1	3	7	3,204,000	25.4
West Virginia.....	2	1	1	4	1,801,000	33.3
Wisconsin.....	8	1	1	10	4,218,000	33.9
Wyoming.....	0	0	1	1	311,000	13.8
Guam.....	0	0	0	0	0	0
Puerto Rico.....	0	3	5	8	2,712,000	38.6
Virgin Islands.....	0	0	0	0	0	0
Total.....	163	118	95	376	200,281,000	26.1

CHARACTERISTICS OF CENTER GRANTEES (BOTH CONSTRUCTION AND STAFFING)

Organizational nature of grantees	Number	Percent
General hospitals (15 public, 76 private nonprofit).....	95	25
Mental health clinics.....	13	3
Mental health center and special-purpose corporation.....	98	26
Mental hospitals.....	14	4
Others (mostly local government units and charitable institutions).....	156	42
Total.....	376	100
Public versus private nonprofit:		
Public:		
State.....	53	14
County.....	77	21
Municipal.....	28	7
Others ²	24	6
Total public.....	182	48
Private, nonprofit.....	194	52
	376	100
Joint endeavors:		
1 agency.....	57	15
2 or more affiliating agencies.....	319	85
Total.....	376	100
Urban rural:		
Cities of 500,000 plus.....	64	17
Cities of 25,000 to 500,000.....	183	49
Cities of less than 25,000.....	129	34
Total.....	376	100

¹ An additional 180 CMHC's have general hospitals as affiliates.² Public agencies responsible for areas larger than single counties; i.e., hospital districts, regional boards, etc.

CONSTRUCTION GRANTS—AVERAGE COSTS AND SOURCES OF FUNDING

	Average costs	
	Per grant	Per center
Federal grant.....	\$296,556	\$548,629
Grants/center (percent).....		1.85
Federal rate (percent).....	51.43	51.43
Total eligible cost.....	\$576,621	\$1,066,748
Total construction cost.....		\$1,694,000

SOURCES OF INCOME

	Percent
Federal grant under Public Law 88-164.....	30
Cash.....	17
Pledges.....	4
Gifts.....	3
Bonds.....	9
Mortgage.....	10
Appropriations:	
State.....	16
Local.....	7
Appalachia.....	1
Other.....	5

AVERAGE PROJECTS COSTS AND SOURCES OF FUNDS

	Average per center
Construction:	
Total construction cost.....	\$1,462,902
Total eligible cost.....	923,502
Federal share.....	475,000
Distribution of funds by source (percent of total):	
Federal grant under Public Law 88-164.....	30
Cash.....	17
Pledges.....	4
Gifts.....	3
Bonds.....	9
Mortgage.....	10
Appropriations:	
State.....	16
Local.....	7
Appalachia Commission.....	1
Other.....	5
Staffing (for 51 months):	
Total operating cost.....	\$3,174,750
Total eligible staffing cost.....	1,615,000
Federal grant, 55 percent.....	888,917
Matching, 45 percent.....	725,083
Federal share of total operating costs, 28 percent.	
Distribution of funds by source (percent of total):	
Federal Government.....	37
State governments.....	21
County or local governments.....	6
Patients payments.....	14
Philanthropy.....	2
Third party payments.....	10
Other.....	10

STAFFING GRANTS—AVERAGE COSTS AND SOURCES OF FUNDING

	Average costs	
	Per grant	Per center
Federal costs:		
1st year.....	\$321,000	\$385,200
51 months.....	979,050	1,174,860
Non-Federal costs:		
1st year.....	392,300	470,760
5 years.....	2,587,450	3,104,940
Total operations:		
1st year.....	713,300	859,960
5 years.....	3,566,500	4,279,800
Federal share of total operation (percent):		
1st year.....	45	45
5 years.....	27	27

	Percent
Sources of income (new services):¹	
Federal grant.....	37
Other Federal funds.....	4
State funds.....	21
Local funds.....	6
Patient fees.....	14
Insurance.....	6
Medicare.....	4
Medicaid.....	5
Other service receipts.....	2
Fund raising.....	1
Other.....	1
Total.....	100
Expenditures (all services):²	
Mental health personnel.....	60
Nonmental health personnel.....	11
Operating expenses.....	22
Capital expenses.....	7
Total.....	100

¹ Based on reports from 32 CMHC's in their 2d and 3d year of support.² Based on 1968 inventory from 80 CMHC's.

STAFFING PATTERNS OF 82 CENTERS OPERATIONAL IN 1968

Community Mental Health Centers are employing a very wide range of professional and nonprofessional workers. They provide training in addition to mental health services, and supplement the work of their paid staff through extensive use of volunteers.

Employment category	Full time	Part time	Trainees	Volunteers	Total staff	Average number per center ¹
Psychiatrists	210	397	137	47	791	6.0
Other M.D.s	6	62	33	6	107	0.3
Psychologists	223	142	35	24	424	3.4
Social workers	496	170	63	46	775	7.2
Registered nurses	495	152	122	36	805	7.8
Vocational rehabilitation	42	31	19	9	82	0.7
Occupational therapy	34	17	2	16	153	1.4
Recreational therapy	54	17	2	18	91	0.8
Other professionals	270	129	18	139	556	3.6
LPNs, aides, attendants	1,209	360	61	39	1,669	17.9
Other nonprofessionals	292	48	8	643	991	7.1
All other (clerical, maintenance, etc.)	1,049	224	6	56	1,335	14.4
Total, all personnel	4,430	1,766	504	1,079	7,779	70.6

¹ Includes salaried full-time employees.

STAFFING PATTERNS

	53 metropolitan centers	7 university centers	50 rural centers
Average full-time equivalents for:			
Psychiatrists, medical directors	9.4	9.8	1.8
Psychologists	5.0	4.7	2.2
Social workers	14.4	14.9	4.5
Registered nurses	12.9	10.7	5.3
Occupational therapists	2.0	1.4	.4
Other therapists	1.8	.9	.5
Clergy	0	0	.2
Other professionals	4.6	6.3	1.0
Educational	2.5	1.3	.3
Consultants	.3	0	.3
Administrators	1.0	.9	.5
Licensed practical nurses (LPN)	3.2	5.6	2.2
Medical record librarians	.1	0	.1
Secretary-receptionists	4.4	6.1	2.7
Aides	12.3	5.9	5.2
Technicians	1.0	0	.2
Attendants	3.0	6.8	3.1
Ward clerks	1.6	.3	.5
Community counselors	0	0	.2
Other nonprofessionals	5.0	7.0	1.8
Average total	84.5	82.6	33.0

PREVIOUS CARE OF PATIENTS RECEIVING CMHC CARE DURING 1969

Over 16% of all patients seen in CMHC's during 1968 had at some prior time been patients in State hospitals. Were it not for the presence of Centers, many of these patients would have to return to the State hospital. Nearly 34% of all patients in CMHC's had no prior treatment. This is an indication that Centers are visible, accessible and providing services in areas where no mental health services had previously been available.

Previous mental health services:	Percent
Public psychiatric hospitals.....	10.6
Other psychiatric hospitals (including psychiatric unit in general hospital).....	4.1
Other community mental health centers.....	0.9
Other mental health inpatient facilities.....	1.5
Outpatient mental health clinics.....	6.2
Private practice mental health professionals.....	3.7
Family service and other social agencies.....	3.0
Other.....	3.2
A combination of the above:	
Including public psychiatric hospitals.....	5.6
Not including public psychiatric hospitals.....	2.8
This center only prior to 1968.....	14.7
No previous mental health services.....	33.7
Unknown.....	10.0
Total ¹	100.0

¹ Total number of persons involved in the study is 47,424.

Mr. ROGERS. What is the percentage operation?

Mr. BLACK. Forty-seven percent.

Mr. ROGERS. What does that mean?

Mr. BLACK. That is the percent operational of the total funded.

Mr. ROGERS. You have funded in some degree 376.

Mr. BLACK. Yes.

Mr. ROGERS. But 47 percent are operational.

Mr. BLACK. Actually in business as of June 30, 1969.

Mr. ROGERS. Now under the proposal how many do you intend to fund under the administration's proposal that you are presenting now?

Mr. BLACK. Well, as of June 30, 1970, when this act expires, we will then have funded a total of 454. We estimate that as of that date 225 will be operational. How many more we fund beyond that either for construction or staffing will depend, of course, upon the availability of resources, money appropriated by Congress.

Mr. ROGERS. Now this is what I want to get to. We talked about tightness of money and at the same time you are talking about expanded coverage. Now if you are going to have the entire maintenance undertaken, you are going to have to cover all centers, and then it seems to me to maintain the ones you have, the grants will have to go up for the ones presently in existence?

Mr. BLACK. Well, they will not go up too much, Mr. Rogers; those presently in existence because of the maintenance of effort provision in the present law. The main difference in the cost will be in the centers which get new grants.

Mr. ROGERS. Well, that would be considerable if you plan to have 451 by 1970, by June of next year, because that is quite an increase over the ones presently in being.

Mr. BLACK. That is right.

Mr. ROGERS. Only partially funded and not even operational yet.

In other words, as I see it, only 47 percent are operational, so that means that level of effort might have to continue for 175, but you have got 376 partially funded, which means that the difference between 175 and 376 would be entitled to additional funding as you recommend, plus the additional to take up to 451. Well, now, that will be a considerable increase to the Federal Government in keeping in existence the present centers that have not yet been fully funded because then they would be entitled to coming in for additional funds.

Secondly, it seems to me where you have new ones coming in, this is going to increase the cost to the consumer and it seems to me somewhat of a paradox to say we ought to widen, to include maintenance to actually maintain every one of these at a time when you say we are really not going to have funding to do it and you would rather just do a few on quality and not expand. I find it difficult to reconcile this approach. Now maybe you can do it for me.

Mr. BLACK. In a minute, I would like the program people to get into this financing with you because as you know it is a very complex area.

Mr. ROGERS. Yes; it is.

Mr. BLACK. But I want to make a general observation that obviously over the long haul this program we are proposing will cost more money, just as your proposal would, to, extending the support period by 2 years.

Mr. ROGERS. I agree.

Mr. BLACK. Mr. Staggers' bill would also.

It represents a very deliberate policy decision, as reflected in the testimony. Considering the difficulties that the communities have had in getting the kind of local support that has been anticipated and considering the slowness with which the third-party payments have developed, the people who are administering this program feel—and the Department and the administration agree—that we would be better off to settle for fewer centers but have those just as strong as we can make them without taking smaller amounts of money and spreading them over more centers.

Now specifically on the question of this funding, it is my understanding that the 454 we are talking about which will be funded as of next June will all be funded under the present legislation. The greatest additional cost would come over the long run in the centers which we would be funding after next June under the new legislation.

Mr. LEWIS. I would just say, Mr. Rogers, what the proposal contemplates is that in lieu of the Federal support to existing centers continuing to decline and then fall off precipitously and at the same time devoting Federal resources to the creation of new centers which may find themselves in the same unstable situation in 3 or 4 years, the administration proposal would require the existing centers to maintain a level of effort that they have currently put into their existing centers. I mean those which have been funded prior to the date we go into business with the new proposal, would be required to maintain their originally agreed upon level of local support. The administration budget to the extent it could stand it is a question I think none of us at this point could speak to affirmatively because that obviously comes out of a presidential route.

Mr. ROGERS. Do I understand you to say then 451 will be funded with the old formula?

Mr. LEWIS. They will either have received construction grants or staffing grants or will have received both by June 30, 1970.

Mr. ROGERS. So what you are telling me now of your proposals would not affect any of the 451?

Mr. LEWIS. Yes, it would affect them in that the proposal would insure that their mental health care capability would not decline.

Mr. ROGERS. If you have a maintenance of effort and they are going to be funded under the old formula by June 30 of 1970, the provisions in this bill would not be in effect for existing centers?

Mr. LEWIS. It would affect them in future years, sir.

Mr. ROGERS. How, if you are requiring a maintenance of effort?

Mr. LEWIS. In that the present law would require Federal assistance to cease after 51 months. Therefore, when a center had reached its 51 months of support it would have to be totally dependent on its own or third party or other resources, whereas the administration's proposal would continue to provide support beyond the 51-month period. That means that centers which are now in their third or fourth year know as they look toward their seventh or eighth year or sixth or ninth, depending on which kind of centers we are talking about, can count on Federal support but they must maintain their present level of local financial support.

Mr. ROGERS. Then you are saying that every center at the end—suppose it just got construction, it didn't get staff. It would then qualify?

Mr. LEWIS. It could now qualify for a staffing grant.

Mr. ROGERS. What would it have to do as to maintenance of effort? It is paying all its staffing now, it is carrying the whole maintenance.

Dr. YOLLES. Mr. Rogers, if I may.

Mr. ROGERS. Yes.

Dr. YOLLES. Support the new services only, and we propose to continue that.

Mr. JARMAN. Do you propose paying part of the cost of all personnel?

Dr. YOLLES. Yes, sir.

Mr. ROGERS. Operation?

Dr. YOLLES. Yes, sir.

Mr. ROGERS. That is pretty broad and this committee has not got quite that far because we feel that there must be some effort at the local level to want to do something.

Now I am really concerned about what you are proposing here and how broad it will be and who it will really affect. If we have a maintenance of effort, then I am not sure to what degree that is going to require those that are presently putting in the funds—if that bars them, do they have to maintain it or don't they? I think we better get this clear on the record. Perhaps you would like to give us something in writing on this, your thinking on it. I realize you may not have the answers right now but I think this should be presented to the committee before we make our decisions.

Mr. LEWIS. Mr. Chairman, may I say when we use the phrase "maintenance of effort" we are directing the phrase toward the effort in dollars that the center is now applying to the existing approved services

under the mental health center program. We are not directing the phrase toward the services which they are now running, for example, which you cited where a staffing grant has not yet been given.

Mr. ROGERS. As I say, if you have not given them a staffing grant, they are presently paying staffing if they are operating.

Mr. LEWIS. They may not be.

Mr. ROGERS. Someone has to or they are not operating. No one is offering their services for free, or at least I have not heard of it.

Well, I just think this is a matter that we ought to go into and know what we are getting into. First on the maintenance, if we are going to require it, I am not sure if we are going to extend the provisions of the law if we should bar present centers in effect because of the maintenance of effort clause or whether this committee should come to some determination as to what we want to do, whether we want to get into operation, maintenance, or pretty much keep it as we have because what we have been trying to do is to supply funds to build and then supply the professional help, the expensive help of the psychiatrists, the psychologists, the nurses, the backup, the technical people.

Now we have not gone into the maintenance, and I have some concern frankly about moving into the full area. I think I would like to know more about just how this would affect ongoing centers, those that have partial staffs and so forth.

Mr. Chairman, I have many questions but I know other members want to ask so I will pass if I may and come back.

Mr. BLACK. Mr. Rogers, we would be glad to provide you with some additional material. We have some tables which would help illustrate just what would happen in the case of an individual center.

Mr. ROGERS. I think that would be helpful to the committee.

Thank you.

(The following information was received for the record:)

WILL THE PROVISIONS OF H.R. 14617 BE APPLICABLE TO COMMUNITY MENTAL HEALTH CENTERS THAT ARE ALREADY FUNDED?

The new construction provisions would be applicable only to construction grants made after 6-30-70.

As of June 30, 1969, 376 centers have been funded through the Community Mental Health Centers Program; 213 of these centers have received staffing grants; 175 of these centers were operational, and five of the operational centers have construction grants only. It is anticipated that 225 centers will be operational by June 30, 1970.

The new provisions pertaining to costs of operation would be applicable after 6-30-70. It is expected that many of the 163 centers currently funded for construction only, will apply for support of costs of operation under the new provisions as they prepare to become operational. Many of the existing centers, already funded for a minimal program, are planning on adding additional needed services, and will apply for new costs of operation grants to assist in establishing these new services.

Additional assistance under the new costs of operation provisions will also be available for continuation costs with respect to the existing staffing grants—increasing both the length of the support period and the rate of support up to the limits imposed by the maintenance of effort provisions of the existing law. The law stipulates that the Federal funds for costs of operation are to be used to initiate new services and that Federal funds are in no way to supplant state, local and other non-Federal funds previously being expended for mental health services.

The following table illustrates the effect of the new amendments and the maintenance of effort provisions for the average staffing grant made in FY 1967:

AVERAGE NEW STAFFING GRANT BEGINNING IN 1967

Fiscal year	Grant year	Under existing program		New amendments in effect in fiscal year 1971	
		Federal grant	Non-Federal support	Federal grant	Non-Federal support
1967	01	\$321,000	\$493,300	-----	-----
1968	02	272,850	440,450	-----	-----
1969	03	208,650	504,650	-----	-----
1970	04	144,450	568,850	-----	-----
1971	05	32,100	681,200	\$144,450	\$568,850
1972	06	-----	(713,300)	144,450	568,850
1973	07	-----	(713,300)	142,660	570,640
1974	08	-----	(713,300)	71,330	641,970
		979,050	4,727,350	1,449,840	4,256,560

In fiscal year 1970, under the provisions of the existing program, this grantee would receive \$32,100 in Federal funds and be required to increase the non-Federal support by \$112,350 over fiscal year 1970 to a total of \$681,200. By 1972 the Federal assistance period would have expired and the grantee would have to increase the non-Federal contribution by another \$32,100 for his total program at level of \$713,300.

Under the provisions of the amendments, however, this grantee would be required only to maintain his fiscal year 1970 level of non-Federal effort (\$568,850) until the *new rates of Federal assistance* decreased to an extent requiring further increase in his non-Federal effort. For this grantee, the Federal and non-Federal levels of effort would remain the same for three years (fiscal years 1970-1972), and an increase of only \$1,790 in non-Federal funds would be required for fiscal year 1973. With the amendments applicable in fiscal year 1970, this grantee would receive \$1,449,840 in Federal funds over eight years, compared with only \$979,050 over a 51 month period under the existing program.

Mr. JARMAN. Mr. Nelsen.

Mr. NELSEN. Thank you, Mr. Chairman.

I want only to reemphasize what my colleague from Florida said. For years there was even a resistance on our committee to staffing because we were of the opinion that this part should be carried locally. We find, however, that staffing was one of the real major financial burdens. So I think there is real reason to be cautious about expanding too far in removing some responsibility from local areas. I think we have learned in many, many programs that there has to be a combination of both to have it durable and responsible. I think this is something you might look at.

I was rather surprised that there were only 175 operational as of June 30. Is this nationwide now, when you refer to the 175?

Mr. BLACK. That is right. That is the figure for the whole country.

Mr. NELSEN. I remember years ago in the Minnesota State Senate we provided for community health centers. It must be 20 years ago I think when we started. I want to report that I attended a meeting at one of those centers recently and I made inquiry about the population of our State mental hospitals as compared to years ago and it is just astounding—it is way, way down. So many things have been done in the community health centers that have eliminated the problem of going to these State institutions. It has been so effective in our State that this program really has great merit and I hope we can work things out. I can well understand that when a new administration

comes into office, it takes a little time to get your feet under your operation. I ran an agency myself and I know it is not easy, but I am sure we will work it out.

Thank you for your appearance here.

Mr. BLACK. Mr. Nelsen, let me make one observation on the point of local effort which you raise and which Mr. Rogers also mentioned.

We are thoroughly committed to the concept that this has to be a Federal-State-local partnership. The program was started as a seed money program and we want to continue it that way. We have to remember that obviously we are not proposing that you eliminate the local support because even if you are including all operational costs, you are still paying only a percentage of the total cost and in our proposal it declines rather sharply.

We start at 75 percent for the first 2 years and then it goes to 60 percent and then goes down 10 percent every year after that, so that the last year we would be paying 10 percent of the total operating cost, meaning 90 percent local effort, third-party effort or something else. Next to the last year it would be 20, the year before that it would be 30. So we certainly want to maintain this concept; it is not our thought at all that the Federal Government should take over this program in perpetuity.

Mr. ROGERS. Would the gentleman yield?

Mr. NELSEN. I would be happy to yield.

Mr. ROGERS. I think I understand and I commend you for supporting this program strongly and I think the administration is doing it. I have some concerns as to the direction in which you are moving and I think the committee would.

Now my concern is that if you take in all operating costs that means a larger portion of the 70 percent saving must be supported so that your money is increased, the Federal contribution to that center, because you are considering costs that we have not considered before. And it seems to me that this way there would be less for staffing so that maybe you are not going to have as much to get good professional people. I just have some concerns about it.

Mr. BLACK. Unquestionably if you do this you are going to have less money to put into other centers. As far as individual centers are concerned, I don't think you will affect the staffing problem. But it means if you spend more money on centers already in existence you are not going to have that money to help start new ones. As I said, this was a policy decision.

Mr. ROGERS. I want to know how many new centers you project in the next 3 years are covered by this as well as if you can maintain those that are already started. This is what we want to know, too.

Mr. BLACK. We certainly can maintain the ones that are started, and any proposals that we come in with would certainly be consistent with the commitment that we are making in the legislation. Now how many more we can start beyond that is something that will depend on the amount of appropriations.

Mr. ROGERS. I want to know what your projections are. I realize you might get what you are asking for and I think that is what the chairman is asking.

Mr. BLACK. We will certainly try to come up with some estimate.

Mr. ROGERS. We understand it would be an estimate because you don't know.

Mr. JARMAN. Mr. Preyer.

Mr. PREYER. Thank you, Mr. Chairman.

I want to thank you, Mr. Black, for making so much material here available to those of us who come new to this subject. It is very helpful.

Mr. BLACK. I include myself in that number, Mr. Preyer.

Mr. PREYER. Since I am new I will just ask two general questions and then yield back my time to those who are more knowledgeable in this field.

You mentioned that the local cooperation has gone a little more slowly than you anticipated and you mention that there are problems of organization and also in achieving a public mandate. I wonder, is the problem at the local level mainly money and matching funds or is there a problem of a public mandate? Do you find local communities resisting this whole idea to the mental health center or is it purely a financial problem?

Mr. BLACK. I would say, generally, I don't think you are finding resistance, certainly not as far as basic centers are concerned. We have a large number of applications, and, as you can see from these figures, we are moving along quite rapidly, with 454 to be funded by the end of next year. There is a little bit more resistance, Dr. Yolles tells me, in the area of narcotics and alcoholism because these are very difficult problems and to some extent in the minds of some people have a stigma attached to them, which is one of the reasons we are proposing preferential grants for those to help stimulate them.

I would like Dr. Yolles to add anything on this subject of community attitudes toward the center.

Dr. YOLLES. I think very clearly that the general public is overwhelming in its support of the community mental health centers program. Our experience has shown that there are far more communities that want to start community health centers and need the service but are unable to do it for various reasons, among them no provision of planning funds or person available to do the planning, or they have been very seriously concerned because of what they consider to be a short term of support, and they are concerned that they will not be able to raise the matching money to pick up their part of this because of the rapid decrease in support over the period of 4 years and 3 months presently existing.

But this program has really gone across with the people of the United States and its results are impressive. As has been mentioned just a moment ago, I think by Mr. Nelsen, largely because of the impetus of community mental health centers we have seen a startling reduction of patients in mental hospitals in the United States. We are predicting now that instead of having reduced the population of mental hospitals, in the 10-year period 1963 to 1973, by one-half we will reduce it by two-thirds because of the services thus provided.

Mr. PREYER. That was my impression of a program like that.

The other general question, you mentioned the development of third-party payments has been slower than anticipated and on page 9 you discuss the efforts that are being made with the health insurance

industry along this line. Are those efforts beginning to bear fruition in the near future? Are you encouraged about this or discouraged?

Mr. BLACK. I don't think we would say in the near future. We expect a rising level of support. I believe that our figures show that of the total income of these community mental health centers now, about 10 percent is coming from third-party payments. With the developments in the field generally as indicated in the testimony, this kind of care is now provided in some insurance systems, some of the Government plans, some trade union plans. Blue Shield is moving in this direction and giving more encouragement to it.

The Secretary, as I indicated in my statement, has called on all the insurance agencies to do more in this area. It is optional so I think our anticipation is that the third-party payments will increase progressively over the years, but I don't think anybody will expect a dramatic breakthrough in the next year or two.

Mr. PREYER. Do you have an optimum percentage that you would hope third-party payments would reach? You say it is 10 percent now. Is there a goal that you—

Mr. BLACK. Dr. Buker.

Dr. BUKER. No, no specific optimum. We do see the program as requiring a balance of funding involving the efforts of all public and private sources.

Mr. PREYER. Thank you very much.

Mr. JARMAN. Dr. Carter.

Mr. CARTER. Thank you, Mr. Chairman.

I certainly want to congratulate the distinguished gentleman for his presentation. Actually, I am extremely pleased that it is forward looking and not regressive. It is designed, it seems to me, to improve and strengthen their methods of taking care of patients. We have heard lots of complaints in the past few months about cutting back on various things and I think that this program is—at least I hope it is not going that way.

I noticed the chairman asked about the amount of money for construction. This is an authorization, is it, of \$29,200,000? Is that right?

Mr. BLACK. Authorization of \$70 million, Dr. Carter. The appropriation for construction for 1970 is \$29,200,000, which I might point out here is about twice as much as the construction appropriation was in 1969.

Mr. CARTER. For 1970. What will it be for 1971?

Mr. BLACK. Well, as I said earlier, that figure we do not have yet.

Mr. CARTER. Yes, sir, but this is twice what it was in 1969.

Mr. BLACK. Yes.

Mr. CARTER. And staffing, \$51 million. That is the appropriation in that case.

Mr. BLACK. That is right.

Mr. CARTER. What relation does that have to the appropriation of 1969?

Mr. BLACK. \$46,100,000 in 1969. I will give you a comparable figure. There were some reserve funds involved here but I think maybe a better picture can be gained from the obligation for the 2 years. They are the same in construction grants, \$15 million obligated in 1969; \$29,200,000 in 1970. Staffing, \$45,934,000 obligated in 1969; \$51,300,000 in 1970.

Mr. CARTER. And for narcotics, \$8 million for 1970. What was it previously?

Mr. BLACK. Eight million.

Mr. CARTER. The same. Alcoholism, \$4 million. What was it previously?

Mr. BLACK. The \$4 million as Mr. Rogers pointed out—

Mr. CARTER. Was added.

Mr. BLACK. Was added.

What was that figure? Nothing in 1969.

Mr. CARTER. Certainly I think that is an improvement in that. I think we have got to go forward. Personally I realize, as you have stated on page 3, that many communities are aware of their needs and that they are afraid they cannot continue to come up with their share, with their proportion of that. We must realize that. Many times they cannot and in many cases I think it is the duty of the Federal Government to go in. We have to do that because after all the Federal Government gets most of the tax money, does it not?

In certain areas I notice that as much as 90 percent of the staffing or of the construction will be paid in poverty stricken areas. Again I think that is good. I think it is necessary. Thinking of a good program, I think you are moving forward and certainly we all will be part of this because it is extremely essential throughout our country.

I followed this program and I visited some of the centers of our country. I have noticed the organization particularly in my area and I notice the fine people who are involved. Many of them give their own time, a large number of them do this. They have established these clinics. Where it is impossible to build, certain hospitals have given a portion or have allotted a certain number of rooms for the care of the mentally ill. I should like to see this extended on to include our chronic alcoholics.

I think this is a very necessary thing and I would like for us to try to implement this from here because so many times people are backward to try to help our unfortunate brothers who are victims of alcoholism. Sometimes they are the finest people, they are good people, but they have this disease and they must be treated. I think you have a good program and I certainly support it.

I have no further questions about it. Thank you, Mr. Chairman.

Mr. BLACK. Thank you.

On this subject of alcoholism I just want to make one point. The fact that we did not request money this year does not indicate a lack of concern about the alcoholism problem; it is simply one of those hard financial choices that had to be made. Dr. Egeberg is personally very concerned about the problem of alcoholism and this is one of the reasons we want to see this authority continued. I would certainly hope that the next budget we present to the Congress would have in it some funds to implement this part of our program.

Mr. JARMAN. Mr. Hastings.

Mr. HASTINGS. Thank you, Mr. Chairman.

And thank you, Mr. Black. Just a couple of questions.

I note at the bottom of page 6 and continuing on to page 7 you make reference to the objectives of the administration being to reform the grant-in-aid system and that the President has proposed a Grant Consolidation Act.

As to what is under consideration and changes in the system, can you tell me how this would affect this program specifically as you see it now?

Mr. BLACK. As we see it right now, we don't have a specific consolidation in mind. I pointed out a couple of reasons. One is that there is before the Congress, coming from the other body, a proposal that would separate alcoholism and narcotics from the community mental health centers program. We think that it is very important that we not splinter this program, that we keep consolidation of these grants.

Beyond that I just wanted to make the point that we are looking at ways in which we can simplify these programs and consolidate related construction programs. We have a number of ongoing studies, Mr. Hastings, of construction programs in the health area. We are not ready with recommendations at this point, but we do think that we should make the particular program here as consistent as we can with our overall planning mechanism, so that if at some future time it seems desirable to consolidate this kind of construction program with some of the others, we will be that far down the road.

Mr. HASTINGS. I have one place of concern in relation to all the programs in that I recognize the need for grants to perform certain functions, but at the same time I strongly urge that you continue taking into consideration the local effort, particularly State effort, as a prime consideration in continuing grants-in-aid such as looked at in the future.

My other question is with relation to the drug abuse centers who link alcoholism and drug abuse together. On page 9 you indicate that you feel that the services offered related both to alcoholism and drug abuse are totally coordinated with the existing mental health centers. I take it that you include combined facilities.

Mr. BLACK. Yes. We would prefer to see integrated facilities, have them under one roof. You could have in that context separate alcoholism and narcotics treatment centers, but administratively and otherwise we think it makes sense to put these together rather than to have the community mental health center on one block and the narcotics center and alcoholism center on the next.

Mr. HASTINGS. I am sure you are aware that New York State is the State that I am most interested in, of course, which has a very comprehensive narcotics program on the way which utilizes separate facilities for rehabilitation of addicts. You are saying in effect that if in HEW there is not approval in this direction that you would prefer to see that type not be done and that it be done in coordination with the existing community health facility?

Mr. BLACK. I would like Dr. Yolles to answer that one.

Dr. YOLLES. Speaking professionally, as far as treatment of narcotics addicts is concerned, at our present level of knowledge we use the same types of personnel as we do in mental health institutions. We use many of the same techniques that are used in health centers attached to general hospitals. What it all boils down to is this: that the consensus of professional opinion in this country at this time is that you should not have separate institutions for narcotic addicts.

As a matter of fact, we are trying as hard as we can to reduce the patient loads at Lexington and Fort Worth, which are the two principal Federal institutions, so that these patients, our own beneficiaries,

can be seen in the communities from which they come. We feel that this is a most important approach in treatment. For far too long we have had the policy, much like that for the mentally ill, of moving the drug addict out of sight and out of mind to large institutions, away from the community from which he comes and away from his friends and relatives.

Mr. HASTINGS. As I understand New York's problem does not go in that direction, it does not try to hide the addicts in the woods somewhere. As a matter of fact, in Brooklyn and Yonkers, major metropolitan areas where we have located these centers, they are located there for one reason—because that is where the addicts are.

Now the fact that there are separate facilities, my understanding at least is that they felt—and this is based on the California plan. As I recall we brought the Commissioner of Narcotics from California to New York and hired him because they have had a successful program, and this was part of their success in the State of California. I am not that much of an expert on it; I put that question to you. However, I would be concerned that in moving in the direction that you are suggesting, that we run this program with the comprehensive basis, it may be at odds with the recommendation of HEW.

Dr. YOLLES. Not necessarily. I didn't mean any criticism of the New York State program. The New York State program is a derivative of and influenced by the Corona system in California which was a large institutional system. The program under the Metcalf-Volker Act also used the large State hospitals for these purposes. We have the same problem with Community Mental Health Centers and the large State hospital. These are being integrated and these large hospitals are moving out.

So I would be hopeful that this program would become increasingly integrated with local and community efforts. I don't see it opposed to the new direction at all.

Mr. HASTINGS. I am looking at it from a constructive point of view, believe me. The State of New York has recently established a State legislative group and the staffing is the type of thing that should be well discussed with people in the State legislature, particularly as they allocate funds from the State for these programs. I would be most interested, in fact, if you are thinking we could work that in, too.

Thank you very much. No more questions.

Mr. CARTER. Would the gentleman yield?

Mr. HASTINGS. Yes.

Mr. CARTER. These functions are being carried on more economically under one roof and with the same amount of personnel, perhaps at much less cost.

Mr. HASTINGS. I would agree with you, Doctor. Our problem was we had too many narcotics centers in one metropolitan area.

Mr. JARMAN. Mr. Secretary, what do you think would be the possibility of using medicare and medicaid to reimburse those programs to provide a greater share of costs of operating these centers?

Mr. BLACK. Well, I think in my general comments about the third-party payments I indicated we would anticipate an increasing amount from these sources. Under the medicaid program, it is optional in the State as to whether they include this kind of community mental health care. The medicare situation is a little bit different.

Dr. Yolles, do you want to give us the figures on medicare.

Dr. YOLLES. I was just looking at a chart of the sources of income for community mental health centers. Medicare funds amount to about 4 percent of the income of operating centers. This is based on reports from the small number of them, 32 to be exact, that we surveyed in year two and three of support. They reported no aid from medicaid at all. As indicated before, private insurance would amount to about 6 percent as well.

Mr. LEWIS. Mr. Chairman, may I add something on that?

Mr. JARMAN. Yes.

Mr. LEWIS. On both medicare and medicaid, just a couple of words on the facts and then the general question of whether they should be reimbursed.

Under medicare, part A, which is the hospital portion, the community mental health centers do of course provide hospitalization. Medicare has a very restrictive provision. There is only, I think, a lifetime of about 190 days coverage. Under medicare, part B, the maximum outpatient service is limited to \$250 a year or 50 percent of the total charges, so it is a fairly limited kind of reimbursement.

Medicare covers the aged only in institutions, and on the outpatient side it is totally optional as Mr. Black said. If a State really wishes, the option is with the State and if the State really wishes to have an expanded program to cover the centers it can.

One of the basic problems which is, I think, why the administration is very strongly committed to seeing that this program is firmly in place is that if the current studies, with respect to expanded coverage under medicare or medicaid should lead to a liberalization of benefits we could find ourselves in a position of once again having expanded the financing position of the American citizen to take advantage of medical care or health care without at the same time having expanded the capacity.

I hope that our answers to your earlier questions, Mr. Rogers, with respect to maintenance of effort and what we will do about dollars will show that what we are interested in doing is seeing that this capacity which we have created that could lead us to 450 centers is firmly in being.

If we gradually increase the benefits available under both medicaid and under medicare, it is equally important to have increased the capacity as well, otherwise inflation may result, which is what has happened as you know under the medicaid program.

So I think in time we would expect to see medicare and medicaid have broader benefits but we would not get the results in terms of treatment unless we actually organized the capacity, and this is the program which really organizes the capacity because medicare and medicaid will only pay for the bills if the capacity is there.

Mr. CARTER. Mr. Chairman.

On that, about what you receive from medicare and medicaid and insurance companies, isn't it true that most of the insurance companies rarely include mental illnesses? Is that not true?

Mr. LEWIS. That is right, with quite a varied pattern.

Mr. CARTER. I think even Blue Cross and Blue Shield until recently did not. They may now, but it was just within the past few years.

I think most of the insurance companies have not included mental disease until recently.

Mr. BLACK. But don't you think, Dr. Carter, in the future we will see more of this, partly because of the nature of treating the illness with the new drugs is changing, so instead of being consigned to an institution for years persons with mental illness can be treated as they would be for other ills.

Mr. CARTER. Yes, sir, I should say that is true. There has been a revolution in this and I hope that in the future there will be more coverage at not so prohibitive a price.

Mr. LEWIS. The insurance companies' historical development has been one of concentrating on in-hospital treatment. Against that background they have been unwilling to go into extensive coverage of in-hospital treatment of the mentally ill. If we organize at the community level where it is possible to treat people without putting them into the hospitals and we develop that community-level capacity, then the insurance companies are more willing to take on that kind of coverage. For example, under the Government employees' programs they all cover mental illness fairly extensively.

Mr. CARTER. Certainly hopeful.

Mr. BLACK. Mr. Chairman, on your question of medicaid, you are aware of course that we do have a task force at work right now headed by Mr. McNerney. They have just come in with some of their first recommendations and we will be getting many more. I assume that they will address themselves to other problems. I might say that talking about a program involving the National Institute of Mental Health dramatizes the importance of trying to bring the whole medicaid program and inflation of medical costs under control. Our figures show that this year our Department is going to have to come up with about \$350 million more than we originally expected on the basis of the first State estimates just to take care of the increased costs of the medicaid program. This is more than the total budget of the National Institute of Mental Health.

Mr. JARMAN. Mr. Rogers.

Mr. ROGERS. Thank you, Mr. Chairman.

Talking about capacity, you are saying this program goes to capacity, that now medicare and medicaid would not be included in any terms, some of this program is such as a Federal contribution, is it not?

Mr. LEWIS. No.

Mr. ROGERS. And this is another reason because I think this is going to expand. In fact, I think the States have come in with their programs for January of what they are going to do.

Mr. BLACK. Yes.

Mr. ROGERS. The medicaid I think must be presented, their plans and so forth.

Mr. BLACK. Yes.

Mr. LEWIS. They come in with an annual plan, yes.

Mr. ROGERS. And January is the time if they are going to participate in the program. I know our State is having some difficulty now.

So I would think that these funds will have a tendency to increase and this would help the local areas carry the maintenance, carry the operation of the center because that is not a factor that we consider in giving funds to the center. So I think this is another factor

we ought to consider in deciding whether you want to go the whole way of maintaining and operating a center.

Mr. LEWIS. The point I want to make is that I personally would not want to see an expansion under medicaid or under medicare with respect to the ability to pay a bill unless there was a facility other than a mental institution, that is, the large State institution, in which to take care of the patient.

Mr. ROGERS. What I am saying is that the theory you have given us is that you would rather have fewer institutions with quality, but if we don't expand the amount of money we have to give every institution then you can probably have more capacity. This is the point I am making: probably have more centers if you don't put all your money in just a few centers. In other words, if you will expand it some.

Mr. BLACK. Well, I think, Mr. Rogers, we would have to be guided by experience on how much medicaid increases because of these bigger figures. Dr. Yolles has right now indicated the amount going into medicaid is negligible. Our experience overall is that, because of the rising costs, more States are looking for ways to cut back on services right now rather than expand.

Mr. ROGERS. Yes, but for instance Florida does not participate and now they plan to. This probably will be so all over the country and this would change these figures that you have with this limited experience.

Now let me ask you this. I notice in your statement you say that local health planning agencies should have a review—not an approval but a review.

Mr. BLACK. Areawide.

Mr. ROGERS. Areawide. Then you jump to the State health plan and you say it must give approval.

Mr. BLACK. That is right.

Mr. ROGERS. Does this give it a veto of whether it goes in or not?

Mr. BLACK. That would be approval of the overall State plan, not of individual projects. The local agency would review and comment on individual grants.

Mr. ROGERS. I wonder if we are at the stage yet to actually give State comprehensible health planning agencies an actual veto. I am not sure that we are quite at that stage yet. I think eventually we want to bring all of our facilities together, this is the extent of our comprehensive planning.

From what I have seen so far—and we would have to go into this in comprehensive planning legislation—I don't think enough States have got to the point where they have built a competence at the State comprehensive planning level and to actually come in and give vetoes as such. I think they should be consulted and have the opportunity for review at this stage with the view of maybe in 2 or 3 years tying it into an actual approval. I would hope that you would look at that and let us have your views on that and see how many States you think are actually ready to have this authority in the State comprehensive health. I question whether we are quite ready to move into it.

Mr. BLACK. I know of your concern in this area. The judgment of our program people in that the States are ready. As you know, we made the same recommendation in our Hill-Burton legislation.

Mr. ROGERS. How many States actually have an on-going functioning State comprehensive planning agency?

Mr. BLACK. I believe they all have.

Mr. LEWIS. All States now have. I think there has been some amount of change in one of the Western States but all the States have grants and have organized their agencies, but they are at varying degrees. Obviously it is a matter of judgment when you talk about a functioning planning agency.

Mr. ROGERS. It has varying degrees.

Mr. LEWIS. Right.

Mr. ROGERS. I would like to have a rundown if you could as to the States and where they are in the comprehensive planning because that would influence my judgment on whether I would be willing to go into that yet.

(The following information was received for the record:)

REVIEW OF STATE PLANS BY STATE COMPREHENSIVE HEALTH PLANNING AGENCIES

All of the states except Nevada now have operational comprehensive health planning agencies. They vary in degree of organization and planning capability, but recognize a responsibility to include mental health in their total concerns.

They are prepared to meaningfully review state plans for community mental health centers as part of their effort to improve planning coordination at the statewide level. This review is designed to assure that population health needs are met, resources are effectively utilized, and mental health programs are related to similar efforts in physical and environmental health. It is anticipated that such a review process will lead to development of common health goals and the stimulation of new relationships for the implementation of program objectives. It will not be concerned with the evaluation of specialized program requirements which are the responsibility of state mental health agencies and the National Institute of Mental Health.

Some of the comprehensive health planning agencies already have provided planning assistance in the area of mental health. Last year, Minnesota's 314(a) agency conducted a study of residential care. It resulted in legislation permitting detoxification programs in community mental health centers and increased appropriations for long-term sheltered workshops. Idaho's agency produced a task force report on mental health which supported the accelerated development of community programs. It recommended more effective coordination of existing services, the development of programs for groups with specialized problems such as the elderly and Indians, the initiation of graduate training in clinical psychology and social work, a review of pay schedules, and encouragement of innovation in use of nonprofessional workers and volunteers. Hawaii is phasing out the planning responsibility of the Division of Mental Health and transferring it to the comprehensive health planning agency. The 314(a) advisory council in Arkansas is supporting the development of community mental health centers in needy areas and has obtained state financial support for the program.

Placing review and approval authority with the 314(a) agencies should be an effective technique for maintaining their involvement and support of mental health needs and services. It will help maintain a program balance in the 314(a) agencies so that they do not become excessively committed to the development of public health facilities at the risk of ignoring mental health concerns.

It cannot be expected that all comprehensive health planning agencies will be able to perform the review and approval function with equal capability in the immediate future. However, giving them the authority in regard to planning coordination will encourage them to develop such potential. In the beginning it is probable that they will rely heavily on the recommendations of state mental health authorities and other groups which have been involved in comprehensive mental health planning. It should also be noted that this responsibility for improved planning coordination does not relieve state and community mental health agencies of responsibility for program planning.

Mr. ROGERS. Now, Dr. Yolles, you said you had great progress. I know, I have read your statements which I commend you for on curing, bringing about a cure, so that we can reduce the number of hospital beds. You say that the figure is to be now two-thirds. By what year?

Dr. YOLLES. 1973.

Mr. ROGERS. By 1973. Now where are we seeing a reflection of that in expenditures on mental health?

Dr. YOLLES. I think the expenditures have increased in the States over the last 10 years for local community mental health services. The question is, how far can they expand these services? How far can they expand the dollars that the States have available to provide further community health services?

Mr. ROGERS. No. What I am saying, I don't think you need as many community mental health services. If you have cures, you don't have to spend as much to maintain hospital beds and all this, do you?

Dr. YOLLES. We are talking about "cures," similar to "5-year cures" for cancer. These are qualified terms, Mr. Rogers.

Mr. ROGERS. This is what I want to know because people ask me, they say, "Well, why are you having to do this if we are not even going to need two-thirds of the beds by 1973?" That means only one-third the number of beds.

Mr. CARTER. Would the distinguished gentleman yield?

Mr. ROGERS. Yes.

Mr. CARTER. I think it is quite apparent that the reason for this is the increased number of community health facilities and that we are undergoing a change here. We are concentrating on them and they are going to have to be built, organized all over the country. This will cost some money. Eventually when larger institutions, some of which have been called snake pits in the past, when they are phased out perhaps we will notice greater savings.

Mr. BLACK. Mr. Rogers, I think the answer to part of this would be that in most of the States the number of people institutionalized has been steadily increasing and that would be one place where savings would be reflected. I don't have any figures.

Mr. ROGERS. I have not seen any figures of savings and I hear that we are going to only have a third the number of beds, but I would like to see some figures that substantiate some savings.

Now I understand that we need community mental health centers and this will help to avoid having people in hospital beds. I understand that is the program but we ought to see reflected somewhere savings in large hospital centers that have been devoted to mental health, the mentally ill. There should be some correlation somewhere, and I have not seen those figures. If you have them and can supply them to the committee, it would be helpful.

Dr. YOLLES. We can supply figures.

(The following information was received for the record:)

WHAT IMPACT IS THE COMMUNITY MENTAL HEALTH CENTERS PROGRAM HAVING ON STATE HOSPITALS?

The increased rate of decline in the resident population of state hospitals since 1963, and other pertinent evidence, indicates that community mental health centers are already having a measurable impact on state hospital programs—

principally by prevention of admissions and by making possible earlier return of state hospital patients to the community.

Up until 1955, the number of patients resident in state mental hospitals had steadily increased. Since 1955, the number of resident patients has declined, and since 1963, when the Centers Program was initiated, the rate of decline has been even greater. This trend, however, does not mean that state hospitals are delivering less care, for at the same time the number of both admissions and releases has increased year by year. This means that the state hospitals are treating more patients, but for much shorter periods of time.

These trends are associated with the initiation of a small number of community mental health center programs. Only 175 were operational at all in 1968 and only 104 were operational for the entire year. Data for 1969, when it becomes available, is expected to show even greater progress. The 175 centers in operation as of July 1, 1969, are available to serve roughly 12 percent of the nation's population.

The existing community mental health centers are giving high priorities to provision of services to those at greatest risk of state hospitalization. Thirty-four percent of all new inpatients in center programs are diagnosed psychotic, and 11 percent of center patients have had previous care in public mental hospitals. The average length of stay for inpatient treatment in centers is 19 days, compared with a median length of stay of 67 days for admissions to the state hospitals of one of the largest states. Less than 10 percent of center inpatients remain in inpatient service as long as 60 days.

The nature of the impact, of course, has varied from community to community depending on the way the individual state hospital traditionally was used. For example, in communities where local mental health services have been virtually nonexistent, new community mental health centers may actually tend to increase state hospital admissions by identifying individuals in need of care—some of whom may eventually require longer term residential treatment in a state mental hospital.

The average cost per patient day in a state mental hospital in the State of Hawaii in 1968 was \$15.49. In the United States this average was somewhat lower—\$10.47 per patient day.

At these rates a patient care episode of 3 to 6 months in a state mental hospital would cost between \$940 and \$1,880. If such an episode occurred in the State of Hawaii, the cost would be between \$1,400 and \$2,800.

A person experiencing the same episode of mental illness, but treated in a community mental health center would be actually hospitalized for approximately 19 days. He would in all probability receive further care on an outpatient basis and some non-direct services including, for example, consultation between center staff and his family or employer. The total cost to the center of meeting such an individual's needs would be approximately \$522.

Considering the very significant difference in the length of time the patient is separated from his family, his job, his normal social contacts (3 to 6 months vs. less than one month), the indirect costs in terms of lost wages, social breakdown, and all its attendant costs to society would be far less should the individual receive care in a community mental health center.

Despite the reduction in number of resident patients and length of hospitalization in state hospitals, monetary savings within the state institution budgets have not been effected, nor can they be expected in the near future. There still are over 400,000 resident patients in the nation's state and county mental hospitals. As indicated, the average per patient daily treatment and care expenditure still is just \$10. If the total amount invested in care of residents of state mental hospitals were just held constant, and the number of resident patients were reduced by half, the daily cost per patient still would average less than \$20—and this still would be less than the amount needed for an adequate treatment program for those 200,000 patients. Both the severe current under-funding of state hospital programs and inflation in costs make further increases in state hospital expenditures necessary. The phenomena of short patient stays also will tend to push state hospital costs up. Short term, intensive care necessarily is more expensive (and of course more beneficial) than custodial treatment. Even the \$20 figure cited above is inadequate for most methods of care.

However, there are some examples of states where a dollar investment in a community mental health center program may result in a corresponding dollar decrease in the state hospital budget. Iowa counties, for example, are charged \$685 per month for each county resident hospitalized in a state hospital. Presumably

investments in community programs which reduced admissions to the state hospitals would result in reduced county payments to the state hospital system.

In West Virginia, counties are required to pay for state hospitalization although not on a per-patient basis. The state has established an incentive for development of community mental health center programs by providing that for every dollar budgeted for a community mental health service, the county's assessment for state hospitalization will be reduced by a dollar.

Although a number of states use variation of these funding devices, the national prospect is one of increasing costs in all segments of the mental health care system because of:

- (a) our increasing population;
- (b) better, but more costly treatment;
- (c) recognition of the need for treatment of an increasingly larger percentage of our population; and
- (d) inflation.

Mr. ROGERS. All right. Let's talk about children. Is there any reason why children cannot be treated right now in these community mental health centers that we built?

Mr. BLACK. They are being treated.

Mr. ROGERS. I would hope so. I noticed something in one of the bills that it is just for construction for children.

Mr. BLACK. That proposal is not in our bill.

Mr. ROGERS. I agree. I would hope that the current centers that are being built would treat the entire spectrum of those that need help, including children. I presume that is your intention and that is what is being done. Is that correct?

Dr. YOLLES. Yes.

Mr. ROGERS. Thank you.

Let me ask about the alcoholic and drug abuse. It is your thinking then that we will begin more and more to treat the alcoholics who are ill and include the drug abuse and narcotics bill in the community mental health center as such rather than build separate facilities. I think this was generally rejected in the legislation we wrote before. This was our general intent although we made it clear that if a community was at a point where it was unable to build a community health center in an area where it really is needed that there would be nothing to prevent an alcoholic treatment center to be built there or narcotic treatment center to be built. Is that not generally quite correct?

Dr. YOLLES. Yes.

Mr. ROGERS. So that we could still permit where needed and where the need could be shown to have a separate narcotic treatment or an alcoholic treatment center.

Dr. YOLLES. Yes, until such time as the community could develop a community mental health center.

Mr. ROGERS. I agree with you it should be kept under the mental health center. That is correct.

Mr. BLACK. Dr. Yolles tells me that has been done successfully in a number of instances.

Mr. ROGERS. That has been done?

Mr. BLACK. Alcoholism and narcotics have been combined successfully with the community mental health centers, but it is also indicated that communities are slower to invest their own funds into these narcotic and alcoholism centers or even parts of the larger center.

Mr. ROGERS. Now you say that you are very interested in building alcoholic centers, Mr. Black. This is not reflected in the budget. The

Congress has put \$4 million in but you hope to remedy this in the next budget; in other words, the Department plans to do something about it.

Mr. BLACK. We hope to.

Mr. ROGERS. What about drug abuse, to, and narcotics?

Mr. BLACK. We have indicated \$8 million this year which is the same as requested last year. Again we are putting the emphasis on that, and I would hope that we can secure additional funds for that part of the program also.

Mr. ROGERS. Is there any reluctance of people to go to mental health centers if narcotic users and alcoholics are going there?

Dr. YOLLES. We do not have any experience which would indicate that that was so in the places that have narcotic treatment programs in the community mental health center. We have not seen it yet. There is a possibility until people become used to them and see that these people are pretty much the same as others.

Mr. ROGERS. You feel this should be no problem.

Now let me ask you this. What is the effort of OEO at the neighborhood health centers and the Model Cities program to go into the core city or the core area where they need services? What is the present situation?

Dr. YOLLES. With regard to drug abuse?

Mr. ROGERS. Yes.

Dr. YOLLES. I know both OEO and Model Cities have been working in the area of narcotics and drug abuse and we have been trying to coordinate these efforts with our local efforts in the areas.

Mr. ROGERS. What funding do they give; up to 100 percent, 90 percent?

Dr. YOLLES. I believe they give up to 100 percent in some cases.

Mr. ROGERS. Do you hope to match that by 90 percent grantsmanship total?

Dr. YOLLES. Well, we hope that community mental health centers, on a firm base, will accept an increase to 90 percent, as a means of developing a service in that center which is very needed in the community. After all, the OEO efforts and the Model Cities efforts are demonstration efforts and we are hoping to build a continuing system of care here. I believe the people in local communities and community mental health centers are interested in doing that.

Mr. ROGERS. I would think if they have a chance to pay 100 percent, I would doubt if they would come to us now. I would also hope that there could be good coordination. I would also hope that we can soon have an Under-Secretary of Health where all of these programs can be run under health. This is what we need. I hope the executive branch is looking into that; I believe you are.

I would think any of those health programs should come under the Department of HEW even though it is in model cities and OEO so we can coordinate and have, as you say, this Grant Consolidation Act which might be a means of doing this. I would certainly support some approach like that.

I wonder if it is actually necessary for us to get into that at this time until we decide on how we are going to consolidate as long as we have two other programs which would go to that effort now. Do you think that is absolutely necessary until we come to some determination, or how do we approach this problem?

Mr. BLACK. As I said, Mr. Rogers, on grant consolidation, I mention it now only in the larger context that we do want to try to keep the coordinated programs as closely together as possible. One thing I want to do is warn against a separation of these programs. I say we have this specifically in mind at this time on consolidation.

Mr. ROGERS. What study have we made on the function of existing centers? Has any study been made?

Mr. BLACK. We have an on-going evaluation program both in the centers and then through National Institute of Mental Health. We have people from the Institute visiting these centers. I think Dr. Yolles could give you a rundown on this.

Mr. ROGERS. What do we have on them? What do you evaluate?

Dr. BUKER. We have a core program in terms of follow-up.

Mr. ROGERS. You have a what?

Dr. BUKER. What I would call a core program in terms of central office and regional office staff actually visiting each center within 90 days after it has notified us that it has opened its doors, and then it is visited annually thereafter. Actually our staffing in the regional offices work very closely with the States and pursue this quite closely in terms of remaining in contact with the center. One of the purposes of this, of course, is that we may learn ourselves and pass the learnings from these operations along to other centers, and so that we can spot problems that are developing early and give them assistance to prevent those problems from getting worse.

Mr. ROGERS. Where is all that information consolidated? Have we got such reports that you could furnish the committee?

Dr. BUKER. Reports of such visits?

Mr. ROGERS. I would like to know how many centers there are, how many people are being treated, what the cost element is and how many cures, if there are.

Dr. YOLLES. We can give you such reports. We did a study of some 82 centers that were functioning in 1968 and we can give you the results of those. They don't cover all the results but we can give you other studies that might complement that.

(The following material was received for the record:)

COMMUNITY MENTAL HEALTH CENTERS EVALUATION

I. CURRENT EVALUATION ACTIVITIES

The purpose of program evaluation is program improvement. Evaluation efforts therefore are concerned with two levels: National program improvement and individual center self-improvement. National program improvement is aimed at discovering within the program ways of operating which will be more effective or efficient. Improvements might consist of greater program articulation or program modification. Comparisons are between procedural options which exist within the program or which can be incorporated into the program. Similarly, at the level of individual centers there is focus on potential changes in the individual center program. Of course, the ultimate result of evaluating one center might be to improve all centers.

There are a number of valuable resources being tapped to evaluate the Community Mental Health Centers Program. A primary resource is the NIMH staff who are engaged in a comprehensive variety of program analytic and formal data gathering, evaluative studies, and site visits. The major yields of these studies are explained below.

A second resource is the community mental health center staff occupying positions in the research and evaluation services of operating centers. The typical center program has at least one professional staff member assigned to this func-

tion. The objective of such efforts is to assess the effectiveness of the center's program by determining whether program goals are being met (e.g., whether identified high-risk groups are utilizing the center, whether there is any reduction in State hospital admissions from the catchment area, etc.).

Effective in fiscal year 1969, the Community Mental Health Centers Act was amended to permit up to 1 percent of the appropriations for both staffing and construction to be used for evaluation of the CMHC Program.

During 1969 these funds were used to fund contracts for the following purposes:

A. Development of a system for producing analytical profiles of center catchment areas from census data. The system will be applied to 1970 census data to study accessibility and integration of centers with other human services, including OEO and Model Cities Projects.

B. Development and dissemination of procedures that centers can use to allocate the cost of providing services.

C. Investigation of the present and expected patterns of funding for center programs.

D. Development of procedures for patient care evaluation.

Three of these four are essentially "enabling" projects which will subsequently make it possible for individual centers to make more sophisticated inputs into second order evaluation efforts.

The remaining major resource is the Institute's capacity to make regularly funded research grants and contract awards to study mental health services. An example of this kind of activity is a grant made last year to the Menninger Foundation to conduct a case survey of new careers in mental health systems.

II. RESULTS

Each Federally-funded center is site visited after approximately 90 days of initial operation. An important phase of this visit is an evaluation of how successfully the particular center's program has been implemented. A major conclusion formed to date is that the typical center can recruit professional and technical personnel to fill only a little more than half the funded positions in the first few months of operation, and that inability to fill a key position may seriously compromise a center's ability to deliver an essential service. This frequently is related to a second problem which is an inability on the part of most centers to raise sufficient matching funds in the first year of operation to derive the maximum dollar amount of Federal support from their staffing grant.

The annual inventory of psychiatric facilities conducted yearly by the NIMH covered community mental health centers as a discrete category for the first time in 1968. It yields systematically reported data on:

A. Numbers, ages, sex, etc., of persons receiving direct services during the year.

B. Patient movements between services, e.g., from 24 hour hospitalization to day care.

C. Sources of referrals and disposition of patients.

D. Itemized expenditures.

E. Staffing patterns by discipline and staff activities.

The results of the inventory covering 165 centers operational in 1968 may be summarized as follows:

An estimated 272,000 persons received care in community mental health centers in 1968—an average of over 1,600 persons per center. Community mental health centers *admitted* roughly 10 percent of all persons who came under psychiatric care in 1968, and these centers delivered about 9 percent of direct services to all persons under care. (This includes individuals receiving outpatient care outside the hospital setting.)

Centers are doing a good job of serving all age groups. Except for small children (under 5), centers are serving age groups in numbers very close to their proportion of the total U.S. population. For example, persons between 5 and 18 comprise 25 percent of the Nation's population. CMHC outpatient services—where school-aged children are most likely to receive care—report that 25 percent of their caseloads are in this age group. A significant number of center patients are over 65, reflecting the greater increase of this age group in our population.

Centers have also been found to provide services to patients with a wide variety of mental disorders. They are giving highest priority to the more serious disorders—those which place persons at highest risk of admission to public mental hospitals—34 percent of new inpatients were diagnosed as functionally psychotic,

and 22 percent of these as schizophrenic. Thirteen percent of new inpatients had a diagnosis of alcoholism. Similar patterns prevail among admissions to the partial hospitalization services of community mental health centers. In spite of the fact that centers are serving those with serious and disabling mental illness, patients' stays are only one-fourth as long as those in State hospitals. The median length of stay is 19 days—three-fourths of all patients are hospitalized less than a month; only 7 percent stay more than two months.

Over 16 percent of all patients seen in centers in 1968 previously had been in State hospitals. Presumably they would have returned to those hospitals had it not been for the advent of the center program in their community. Thirty-four percent of patients had had no prior mental health care at all. This is an indication that centers are visible, accessible, and provide service in areas where it previously was not available.

We now have a more complete picture of how centers are staffed. They are employing a wide range of mental health professionals and nonprofessionals as well. They are providing training in addition to their service function and supplementing the work of their paid staff through an extensive use of volunteers.

III. ONGOING AND PLANNED ACTIVITIES

Because the amounts of money available for CMHC program evaluation are quite limited, and because there are many program goals and concepts and a wide range of conditions to which the program must be applied, it is necessary to select carefully among possible topics for study. Most studies will involve center processes or concepts, either as criteria by which to evaluate programs or as independent variables whose efficacy is to be investigated.

The following topics have been tentatively identified as the issues of most immediate concern for center program evaluation. These topics are not listed in order of importance. Rather, it is felt that some evaluation efforts should be undertaken in each of the eight general topic areas. The actual distribution of support will depend upon the cost and quality of proposed studies.

1. *Funding of centers*

We are surveying our total needs for financial information about mental health services, and present mechanisms for providing such data on a one-time or continuing basis. In addition to the previously mentioned study of sources of funds of CMHC's, we are conducting staff studies of centers successful in organizing community support and of funding sources of centers affiliated with private general hospitals.

2. *Continuity of care*

In its several aspects, is one of the main ways in which the centers program promises to improve upon services to a community. In avoiding prolonged custodial hospitalization and utilizing instead appropriate community services, persons are likely to experience more changes in the modes of treatment, thereby increasing the likelihood of discontinuity between these modes. It is, therefore, important to monitor this feature of treatment. A number of NIMH procedures help to determine the amount of continuity at centers: the site visit reports, an annual inventory of facilities, and the continuation staffing grant application. Results from the annual inventory suggest that, early in their career as centers, few centers keep records in a form that permits convenient reporting of cumulative experience by patients in several services.

The site visit reports suggest that even early in the life of the program most centers had adequate provisions for continuity of care among services in the center (transfer of patients and records). Out of the first 82 centers visited, 78 percent were judged adequate in this respect, and only 10 percent not adequate. Even though most centers (93 percent) were considered to be "maintaining satisfactory relationships with pertinent community organizations and community resources," fewer (61 percent) were judged to have "follow-up practices adequate for patients referred from the center to other resources." Frequently this characteristic could not be determined by the site visit; only 8 percent were judged not adequate in this respect.

A recent survey¹ of centers has elicited information about the administrative practices centers use for continuity.

¹ J. R. Gray, continuity of care in the Community Mental Health Center: Measurement and evaluation of selected Administrative dimensions. M.S. Thesis, Univ. of N. Car., April 1969, p. 107.

Still lacking to date are studies contrasting the amounts or types of continuity of care provided to catchment areas by centers and by other mental health systems, and the impact on persons treated of various levels and types of continuity of care. The NIMH evaluation plan for FY 70 includes (a) a literature review in the area of continuity of care, (b) support for a study of the factors associated with amounts and types of continuity in operating multifacility centers, and (c) support for a study of the factors associated with amounts and types of continuity between centers and other care-giving agencies. In future years we will try to determine the relation between amounts and types of continuity and patient outcome.

3. *Accessibility of service*

One of the main advantages of community location of services is their accessibility. Information regarding accessibility comes in part from utilization statistics assessed qualitatively by site visits and continuation staffing grant applications and collected quantitatively by the annual inventory and by sample surveys. There is, however, a need for data on the views of community residents concerning accessibility, and how these views are related to program conditions, both those which are part of the center program concepts and those which are optional.

4. *Equity of services*

The extent to which the poor, for whom high quality services have not been available in the past, are now being served by the centers program is a serious issue. Even though priority is given to poor areas in need of service for obtaining construction and staffing grants, these areas have difficulty in organizing and applying for grants. As a result, centers are about as likely to exist in non-poor as in poor areas. Within centers, however, based on a small sample, more of the poor than the non-poor appear to get direct treatment services. Whether this greater proportion is consonant with greater need remains to be determined. It is planned to study specifically the extent to which the poor receive various types of services in areas with and without centers, and to identify the types of services most appropriate for the poor.

5. *Community involvement*

Among the new emphases of the last few years has been recognition of the importance of citizen participation in service programs. CMHC programs offer greater possibility than the State hospital system for citizen participation in a variety of roles. Survey results indicate that 14 percent of the staff (though not of staff time) working in centers in 1969 were volunteers, suggesting a high level of community involvement.

The FY 70 plan for center evaluation includes an attempt to arrange for (a) a survey of the extent of community participation in planning and in policy formulation of centers, (b) a study of the conditions associated with and resulting from such citizen participation, and (c) an examination of the impact of citizen evaluation procedures on type of services provided by centers.

6. *Relationships of centers to state mental hospitals*

Dissatisfaction with the State mental hospital system was one of the main incentives for the centers program. It was hoped that a community oriented program would prevent most persons from needing prolonged hospitalization and would shift the location of treatment of others to their communities.

There are two types of issues requiring examination: what impacts on the State hospital system do various types of center programs have, and what overall patterns of care in given areas result from various relationships between State hospitals and centers. To answer the question of impact on the State hospital system, a series of contracts with centers has been made to provide data on admissions to State hospitals now and before the center program started from catchment areas which centers began to serve and those they do not yet serve. Further, data reported annually by States will be examined to determine if a contract can be made between counties served by centers and those not served by centers.

Lastly, there is some evidence that State mental hospitals are themselves changing to be more community oriented. Not only are custodial facilities being replaced in part by centers, but many of these facilities are competing with centers in implementing the current concepts of appropriate treatment. The best way such changes can best be assessed is to examine the range and types of

service available to communities longitudinally, trying to determine logically and from the views of caretakers and other community citizens what factors led to changes. This study would have to examine a sample of instances where pre-center program data already exist—for example, in the 15 counties surveyed in the 1950's by the Joint Commission on Mental Illness and Health for community resources for mental health. A specific type of relationship between centers and State hospitals is the after-care service. The extent and correlates of this service may be surveyed.

7. *Comprehensiveness of services*

Comprehensiveness is closely related to being able to meet community needs, to provide continuity of care, and to coordinate center services with State mental hospital services. It goes a step beyond some of these other characteristics in relating mental health services to non-mental health services. Some efforts to collect data on the relationship of centers to non-mental health facilities are already planned (e.g., an examination of multi-problem families in one metropolitan area; an analysis of overlaps in catchment areas of various programs; and study of consultation services). In addition, a study may be supported of the relative effectiveness of mental health services in isolation, as part of health services, as part of educational services, or as part of welfare or human services.

Mr. ROGERS. In other words, how can you determine if you should expand into operation and maintenance, that you ought to, is this what you mean?

Dr. YOLLES. Some of the operating difficulties which have been reported and have been observed and measured would be in those reports, and we can supply additional information that may be helpful to your committee.

(The following information was received for the record:)

NEED FOR LEGISLATION

As of June 30, 1969, the Federal Government had funded, through the National Institute of Mental Health, 376 community mental health centers in 50 states, the District of Columbia and Puerto Rico, and in so doing, assisted in making vitally needed mental health services available ultimately to more than 52 million people. Of these centers, including those funded for construction, staffing, or both, 175 currently are making such services available to 24 million people and are providing approximately ten percent of all mental health services delivered throughout the country. The communities to which these services are provided range from the poorest counties in Appalachia to the affluent urban-suburban fringes of our major cities. All people, regardless of their race, color, creed, national origin or economic status can avail themselves of the needed mental health care which the centers are prepared to provide.

The fiscal viability of most of the federally assisted community mental health centers is a problem of critical dimension from the moment they begin to operate. Under present legislation, staffing grants are made to qualifying centers only for a part of the initial salary cost of just the professional and technical personnel of the center. The eligible salary costs of a center represent approximately 60 percent of the total costs of operation and are supported by staffing grants averaging only fifty percent of these salary costs. No provision is made for the support of other costs of operation, which includes other salaries, equipment, cleaning supplies, utilities, housekeeping services, rental or leasing costs, insurance, fringe benefits, and travel allowances. These costs, ineligible for Federal support under current legislation represent, on the average, forty percent of the total operational costs of a center. They must be met by the center itself from other sources of funds which all too many centers have been unable to develop in the relatively short period of declining support from the Federal Government.

An extension of Federal support to include assistance in meeting the overall costs of operation of a community mental health center, for a longer period of time than presently authorized, would facilitate the initiation and continuation of the delivery of sufficient qualitative mental health services in centers now funded and operating, those funded and beginning to operate, and those which will need and which will request initial Federal support in the years ahead.

Typical of the many centers which would benefit from such an increase in Federal support is the W. H. Trentman Community Mental Health Center of

Wake County in Raleigh, North Carolina. The center has been in operation as a federally funded mental health center since 1967. Two services—inpatient and partial hospitalization—were budgeted at \$340,000, of which the Federal grant accounted for less than 38 percent. In the second year of operation of the center, there was an increase in costs of 25 percent for these two services alone and the Federal grant accounted for only 25 percent of the total costs. Inasmuch as only the professional and technical personnel costs were and are fundable, the center had to meet the remaining costs—and did so, with great difficulty through the Wake County Hospital System, Inc.

The Director of this center, Dr. Nicholas Padiaditakis, described the support issue in these terms:

"The cutting-off period (fifty-one months for a staffing grant) is entirely too precipitous. The local authorities are not prepared to assume such sudden responsibility. The phasing-out must be a more gradual one. Unless the Federal Government continues to support centers at a higher initial level and for a longer period of time, the now-enlightened public and the sympathetic local legislators will take a U-turn towards the mental health program. They are under extreme pressure for all kinds of public services, topped with demands for tax-cuts, and increasing pressure from us may destroy the good will it has taken years to build for our work".

The entire mental health service program of the Northeast Region Mental Health and Retardation Center in Grand Forks, North Dakota, appears seriously threatened by the immediately impending phase-out of the Federal staffing grant support. Currently the center receives 30 percent of total operating costs from three of the four counties it serves, another 30 percent from the State of North Dakota—which had initially pledged up to 40 percent of total costs—and the support of the Federal CMHC staffing grant. The decline of Federal support with no immediate prospect for an increase in state or county support will leave the center with an estimated 40 percent or greater deficit operation by March of 1971. The administration of this center which makes its services available to 86,000 citizens of this largely rural area holds little hope for the development of sufficient replacement and additional resources in sufficient time to enable the operation to continue at its present level and quality of operation beyond 1971.

Since it opened its doors to an inner-city community of 150,000 three years ago, the St. Joseph Hospital-Mid Houston Community Mental Health Center in Houston, Texas, has developed a program of care designed to meet the needs of the more than 50,000 families occupying this predominantly poor area of the city. Close to 50 percent of the population served have an income of less than \$4,000 per year.

From the outset, this center has operated with a deficit ranging from \$42,000 in 1967 to \$400,000 during the current year. With an additional budget of \$1,245,764 during 1967, the center received Federal staffing grant support amounting to \$609,299. The following year the budget increased but Federal support declined to \$465,935 and the deficit increased to \$260,000. The State of Texas, through a contract for services with the center, pledged to purchase up to \$100,000 of services during 1968 but less than 30 percent of this amount was received by the center. The center's administration believes it will take at least four or five more years to develop significant local support from within the community, during which time continued Federal support is critically needed.

Similarly, the Northern Kentucky Mental Health-Mental Retardation Center, Covington, Kentucky, had a first year operating budget of more than \$330,000 of which the Federal contribution totaled only \$94,000 or 29 percent. Total expenditures for the Arapahoe Mental Health Center in Englewood, Colorado, amounted to \$302,000 during their initial year of operation. Forty-five percent was accounted for by Federal funds. The Jefferson Community Mental Health Center in Philadelphia, Pennsylvania, had a first year operating budget of nearly \$950,000, but the Federal participation amounted to only 40 percent.

A recent study of community mental health centers in their second and third years of operation indicated that Federal staffing funds support only 37 percent of a center's second and third year total operating expenses.

The foregoing examples, typical of a wide number of others, demonstrate that Federal support of community mental health centers is often considerably less than would be expected—even under existing legislation. The examples further point to the relatively short period of time under current legislation, allotted for centers to develop on the local and state levels both the resources and the processes of funding necessary for their survival as vital elements of the national system of mental health care.

With regard to the proposed broadened definition of the personnel covered, as well as the proposed covering of a portion of all costs of operation, it should be noted that most of the staff of community mental health centers carry some level of program responsibility relating directly to patients in a therapeutic sense, that is as a part of the planned treatment program. This is a true even of staff carrying out so-called administrative and housekeeping functions which have traditional titles denoting those primary areas of responsibility. For example, telephone operators and receptionists are trained and used as part of the therapeutic team in dealing with patients, families and emergency contacts concerned with suicide prevention. Housekeeping, administrative, and maintenance staff frequently function as part of the therapeutic team in providing industrial, recreational, and other activity therapies for inpatients and partial hospitalization patients. To the extent that such staff are appropriately involved, these positions are currently supportable. Involvement of all staff in the treatment program has been encouraged to make fullest possible use of all potential resources in establishing a total therapeutic milieu, to maximize meaningful communication between center staff and the wide variety of populations served, and to lend impetus to a growing trend of employing subprofessionals in a variety of useful ways.

The definition, justification, and review of such staff positions with respect to eligibility for support has been difficult, time-consuming, and a fertile subject for development of misunderstanding. In addition, the extra cost of justifying, reviewing, and monitoring the current requirement in order to eliminate positions ineligible for support outweighs any savings.

The need for greater assistance to community mental health centers in terms of both the duration of the initial support and the extent of support to the total center operation, is clearly indicated with regard to centers generally. The need is much greater in terms of centers in those areas of the Nation designated as urban or rural poverty areas. There is ample evidence that the condition of urban poverty and its acerbation of social problems and disorganization, and health, welfare and education problems, is accompanied by unusually high rates of social and personal dysfunction and mental illness. Extensive family disorganization and pervasive childhood deprivations so prevalent in urban poverty areas contribute to the creation and persistence of mental disorders. Unfortunately, communities of poor people are least able to effect the necessary organization for planning and least able to develop their own financial resources or obtain funds from outside the community to deal with these conditions. Sparsely populated rural areas face similar problems of lack of organization resources, communication obstacles, and frequently conditions of extreme poverty.

Federal legislation provided funds for construction of community mental health centers on a matching basis with states. However, Federal money could not be used for the cost of the land for center construction. The average cost of constructing a center is \$1,694,000. Not more than two-thirds and usually less of this cost is eligible for Federal funding under present legislation. In point of fact, Federal funds support approximately one-half of these eligible costs. The cost of land and off-site improvements averages one-third of the total construction costs but presently is not fundable through the Community Mental Health Centers Act.

This limitation on Federal support of center construction costs needs to be extended to include a sharing in the mounting costs of land and off-site improvement if centers are to be located where they adequately meet the requirement of physical and environmental accessibility. Many centers have experienced a reversal in plans to locate facilities in high-risk, low economic urban areas as a result of insufficient funds to purchase suitable land. The Mecklenburg County Mental Health Center in Charlotte, North Carolina, found it necessary to locate outside the immediate area of critical mental health service need and in a location less than optimally accessible to those most in need of service. St. Joseph Community Mental Health Center in South Bend, Indiana, also had to consider building in a less advantageous location because of the high cost of land. Similar difficulties and financing problems confront the Los Angeles Psychiatric Community Mental Health Center, the Northwest Oregon Community Mental Health Center, centers in Norfolk, Virginia; Dumont, New Jersey, and elsewhere.

Even though the requirements of the priority ranking system contained in the state plans for the development of community mental health centers places economically deprived areas in the top priority category of need for funds, only 24 percent of the 500 poorest counties in the Nation are represented in the catch-

ment areas of funded centers, and only 29 percent of the over 5,129,000 people living in counties characterized as both very rural and among the poorest in the Nation are represented among the catchment areas of funded centers. Although 40 percent of funded centers serve rural areas at least in part, only 22 percent of all rural counties are covered.

Yet, continuing interest in the centers program has been expressed by citizens in poverty areas, both urban and rural. St. Louis, Missouri, has a community mental health center which is involved in their model cities program. The center wants to develop needed satellite services in five areas and apply for an additional grant. However, the staff is so involved in the provision of already established services that no one currently is available to develop the new program and necessary application. They need additional staff to work with the disadvantaged groups in establishing services for the poor. However, the current level of support available through Federal staffing grants is not adequate—they cannot raise the amount of matching and other money required.

Despite the fact that development of adequate mental health services in poverty areas is recognized as of highest priority at Federal, state and local levels, development of such services for these areas is actually proceeding at a much slower rate than in other less economically deprived areas. Inability to obtain necessary funds is a major cause. Priority of need means little in the face of needing but not having adequate financial resources.

Preferential funding for both construction and operating costs will do much to provide the needed incentive and assistance for the establishment of services in underprivileged urban and rural areas. In addition, the proposed extended length of Federal participation in costs of operation including staffing costs, will provide a longer period of availability of close Federal-State-local partnership and meaningful assistance to these local programs.

Mr. ROGERS. Is this widespread? Are all of the centers in this sort of shape that they must have operation and maintenance?

Dr. YOLLES. No, Mr. Rogers, they are not all in poor shape. There are some which are in good shape but there are a lot of centers in difficulty especially as we come into the third and fourth years of support. The State commissioners for mental health, have also reported this as they come in to their annual meeting, in addition to letters to both the Secretary and to NIMH of the difficulty which they will be experiencing. For one example, there is one State in the East here that at the present time supports some 28 community mental health centers, and picks up their deficits. They project in the next few years the need for about 80 centers to cover the persons in their State but they know full well they are not going to be able to continue picking up the operating deficits and they point out we need more liberal support of these centers in order to overcome the deficits.

Mr. ROGERS. Now anyone who goes to the center, does everyone get free treatment?

Dr. YOLLES. There is free treatment for those unable to pay. There is usually a sliding scale. Patient fees amount to about 14 percent of the support of service.

Mr. ROGERS (presiding). Is this general?

Dr. YOLLES. We are looking into funding problems at present.

Mr. ROGERS. This is the average for those that you looked into?

Dr. YOLLES. Yes.

Mr. ROGERS. What are the extremes?

Dr. BUKER. In terms of patient fees they vary widely from a very, very small percentage to a reasonably high percentage in the sense of perhaps 34 to 40 percent. It depends in part on the location of the

center. For instance, a center that is serving an area that is almost completely a poverty area——

Mr. ROGERS. Are you funding those or is OEO? Did you include the OEO-funded centers in your study?

Dr. BUKER. No.

Mr. ROGERS. I would like to know which ones, if you would point out specifically which ones you looked at and if it is funded through your program or if you receive funds from OEO or any other.

(The following information was received for the record:)

None of the cost data on community mental health centers presented in testimony is based on data which includes Office of Economic Opportunity centers or funds.

Mr. ROGERS. Now do you think it is really going to be much help to them to get it in the seventh and eighth year when you get down to 20 and 10 percent?

Mr. BLACK. Yes, we do, Mr. Rogers. I think, again, this is a sound concept, if you are going to have this seed money approach, to help them phase out in this Federal support over a longer period and continue to decrease in rates.

Mr. ROGERS. It seems to me that that is a little contra to what you have been telling us on the need to expand support and then you drop down to 20 and 10 percent. I agree with the fact that we want to maintain a local effort if we can but I wonder if we are not going to have to at least stop there at about 30 percent. I know the committee, and the bill most of us introduced just to bring into the discussion to at least maintain the 30 percent. From what I have seen in the testimony—and I want to go into some specific centers—I am not sure but what we are going to have to raise a constant level, even higher maybe than 30 percent. This is what I seem to gather from what you are telling me.

Mr. BLACK. You mean on a permanent basis?

Mr. ROGERS. Yes.

Mr. BLACK. That certainly is not our intention.

Mr. ROGERS. You say they don't have enough sources, that the third-party people are not paying and that we need to carry maintenance and operation as well. It seems to me that the testimony is not coordinating with the figures.

Mr. BLACK. The point was, on the local support and third-party payment, that all this has been slower in developing than was expected when the legislation was enacted. What we are proposing here is that we extend this period of Federal support to permit more time so that the local communities must do their own support, and necessarily we do anticipate that third-party payments should be increasing.

Mr. ROGERS. Now why is it necessary to include cost of land? We have never known that before. Isn't that in issue? We have always been able to come up with land, they can find some people around the community or counties or something. Don't you think that is an unnecessary burden for us to assume?

Mr. BLACK. Well, we think that it is a very legitimate part of the total cost.

Mr. ROGERS. I understand that but I think it is not as important as getting the professional help. In other words, what we try to do in the original bill is set up a policy and really provide the service, and I still think this is as much as we want to do.

We ought to look very carefully at this and try to really hold it to the essential elements where they really need help. Particularly if you have already got 451 already set and going by 1970, I wonder if it is necessary for us to get into this land in addition? I question it. I think it might be better to put the money into staffing at a higher level for the years that we go out. I think it might be better to do that rather than the land costs.

Dr. YOLLES. I would like to comment on that briefly.

Mr. ROGERS. Yes.

Dr. YOLLES. I would like to point out in terms of the present bill that over the course of the project, over the life of the project, the Federal contribution amounts to about 27 percent of the operating cost of the center. Regardless of the formula that you use or the method that you use, whether it is increasing the time period or supporting the total staff of the center, or whether it is for operating costs I think the need is for a larger share over a longer period of time to enable these communities to maintain these centers.

Mr. ROGERS. That does not quite get to the answer. I see what you are saying, but when they provide the land that is over and done with and it ought to be provided. There is no reason why it could not be.

Now to say, well, you can call it a contribution one way or the other, I don't think that follows because what we want to do is to get the service out. It seems to me even though you say the 27 percent may be a contribution, whether you give it to land or buildings, I think it is very important what you give it to and what we encourage that the local community do. Where they are going to need help is with staff and professional people rather than the land and probably even build it if they do need help to build it.

Dr. YOLLES. I was referring to site acquisition. I just want to support these presently.

Mr. ROGERS. I understand.

Now in the alcoholics centers, too, I notice you imply all costs of staffing operation.

Mr. BLACK. Right.

Mr. ROGERS. What new training and evaluation programs would you establish?

Mr. BLACK. What new ones would we establish?

Mr. ROGERS. Yes.

Mr. BLACK. I would like Dr. Miller to comment.

Dr. MILLER. In the area of training there is a real dearth of both professional and nonprofessional personnel. It is a problem.

Mr. ROGERS. With alcoholism?

Dr. MILLER. Yes. And the problem is not just the question of developing more manpower, but of upgrading the current manpower in the field. As I think it has been pointed out professionals to a great degree have avoided involvement in the treatment and to an extent this is due to defects in education; inability in their own understanding of the ways which have been developed by which alcoholism can be effectively treated. Such training grants would be used both for developing

new kinds of personnel and to a great extent for upgrading existing personnel in other types of programs which would enhance their ability to deliver services.

Mr. ROGERS. So what you are thinking about is an alcoholic program for the training.

Dr. MILLER. Yes, sir. This is for the training and evaluation section under the alcoholism section.

Mr. ROGERS. This is the only one you are thinking about basically?

Dr. MILLER. Yes, sir.

Mr. ROGERS. What funds do you visualize using and how extensive are the programs?

Dr. MILLER. Well, this would be very much dependent on the level of the appropriation.

Mr. ROGERS. I understand that everything is dependent on that. I am talking about your projection, what the Department thinks. Now I realize that the Department is hunger-bound from the budget. We are not asking you to tell us what your budget figures are going to be, you don't know either. We are asking what you are asking for and what you think we should.

Dr. MILLER. As has been pointed out, in the 1970 budget request there are no funds for any alcoholism support.

Mr. ROGERS. So you don't think it is very important; is that what you are telling us?

Dr. MILLER. No. From a professional standpoint this is a very, very critical type of problem.

Mr. ROGERS. In 1971 I know you do not have the budget figure. I am not trying to badger you to get you to say that because I understand you cannot, but your projection from the Department's standpoint on the alcoholism program of training, have you asked for funds to initiate this program?

Dr. MILLER. Yes, sir.

Mr. ROGERS. All right. And you anticipate that as far as the Department is concerned the Department would like to know.

Mr. BLACK. We have asked for funds, and as I indicated earlier I hope, and I think I can say, that we have confidence that there will be some funds in the 1971 budget to carry on this part of the program because we do think it is important and we want to get the money in there.

Mr. ROGERS. We would like your projection which we understand is for the 3 years for overall programs. The committee would need this in writing the bill because we always put it in.

(The following letter was received for the record:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF THE SECRETARY,
Washington, D.C., December 3, 1969.

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

DEAR MR. CHAIRMAN: During our recent testimony before the Subcommittee on Public Health and Welfare on the Community Mental Health Centers Amendments of 1969, we were asked to provide estimates of the amounts necessary for continuation of the program under the provisions of H.R. 14617, the Administration bill.

In response to the above request, I am forwarding the following table of estimated costs by this Department for the Community Mental Health Centers Program for the three year extension proposed in H.R. 14617:

COMMUNITY MENTAL HEALTH CENTERS AMENDMENTS OF 1969, ESTIMATE FOR 1971-73

[Amounts in thousands]

	1971		1972		1973	
	Number	Amount	Number	Amount	Number	Amount
(a) Community mental health centers:						
Construction.....	63	\$25,000	75	\$30,000	75	\$30,000
Staffing.....	294	75,000	324	92,000	354	108,200
(New).....	(20)	(11,200)	(30)	(17,200)	(30)	(17,200)
Total.....		100,000		122,200		138,200
(b) Alcoholism community assistance.....		10,000		20,000		30,000
(c) Narcotic addict community assistance.....		20,000		25,000		30,000

These estimates are, of course, subject to revision in view of overall fiscal considerations which may be presented to us during the period of extension. They do not constitute a commitment by this Department to request or budget such sums.

Sincerely,

CREED C. BLACK,
Assistant Secretary for Legislation.

Mr. ROGERS. Let me ask this and I will conclude.

Doctor, what real breakthroughs have we had in mental health and particularly with this program?

Dr. YOLLES. Well, I don't know that I can talk in terms of breakthroughs. I think what we are seeing today is the accumulation of all of the breakthroughs, if you will, over the years and now have the opportunity to put it in effect in a community for the first time. We have never had a facility in the community where you could treat individuals rather rapidly as they become ill and apply all of the new methods to them. I will be glad to provide for the record a special report that will amplify this point.

(The following information was received for the record:)

SPECIAL REPORT—COMMUNITY MENTAL HEALTH CENTERS PROGRAM

I. HISTORICAL ROOTS OF THE PROGRAM

The current status of mental health services in the United States has been the result of a long and complex evolutionary process. Major changes or modifications in the nature and delivery of such services have usually been very slow in coming. Within this framework, it is particularly interesting to note that the antecedents of the community mental health centers program are compressed into the past twenty-five years.

Having as its aim the effective delivery of a wide variety of coordinated mental health services, the Centers program is, in many ways, the most vital and dynamic health program in the nation. For years prior to the implementation of this program, the only mental health facility available to the vast majority of Americans was the state mental hospital. Large, isolated and increasingly overcrowded, these institutions offered impersonal custodial care in lieu of treatment. Many patients spent years or decades in such institutions with little hope of returning to their family or community.

A major departure from the public mental hospital system was the establishment of the child guidance clinic. These clinics sprang up as one result of the increasing awareness that early treatment of children could prevent the development of more serious disorders in later life.

There was, however, often little contact, let alone coordination, between the emerging community based mental health and the public hospitals. State hospitals continued to increase their resident populations, taxing further

their already overburdened resources. The clinics, dealing with less severely disturbed populations aimed at providing treatment, most often based on psychoanalytic and psychotherapeutic concepts. In a real sense, these two systems of "care" were essentially autonomous and unrelated. It was not until the second World War that fresh attention was paid to the organization and delivery of mental health services in the United States.

As a result of the large number of American men rejected for military service on the basis of psychiatric disability and unexpected number of psychiatric casualties among fighting men, public attention became riveted on the problem of mental health in the United States. At the same time, the military was able to demonstrate that long-term hospitalization was not the only, nor the most effective response to psychiatric casualties. Through short-term hospitalization and a rapid return to the community—in this case the military community—psychiatric casualties were once more able to function effectively. Such demonstrations that psychiatric disorder was not irreversible were highly successful in reducing the stigma attached to mental illness.

It was against this general background of increasing public awareness and concern that Congress, in July of 1955, passed the Mental Health Study Act. This act established the Joint Commission on Mental Illness and Health, with the specific aim of studying and making recommendations regarding the mental health of the Nation. After five years of intensive study, the Joint Commission released its final report *Action for Mental Health*.

Among the highlights of that report was the recognition that the public mental hospital system had become outmoded and in many cases was no longer able to meet current needs. In addition to reducing the size of these public institutions, it was recommended that smaller, supplemental facilities be developed in local communities.

The report gave particular attention to the need for coordination between mental health resources and services. The insulated and unresponsive systems of care had clearly proven to be ineffective. What was needed was a network of care-giving agencies with a community based mental health facility as its nucleus.

In addition, the need for new and comprehensive treatments was pointed out. Through the use of psychoactive drugs, many patients previously regarded as "incurable" were found to be accessible to therapy. Even more, many standard practices of mental health care were found to be not only non-helpful to the patient, but were, indeed, damaging.

In effect, *Action for Mental Health* recommended a major overhaul of many aspects of the mental health care delivery system. To be sure, not all of its specific recommendations were acceptable to all groups and many recommendations were highly controversial. At the same time, there could be no question of the findings of nationwide neglect for the emotionally disturbed and the appalling lack of appropriate and necessary services.

Accordingly, in the latter part of 1961, President John Kennedy appointed a Cabinet-level committee to study the Joint Commission's final report and to suggest possible courses of action. At the same time, a parallel panel on Mental Retardation was appointed. On the basis of the recommendations of these groups, President Kennedy sent to Congress on February 5, 1963 a Special Message on Mental Illness and Mental Retardation. In his speech, a "bold new approach" to the needs of the mentally disabled was called for. As the key to this bold new approach, the community mental health center was proposed. In striking contrast to the then existing condition of mental health services, the comprehensive community mental health center would make available a wide range of programs for prevention, treatment and rehabilitation to all the people in their home communities.

Congress responded to the challenge with the enactment of the Mental Retardation Facilities and Community Mental Health Center Construction Act of 1963. This act (P.L. 88-164) authorized 150 million dollars over a three year period for construction of community mental health centers. In 1965 the act was supplemented by P.L. 89-105 which provided a total of \$73,500,000 over three years to assist in meeting the initial cost of professional and technical personnel to staff the new community mental health centers program.

This legislation is making it possible for communities throughout the nation to develop mental health programs, either through the creation of new agencies or through the coordination and expansion of existing resources. Each center, serving a defined "catchment area", must make at least five essential services avail-

able—community consultation and education, partial hospitalization, 24 hour emergency care, inpatient service and outpatient care. In addition, centers are encouraged to develop other programs and services of particular relevance to their community.

II. A LOOK AT PROGRESS

Although the Centers program is relatively young, its growth has been rapid and its impact extensive. From the first grant in July of 1965 to the end of fiscal year 1969, more than 376 community mental health centers have been funded. These centers are located in every State of the Union and in communities ranging from urban inner city ghettos to middle-America farmlands, from affluent suburbs to the very poorest counties of Appalachia.

Of the 376 funded community mental health centers, 118 have received both a staffing and construction grant, 163 only a construction grant and 95 only a staffing grant. The proportion of successful applicants, however, who are receiving both staffing and construction grants is continuing to increase. This is entirely consistent with the Institute's expectation that, in the long run, nearly every applicant will require the assistance afforded by both types of grants.

It is of particular interest to survey the applications for community mental health center grants. The largest number of applicants—some 42%—are local governmental units and charitable institutions. An additional 25% of the grantees are general hospitals, both public and non-profit. An increasingly important category of applicants might be called the "special purpose corporation." Forty-two states now have community mental health service acts, most of which require the establishment of regional community mental health boards. Such a board often serves as the applicant for all community mental health centers within its region. These corporations currently account for 17% of all center applications. Independent mental health clinics, public mental hospitals and other agencies account for the remainder of center applications.

In fiscal year 1968, over half of the funded centers were under some form of public control. By the end of 1969, however, only 48% were under such control while 53% were under private, non-profit management. Of those centers under public management, 14% are under state control, 21% under county control, 7% under city control, and 6% are controlled by a hospital district which cuts across county lines or by a special purpose corporation.

Reflecting the attempts to increase coordination among community care givers, 85% of all funded centers represent the joint efforts of two or more affiliating agencies. Further, nearly one-third of the centers are being established in small towns and rural areas where mental health services have previously been virtually non-existent. When all the currently funded centers become operational, more than 58 million people will be accessible to comprehensive and high quality mental health services.

As community mental health centers have demonstrated their usefulness and effectiveness, considerable community support has been generated. Indeed, such support is necessary inasmuch as Federal grants supply only a portion of the costs of center construction and operation.

Construction projects, for example, cost an average of \$1,500,000. Since the typical center elects to incorporate construction features and items of equipment which cannot be funded under current legislation, Federal participation accounts for only some 30%, on average, of the total construction costs. It is of particular significance to note that in some states, construction of community mental health centers is going ahead, without Federal assistance. In Indiana, New York and Oklahoma, for example, the states are matching locally raised funds.

As with construction grants, Federal participation accounts for only a portion of the costs of staffing a community mental health center. On the average, the cost of operating a mental health center is estimated by applicants to be nearly \$750,000 per year. Federal funds, which under present legislation are available only for the salary costs of professional and technical personnel, cover only 40% of first year operating expenses. Thirty percent is covered by state and local governments with the remainder being obtained from patient and third party payments and philanthropies.

III. A LOOK AT IMPACT

The foregoing description documents a significant administrative achievement—an achievement made possible by a sustained cooperative planning effort at Federal, state and local levels. Yet the question may be raised as to the effect those

centers already in operation have had on their communities and on the people in need of mental health services.

In a real sense, such analysis is premature. The first community mental health center grant was approved in July 1965, somewhat less than five years ago. With construction and recruitment delays, many programs were not initiated until well after that date. Indeed, of the 376 funded centers, only 185 were in a position to offer the basic five essential services as of June 30, 1969. Nonetheless, there is evidence accruing of the impact centers have had.

Making mental health services available

One of the major underpinnings of the community mental health centers program is the making of mental health services readily available and accessible to all the population within a given catchment area. Indeed, one of the greatest problems facing mental health planners is the large number of people who have no ready access to mental health services. In rural areas this is often a matter of geography; the distance to the nearest resource is likely to be so great as to be a nearly insurmountable obstacle. In more urban areas the problem is not so much geography as a scattered distribution of services. Eligibility restrictions, duplication of services and gaps in coverage have left millions of city dwellers underserved if not totally unserved.

The fact that 376 community mental health centers are presently preparing to serve 58 million people is only the beginning of the story. At least as important is the evidence they offer that programs can be mounted in "resourceless" areas and that, given time and fiscal support, mental health services can be provided in every community in the United States.

One excellent example of the way in which this is taking place is the State of Kentucky, where 21 centers have been funded, 16 of which are now operating. The fact that this has been possible in an area which includes some of the poorest rural counties in the country and which has had a minimum of psychiatric services available is due to the imaginative leadership of the State Department of Mental Health and dedicated local citizen participation. Citizen-led Regional Mental Health-Mental Retardation Boards have been chartered throughout the state by the Department of Mental Health as autonomous, non-profit corporations to serve as mental health-retardation authorities for multi-county regions. They are charged with the responsibility to plan, coordinate, implement and administer services. An advisory council of professionals and a government advisory council of county judges and local mayors assist each board.

The state provides technical assistance in planning and community organization to the boards in setting up the centers. In addition, multi-disciplinary teams are assigned by the state office to districts covering four to five regions. These teams provide professional consultation to center staffs and boards and, where necessary, offer direct services to fill gaps.

Each center operates an information-screening-referral (I-S-R) unit as the control center for all elements of service. The I-S-R sees all patients initially, making sure that each is assigned to the most appropriate center service. If the patient is referred to another agency, I-S-R staff virtually "hand carry" clients to the appropriate agency. This unit follows its patients, coordinating continuity of care, and maintaining careful records.

With this "nerve center" style of organization it has been possible to make full use of whatever resources may be available to the center. Inpatient services, for example, are provided in small, non-profit general hospitals, most of them with no previous experience with psychiatric patients. Professionals in related fields, such as teachers and non-psychiatric physicians, are encouraged to participate in the center programs. Clergymen have been particularly active in this regard, many of them as regular full- or part-time center staff members. A non-professional mental health associate is stationed full-time in each county, supported by regular visits from a mobile professional team travelling out of the center office and by emergency professional consultation whenever necessary.

Thus, the Community Mental Health Centers Program has stimulated many communities in Kentucky to make a virtue of necessity. With hard work and imagination limited resources have been utilized in such a way as to bring high quality mental health services to those in need. Similar examples could be cited from other states where in impoverished rural areas major efforts are being undertaken to implement local service programs. The total number of such centers, however, is still far short of the demonstrated need. Only 25% of the coun-

ties which are both predominantly rural and among the poorest in the Nation are represented in the catchment areas of funded centers. Presently there are more than 2,100 predominately rural counties in the United States with a total population of over 40 million people. By the end of fiscal year 1969, 530 of these counties, with a population of more than 10 million people will be served by 150 rural-based community mental health centers.

This is particularly impressive in light of the major problems inherent in the development of community mental health centers in rural areas. Rural counties have a low tax base and the operational costs for delivery of services to vast geographic areas are more costly. In addition, professional manpower is scarce or lacking and it is often quite difficult to organize citizen interest and resources.

While urban areas do not present the same type of challenge, their problems are no less acute. While services do exist, they are often scattered, with individual agencies having little interest or contact with other agencies performing similar functions. The problem then is getting these agencies to work together in a manner that is beneficial to the whole community, while at the same time allowing each facility to retain its special skills.

As an example, one may look to San Francisco where the Westside Community Mental Health Center has recently been set up to serve an area of the city with a wide spectrum of social and economic population groups. The area includes the homes of extremely wealthy people as well as the Haight-Ashbury Section. Although this area has been rich in community services, such services have traditionally operated independently and in uncoordinated fashion.

Yet, under the impetus of the community mental health centers program, progress toward meaningful community coordination has been made. For eighteen months prior to the actual staffing grant award, for example, a community group met to discuss the development of comprehensive mental health services. Represented in this group were seven separate established agencies: three hospitals, one Catholic, one Jewish, and one Protestant; two family agencies, one Jewish and one non-sectarian; and two halfway houses. As the result of their planning to serve the community each of the organizations agreed to participate in providing one or more of the ten services of a comprehensive mental health center. In addition to a continuity of care agreement, making it possible for services to be provided by each agency to people being served in any of the others, a common set of by-laws was adopted and the group was organized officially as a nonprofit corporation. Each of the organizations has pledged to place a similar amount into the general fund of the center board for administration and coordination of direct services as well as programs of research, evaluation and inservice training.

A separate consumer council representing the diverse elements in the community is meeting to discuss the basic problems and requirements of the population to be served. The president and vice-president of this council are full voting members of the center board, making possible a continuing working relationship between community leadership and the center's professional directors.

This is a particularly noteworthy example of community involvement and the coordination of services within an entire area. It must be remembered that San Francisco is an older community with each of the participating organizations having a long history and cherishing their individual identities and autonomy. To form this center, the agencies involved and their individual boards have had to recognize the value of the mental health program and its services to the entire community. Equally significant is the fact that this diverse group, including high and low income and a variety of ethnic and racial elements, has been able to come together in a unified decision making organization which will provide a meaningful program of services.

The way in which the program was developed and the continuing concern for providing service to all segments of the community has resulted in an extension of the former constituencies of these agencies. Services are now accessible to large numbers of people who were previously excluded from care, many of whom are unable to pay for such services. In urban areas, therefore, no less than in rural areas, additional funding mechanisms must be developed to maintain existing programs and encourage the growth of new ones.

The problem of funding is rapidly emerging as a critical consideration for the centers program. While many communities have been quite creative in generating financial support, many other communities have found it quite difficult to raise funds.

Federal efforts are attempting to help communities in this regard. With National Institute of Mental Health consultation, applicants are planning pro-

grams of services which reduce the need for additional staff and overhead and maximize the use of existing facilities. In addition, many are urging that their State community mental health center agency adopt a preferential rate of Federal participation for poorer communities as permitted under P.L. 88-164 and urging enactment of provisions in the State's mental health services act which will favor "have-not" communities.

In recognition of the funding problems inhibiting the development and the ongoing operation of centers, the Community Support Section was developed in February 1969, within the Community Mental Health Centers Support Branch, Division of Mental Health Service Programs. This section has launched a program directed toward the study of general funding problems of community mental health centers with a particular view towards the anticipated phasing out of Federal funds at the conclusion of the 51 month period of support—the limit of support allowable under current legislation.

Humanizing the delivery of care

Recent experience in a variety of human service programs has indicated that there is a great deal more to providing such services than merely establishing staff in appropriate locations. In order to reach people effectively programs must be relevant to the real needs of their communities and they must be accessible in a cultural as well as a physical sense.

One very effective means of integrating a center program into the life of its community is through careful architectural planning. NIMH architectural consultants have stressed the necessity for adapting center designs to the specific community by the understanding of local customs, local materials, local topography and climate. Those centers already constructed differ markedly in appearance, providing insofar as possible a familiar environment for the patients and staff.

In some cases it has been feasible to renovate or remodel existing structures. Where new construction has been necessary it has frequently been possible to provide for other useful community functions as an adjunct to the mental health program. For example, the Rainbow Mental Health Center in Kansas City is proposing to convert an old quarry into a public park in front of its new buildings. Residents of the area may enjoy landscaped walks and play areas quite apart from their need for the center's professional services. The center in Winter Haven, Florida is building a small auditorium which will be available for community meetings and recreation when not in use for center activities. This type of planning not only makes the center more visible to the community but additionally, makes the center part of the community.

Affiliation with familiar community institutions may bridge the gap between the new center and people unused to seeking mental health care. In Newport, Vermont an established local thrift shop has served as the basis for a successful sheltered workshop program. Throughout the country center staffs are working closely with local school officials to provide diagnostic and treatment services within the traditional school setting. The Baltimore Inner City CMHC, for example has organized group therapy programs in a local junior and a senior high school for youngsters identified as potential dropouts.

Individual program elements such as these are useful mechanisms for building meaningful relationships between centers and the communities they serve. The larger problem of organizing a total program so that it will be welcomed and used by its constituency demands continuing attention and flexibility on the part of center staffs everywhere. The experience of the Mid-Houston MHC is a notable example of this process.

This program was originally designed to offer the five basic services at St. Joseph's Hospital in Houston, Texas. However, the location of the hospital at one extreme of the catchment area and the diversity of cultural backgrounds in the population proved to be obstacles to full utilization of the center's services. An attempt to modify the program through the use of treatment teams improved the situation but still did not reach large numbers of people who needed help. Therefore, the staff began to move out into the neighborhoods and to establish ties with an old established settlement house program. This program extension has included more emphasis on crisis intervention, early detection and prevention.

Recently, the center further decentralized its services to reach more of the people, particularly those resistant to utilizing services. The catchment area has been divided into three districts, each having a district center. Decentralized outpost workers will provide education to families of hospitalized patients, sup-

port the patient, and provide aftercare. They will identify those needing outpatient care, provide education and support to the patients and their families, and deal with psychiatric emergencies as they occur in the neighborhood. Day and evening care, precare and aftercare, diagnostic services, and outpatient care will be provided in the district centers as well as in the central bases in St. Joseph's Hospital and the Ripley Settlement House.

Over time the center has developed a number of new and interesting programs in conjunction with the state's vocational rehabilitation agency and the Neighborhood Youth Corps. At the end of its fourth year of operation, the Mid-Houston Mental Health Center is providing a program far different from the one originally proposed, but one which is genuinely serving the needs of its people. The importance of the Houston experience (and similar illustrations could be drawn from a number of other centers) is its demonstration of the way in which a dedicated, highly competent staff can adapt a program with built-in flexibility to yield the highest possible human value.

The community mental health center and the public mental hospital

Discussion of the humanizing effects of community mental health centers on the system of delivering mental health services must of course include consideration of their impact on the public mental hospitals. This is, after all, one of the most important reasons for the creation of the program. The Joint Commission Report clearly indicated the weaknesses of the State mental hospital system and called for measures to improve and supplement it. There is considerable evidence already that the centers are doing both.

In areas not yet served by organized centers the public mental hospital remains the chief, and in many cases the only mental health resource. Many of these institutions are now re-thinking program organization and goals in anticipation of the day when local centers will be established. Patients are being regrouped on a geographic basis to facilitate continuity of care with present or future facilities in their home communities. The hospitals themselves are reaching out to establish ties with other agencies and are setting up local aftercare units, many planned for inclusion in projected center programs.

The State of Utah, for one, has taken steps to unify and coordinate existing programs at the State Hospital and local clinics. Aftercare services have been extended throughout the state, through a team from the Utah State Hospital traveling on a regular basis into different areas of the state. Another team from the hospital provides prescreening, aftercare, and trial visit follow-up in the Salt Lake City area. It is planned that the latter team will form a nucleus of professionals who will work with an advisory council to plan and implement a second comprehensive community mental health center in the Salt Lake City area.

Some states have decided to replace traditional institutions entirely with community mental health centers. The State of Arkansas, for example, has decided to build no more large public hospitals. State officials are planning instead a series of centers which will provide long-term care together with a comprehensive range of more intensive services, all at the local level. In planning for these centers, sites are being sought which will facilitate access to colleges and universities, general medical facilities, and other community service agencies in an effort to make available a full range of human services as well as research and training opportunities.

The State of California is closing Modesto State Hospital with as many patients as possible being returned to their communities to be cared for by their community mental health center. Those in need of continued long-term concentrated care will be transferred to another California State Hospital appropriate to their needs.

Part of the reason for this impact is that community mental health centers have been providing services to patients with a wide range of disorders. In fact, they are giving highest priority to those people at greatest risk for admission to state mental hospitals. Thirty-four percent of all new inpatients at community mental health centers, for example, were classified as psychotic, with 22 percent of these being diagnosed as schizophrenic. By the same token, 42% of all new patients receiving partial hospitalization services at centers were psychotic, with 31% being classified as schizophrenic.

Additionally, more than 16% of all patients in community mental health centers during 1968 had at some time been patients in state mental hospitals. Were it not

for the presence of centers, many of these patients would have had to return to the state hospital.

It is the goal of community mental health centers to convey to each patient the conviction that his community is concerned with his return to a full productive life. In the service of that goal the old institutional bagaboos of long waiting lists, isolation and shuttling of people from agency to agency are being replaced by continuing personal contact, coordinated efforts and the full utilization of all the resources available in the community. The fact that nearly 34% of all patients in community mental health centers had no prior treatment is an indication that centers are visible, accessible, and providing services in areas where such services had previously been unavailable or inaccessible.

Problems of manpower and new types of training

When the centers program was first proposed there were grave fears that the new centers would compound the already critical shortage of trained mental health manpower. Recognition of this problem has led to concentrated efforts by the National Institute of Mental Health and by the emerging centers in use and training in manpower. These efforts are being directed in a variety of ways: toward formal professional education and inservice training; toward an extension of expertise through community consultation which strengthens the mental health skills of caregivers such as ministers, teachers, welfare workers and the like; toward the creation of new careers for non-professionals, particularly in poverty areas, and toward utilization of volunteers.

The centers are providing a challenging new training ground for psychiatrists, psychologists, social workers and psychiatric nurses. The training received by these traditional mental health professionals is becoming increasingly pragmatic and relevant to our nation's basic mental health needs. This redirecting of training is occurring both in the training centers of universities and medical schools and in the community mental health centers themselves. Over the past six years a dramatic increase has occurred in the number of medical school departments of psychiatry, university schools of social work and departments of psychology which have broadened their clinical training programs to include a community approach to mental health services. Furthermore, 17 medical schools have sponsored or affiliated with other facilities to establish community mental health centers. Examples of these are Pennsylvania Hospital and Temple University in Philadelphia, Einstein-Lincoln and Maimonides Hospital in New York City, Tufts and Boston University in Boston, Garfield Park and the Illinois State Psychiatric Institute in Chicago, the University of New Mexico in Albuquerque, and Washington University in St. Louis.

Continuing education programs for professionals working in or planning to work in community mental health centers are beginning to be developed, although a great many more are needed. One area of training identified as a critical need is post-graduate training in community mental health center administration. One such program has been developed at the University of North Carolina.

A further method of redefining the training of mental health professionals is through the funding potential provided in the present laws under the training element of service. Formal inservice training programs are included in more than half of all center programs funded under P.L. 89-105. This stems from the recognition of many center directors that community mental health center professional staff members will need additional training and that volunteers and technical personnel will also have to receive training on the job. A three volume annotated bibliography on inservice training for community mental health developed in fiscal year 1968 by the National Institute of Mental Health was designed to provide the community mental health center directors with the most recent information on such training programs and to stimulate and aid centers without formal training programs to find ways of improving the quality of their service.

The opportunities presented by new center programs for professionally rewarding careers has challenged many to leave the traditional metropolitan centers to live and work in areas of the country they might not otherwise have selected. It is not uncommon to find a center director who has been able to recruit staff from among former colleagues in a far distant professional school. Young men and women who have left their home communities for professional training have the opportunity to return and use their skills in new local programs. The potential thus presented for a redistribution of professional leadership is already proving a significant outgrowth of the centers movement.

The inclusion of consultation and education as one of the essential elements of service has served also to stretch professional expertise. By providing train-

ing and technical support to those in the community who are in a position to deal with people in difficulty—ministers, teachers, police, welfare workers and the like—trained personnel are extending their influence far beyond what they might do if they were providing direct service exclusively.

Perhaps the best way to illustrate how one center is recruiting and utilizing professional talent is through the personal experience of a psychiatrist who is serving as the director of a center in a sparsely populated area in the far west.

"... The experts had predicted we would have a great deal of difficulty getting people to come here to live, but it just wasn't so. For example, we had 34 psychiatric social workers apply for one position that was open . . . We now have a staff of 13 people serving this area of 44,000. Seven of those people are full-time professionals. . . .

"Our program is very much decentralized . . . We have a full-time resident mental health professional in each county seat. . . . We try to allocate the professional people in proportion to the population density. The basic idea is that we do not want people to have to travel more than 30 minutes to get to one of our offices. Our staff is mobile; I'm a roving psychiatrist—a circuit rider if you want to call it that. I make regular junkets around the area, stopping at each county seat twice a month to spend a few days working with the staff in each office. . . .

"Another thing that is noteworthy about our program . . . is that we have a powerful volunteer organization. In one county alone there are 30 involved . . . We have several different programs started there now. We do such things as having people just as companions to those who are isolated or invalids . . . We've been involved in sex education programs in schools and premarital counseling programs with the churches. We're hoping to establish a day care nursery . . . Our over-all approach is very much crisis oriented . . . We feel the mental health professional's job is to assist the community in managing the emotional problems of the people who live in the community . . . We use our knowledge of psychodynamics to help the community do that in as efficient a way as possible. . . .

"We've seen some remarkable changes in the county attorneys. They're beginning to approach the whole situation in a more humane way. They're beginning to think through some of the procedures used in the past for committing people. In the past they just put out a warrant, picked someone up, and the sheriff then took the person to the state hospital. These kind of things are changing."

Mental health professionals are redefining their own roles under stimulus of the community mental health centers program. Many functions formerly restricted to those with formal professional training and degrees are being assigned to nonprofessionals, most often community residents who receive inservice training to complement their unique knowledge of the community. For many professionals this represents a unique opportunity, not only to organize new types of services, but to engage in a challenging new type of education activity.

In urban ghetto areas of such cities as Philadelphia, Washington, D.C., New York, Boston and Chicago, community mental health centers have taken the lead in developing innovative services utilizing increasing numbers of knowledgeable ghetto residents. These aides facilitate access to services by their fellow residents. Through inservice training, coupled with their superior knowledge of the communities in which they live, these new careerists leave the ranks of the unemployed to work in varied roles as community counselors, educators, mental health aides and consultants, and researchers.

The Rio Grande Area II Mental Health Center in Kingsville, Texas, has proposed an extensive use of indigenous workers. In fact, the bulk of the staff is to be made up of such workers. The decision to employ people from the area was based on several factors. The area to be served by the center is one of extreme poverty and is nearly devoid of mental health professionals. More importantly, however, the residents are almost entirely Mexican-Americans, who view mental disorder as something to be hidden, not treated. Therefore, the center plans to train community people to bring service into the homes. The first emphasis will be on assisting families to solve their many problems and on providing mental health education. Such workers can be accepted into homes, and through their work it is anticipated that the people of the community will be able to recognize the need for help and seek it out.

This new group of workers, sometimes called mental health workers or aides, have so proven their value that increasing numbers of community and junior

colleges are developing specialized training programs for mental health technicians. In addition, centers officials are assisting civil service personnel boards at all levels to redesign job descriptions so that appropriate career ladder systems can provide on-the-job training opportunities for educationally disadvantaged persons. This twin movement, through junior and community colleges and through civil service boards, holds promise of providing more formal credentials for new technical careers in mental health.

New approaches to treatment

One of the most exciting aspects of the centers program is the opportunity to implement promising concepts and techniques for minimizing disabilities associated with emotional disturbance. All the examples presented earlier bear on this point to some degree. The program innovations which were necessary to bring services to hitherto unserved populations, the attention given to humanizing the system of service delivery, the imaginative use of professional and non-professional manpower—all have drawn heavily on the most advanced psychiatric knowledge and will continue to make important contributions toward further progress.

Partial hospitalization, for example, is a relatively new concept. Based on the desirability of encouraging the patient to retain as much responsibility for his own life as possible, this program offers support during those hours of the day which are most difficult for him. Day care engages him in therapeutic activity during the day, permitting him to return to his family at night and for weekends. Night care assists those who are able to function in a job or at home but require more intensive care supervision than can be provided on an outpatient basis.

Observers of the day care program at the Temple University Mental Health Center in Philadelphia have been impressed by the extent to which this staff has been able to provide an environment which is helping troubled people to help themselves.

This program is based on the theory that a therapeutic community is the primary way through which constructive change can be brought about in individuals. The treatment technique places strong emphasis on the individual patient's relationships with other patients and staff. In practice, this means that patients attempt to relate to each other as individuals and to learn from each other as much as they can about their own problems and how to solve them. In fact, persons in the program are not called patients but are regarded as members, reducing even further the stigma associated with being labeled a mental patient.

Partial hospitalization programs have a variety of goals. They may serve as a means of shortening inpatient stay or provide for intermediate-term rehabilitation of persons who have social and vocational deficits. They may provide for seriously impaired patients who would otherwise require long-term hospitalization. Perhaps the most essential function of partial hospitalization is as an alternative to full-time inpatient care.

Certain programs may emphasize one or more of these functions. The Jefferson County Mental Health Center in Denver, Colorado, for example, operates two day care programs. One is an intensive care program for acutely ill patients while the second is a long-term maintenance care program. Ft. Logan Hospital, affiliated with the three centers in Denver, offers all four types of day care programs. As early as F.Y. 1967, Ft. Logan had approximately 68% more day care patients than inpatients. Increasingly, it is being demonstrated that acutely disturbed persons who would ordinarily be considered candidates for inpatient care can be successfully treated in a day care setting.

While precise figures as to the cost of day care are not available it is certain that it is less costly, both to the center and the patient, than 24 hour inpatient care. The more patients cared for in partial care programs then, the less the financial burden on the center.

Partial hospitalization, however, is only illustrative of the ways in which community mental health centers are promoting new and innovative approaches to service delivery. In every service available at the center, and through the exploration of new and effective treatment modalities, comprehensive and high quality mental health services are increasingly being made available.

The community mental health center and social problems

The test of the viability of any social program is its ability to respond to the changing needs of society. The Joint Commission Report, with its concern

for the weaknesses in the system for delivering mental health services, is certainly still relevant today. Superimposed upon these demands, however, has been the recent upsurge of attention to the special needs of the poor and disadvantaged, to the necessity for citizen participation in the planning, implementation, and support of local services, and the emergence of a variety of related new governmental programs to improve the quality of life in our towns and cities.

The necessity to respond to the new scene has been both a burden and an opportunity for the new centers. From the beginning the social setting has made it necessary for centers to be flexible and adaptable characteristics are proving to be a major asset.

Recent events have made clear the widespread rejection of paternalistic and authoritarian models for human service programs of all kinds. Consumers want and need to play an active role in determining what they will receive. Furthermore, the expectation is now general that services will be rendered on an equal basis and that such services will be truly appropriate in the sense of being geared to the values, style, and needs of the people served. With regard to health services in particular, the move is toward easily accessible coordinated health care, oriented toward prevention.

Community mental health centers can be, are being organized to respond effectively to these forces. The principle of one standard of care for all is basic to the program. If a center also has good community organization behind it, as well as a broad program of treatment and prevention it can then participate in over-all health planning. Indeed, it may stimulate such planning and serve as a model for the delivery of total health services.

Centers also contribute constructively to communities where demands are being made on other institutions. For example, there is an increasing demand for more humane, sensitive and responsive service from the police, the schools, and welfare departments. Through its consultation and education programs and through information contacts using a variety of approaches, centers are helping personnel of such organizations to better understand the behavior and emotional needs of their clients.

One most commonly thinks of this task as the province of the big city center but it is the concern of the rural center as well. The Range Mental Health Center in Virginia, Minnesota, situated in the midst of a large rural area, is devoting approximately 60% of its staff time to consultation, training, education, information, and collaborative services. Practically everyone in the area who is a "care giver" is seen at least monthly by a traveling staff team or individual. Attention is concentrated particularly on six groups: schools, the medical profession; the clergy; welfare agencies; the legal profession, including courts, probation officers and police; and rehabilitation agencies. The staff visits regularly with every school, every judge, every police department, etc.

This consultative function also applies to Federal programs for community self-help such as Model Cities. A community mental health center coordinates its services with existing programs in its area and thus is also useful in an advisory planning role.

Even the process of organizing and establishing a center can affect the community involved. The mobilization of community resources and support for this purpose can produce an effective demonstration of community action which may then serve as a model for planners in other areas. Furthermore, a center can heighten the self-image and self-respect of a community, as well as increase its consciousness of its own particular problems. With their special skills in improving communications, center staff members can stimulate other agencies, organizations and industries to talk to each other, to coordinate planning and to become more responsive to community needs. Beyond this, centers bring in new personnel, offer new jobs and assist directly in such social problems as delinquency and school dropouts.

In all their varied activities centers offer an opportunity for the community to observe new approaches to the problem of delivery of health services.

Such a broad range of responsibilities is a large load for any single human institution to carry. That so many centers are discharging so many of these obligations creditably is a reflection of the fact that they are not working alone but as an integral part of the communities they serve. The Maimonides Mental Health Center in Brooklyn, New York, for example, provides an object lesson in community cooperation. The history and experience of this center will be described in some detail, not so much because they are unique, but because they illustrate both the problems and opportunities of community mental health centers.

The Maimonides Center is located in an area of Brooklyn, New York with a population of 140,000 made up of diverse ethnic groups including persons of Jewish faith representing many countries, residents of Italian and Swedish origin and small numbers of Puerto Ricans and Negroes.

Leadership for center development came from Maimonides Hospital, which started by bringing together organizations with a common interest in being more effective in community affairs. A series of seminars was held to discuss problems of living in the area common to all residents, with particular attention to the potential impact of agency coordination and institutional change. The professionals then went to the people, stopping them on the streets and visiting them in their homes and in their organizations, to get a reliable picture of the neighborhood's problems. This proved so successful as a basis for planning the new program that a continuing organization was formed to represent the community. This forum is not officially tied to the center but works closely with its staff. It will be extended by informal committees on each block which will maintain awareness of potential problem areas and act as a source of referral for people needing help.

Once the center became activated there was no lack of situations requiring immediate attention. A group of teenage boys, for example, was under police scrutiny because the boys were hanging around street corners. These youngsters explained to the citizen group their need for outdoor recreational space, and were assisted in organizing themselves into a young peoples' mental health committee. Through a series of fund-raising projects they were able to raise enough money to match funds provided by the city to pave a special area for their use. The police, seeing the identification with a respected community organization and appreciating the constructive activity, have come to view the youngsters in a new light. The boys continue to be active in the mental health program.

A very different problem involved a schizophrenic woman who failed to appear for an appointment at the center one winter. Investigation by a social worker revealed that she was home in bed with five children in an unheated apartment. The social worker notified the hospital of the lack of heat and the hospital sent some eighty blankets to all the residents of the building. This was followed by a meeting in the lady's kitchen to discuss what could be done. A group was chosen to approach local officials and the housing authority, and the landlord was instructed to provide heat for his tenants. A most gratifying result of this particular incident is the fact that the "kitchen" meetings have continued, and the patient is now showing marked improvement in her behavior and in her ability to relate to her children as a responsible parent.

A remedial reading program developed at Maimonides has received nationwide attention. The director of the center's learning rehabilitation program found that efforts to treat emotionally disturbed children had to include special attention to their reading programs. Unfortunately, the schools did not have the personnel to give these children the remedial reading they required. A team from the center, therefore, went into the school and undertook a demonstration project for a group of young nonreaders with behavioral problems. After four months of special training the children improved markedly in reading ability, in some cases gaining more than an academic year. Most of the children also improved noticeably in their behavior, with a decrease in disruptive behavior.

Having demonstrated the effectiveness of the technique, the center team enlisted a group of 200 parents who will be trained to work with children with reading disorders in schools throughout the catchment area. Young graduates of the program who have overcome their own difficulties are teaching their newly learned skills to younger children. By this method, sixth graders have become a part of a mental health team helping second and third graders.

A particularly important aspect of the Maimonides program is its work with the Council of Social Agencies. The center does not intend to duplicate, but to supplement and fill in gaps where services are not provided by other agencies within the area. As a result of the coordination of effort there have been significant changes in the policies of traditional service agencies with a resultant increase in operating effectiveness.

Though extensive in scope and geared to the special needs of its community, the Maimonides program is, in many ways, not unique. Rather, it is characteristic of an approach that is being duplicated throughout the country, ensuring a ready responsiveness to changing needs.

IV. AREAS OF REMAINING CONCERN

Seen in the context of the original goals of the program, it is increasingly clear that community mental health centers are providing both valuable direct and indirect services and, perhaps even more significantly, are having a constructive impact on the traditional care-giving institutions of our society. Their continued growth and development, however, will depend on farsighted solutions to a number of vexing problems, particularly those relating to manpower, research and evaluation and financing.

Discussion has already focussed on efforts underway to enlarge the pool of skilled manpower. It is clear, however, that the training programs presently available will not be sufficient to provide an adequate number of competent mental health personnel to staff a constantly growing number of centers. The Institute must continue to provide leadership in developing new and more productive ways of training and using mental health and other personnel.

A critical need for the future development of the centers program is the evaluation of systems of service delivery. Careful attention needs to be given to the role of the community mental health center in fostering new models and new forms of services in addition to traditional forms of service. Further, the center must play a part in identifying gaps in its catchment area not only with regard to mental health needs but also in such areas as education, law enforcement and welfare as they affect mental health.

By far, the most pressing problems facing the centers, is that of providing financial support for service programs, particularly disadvantaged areas. The severity of these problems has been observed over and over again by the experienced of state agency staff and staff of the National Institute of Mental Health.

The difficulty of many communities to assure matching costs for ongoing programs has, in some cases, caused those interested to abandon efforts or to delay the planning and submission of applications.

Currently available statistics support these concerns. Only 25% of the population of the poor rural counties are being served by funded centers. A slightly higher percentage, 31%, of the poverty population of the metropolitan areas are within catchment areas of funded centers. Generally, services to the poor are developing at approximately the same rate as are services to the total population. Considering, however, that poverty areas are recognized as of highest priority at Federal, state, and local levels, merely keeping pace is not enough. Inability to assure matching funds and to support programs, many high priority, when Federal funds expire are major causes for the lag in center development in these areas. Priority of need means little unless it can be translated into the demonstration of adequate financial resources.

These problems impinge on development of community mental health centers in several ways. Initial interest in developing center programs in certain urban and rural poverty areas has been dropped or delayed. For example, this has occurred in Newark, New Jersey, Galveston and Fort Worth, Texas, Gallup and Las Animas, New Mexico, Oswego and Chenango Counties in New York State, and Boulder, Colorado. State authorities and regional officials indicate that financial problems have already developed in Austin, Texas, Texarkana, Arkansas, Las Cruces, New Mexico, and Sheridan, Wyoming. State officials in Kentucky, Pennsylvania, and West Virginia indicate that centers in rural areas would be in financial difficulty if Federal funds declined in accord with existing rates because there has not been sufficient time to develop adequate local and state support. State and regional officials note similar problems in such rural states as Alabama and Mississippi, and in relation to centers serving metropolitan poverty areas in New York City, Los Angeles, Hackensack, New Jersey, Philadelphia, and Seattle, Washington. In Pennsylvania, as an example, the State is currently making up the funding deficits of local centers, but such funding will be impossible as the State moves from its 29 presently funded centers to the projected 60 to 80 centers.

The long-term goal of the community mental health centers program is the development of effective networks of comprehensive mental health services that will eventually serve the total population of the United States. The overall response to the program since its inception in 1965 is a testimony to the readiness of the Nation to respond. That readiness is being reflected in a program, that in 1969, is emerging as one of the most dynamic and vital health programs in the Nation.

Dr. YOLLES. As you know, I need not repeat it here, the situation in this country was scandalous for many years. An individual became ill and was shipped off to a large State hospital that was chronically financially undernourished and understaffed and could not give him appropriate treatment. So he languished there maybe 5, 10 years. At the present time an individual becoming ill in a community that has a community mental health center not only has available to him new drug use but the latest in other methods of psychotherapy and treatment of the mentally ill. The average inpatient stay of a community facility at the present time is about 19 days.

Mr. ROGERS. This is what I want to know for the record. We would like to have these facts. The fact that your stay in the large hospital has been reduced as you have given us so that a permanent population year after year after year has been dramatically reduced and that you are able to get people operating at the end of a very short time and treatment given quickly and effectively. I think if you can give us some facts on this, this would be helpful to our committee in presenting this to the Congress.

Dr. YOLLES. Yes, sir.

Mr. BLACK. We would be glad to provide it, Mr. Chairman.

(For information requested see statement entitled, "What impact is the Community Mental Health program having on State hospitals," on p. 47, this hearing.)

Mr. BLACK. From the standpoint of the administration, as we have said before this committee and some others, a number of the programs that we have in the Department we are very uncertain about on the basis of evaluation available to us. I think this one is certainly an exception to that. On the strength of what we see, this seems to be one program that is on target. Although it does have its weaknesses, it does strike us as a program that is soundly conceived and well executed.

Mr. ROGERS. I agree with you, I think it is a good program, and I am glad the Department is pursuing it as diligently as you are. If you have any projections of variance where you think possible improvements are coming about, I think this would be helpful for us to have.

On drug abuse I would like to know, for instance, how much money it will take you to complete your study on marihuana. What would it take to complete those studies, have you any idea offhand?

Dr. YOLLES. Not offhand, but we can provide it for the record.

Mr. ROGERS. I think we should have it because I see we have a commission to go into this. I think we have already been doing this and the work is partially done.

Dr. YOLLES. That is quite right, sir. We do have a contract program in the marihuana area.

Mr. ROGERS. To determine how it should be classified.

(The following information was received for the record:)

STATUS OF THE NIMH MARIHUANA RESEARCH PROGRAM

The major achievements of the NIMH marihuana research program to date have been the development of methods for obtaining marihuana in its various forms and advances in the knowledge of the chemistry of tetrahydrocannabinoid (one of the active substances in marihuana) on the test tube level. Work during Fiscal Year 1970 is focusing on the production of the various forms of marihuana for research purposes. Intensive work on the biochemical and pharmacological analyses of marihuana has been initiated. A number of studies are being under-

taken on the toxicity of marihuana. Also, in Fiscal Year 1970 we intend to develop and implement animal and human research on the behavioral and biologic effects of marihuana. The program cost for Fiscal Year 1970 contracts will be \$1,200,000.

During Fiscal Year 1971 the Institute program calls for the continued production of all marihuana cannabinoids. Certain of the analytic work in the biochemistry of cannabinoids and long-range toxicity studies which are being undertaken initially this Fiscal Year will have to be continued through Fiscal Year 1971. The cost for the contract program in Fiscal Year 1971 will be 1,500,000.

Fiscal Year 1972 should see the successful completion of the first phase of the project with a sufficient initial supply of natural and synthetic material fully characterized pharmacologically, biochemical and of known toxicity to permit an expanded research effort on marihuana utilizing the extramural research grant mechanism. It will still be necessary to maintain contracts to insure a continuous and adequate supply of analyzed marihuana materials. The capability for large-scale extramural research on marihuana is the ultimate outcome sought as a direct result of the first phase of the NIMH marihuana research program.

We also intend to begin an expanded, targeted research program aimed at more rapid development of knowledge regarding the extent of use, causes, and prevention of abuse of stimulants (e.g., amphetamines) and sedatives (e.g., barbiturates) and other non-narcotic drugs. The experience gained through the marihuana program indicates the values of this type of focused effort.

In order to maintain the timetable and quality of the marihuana research program, and meet the National need for accurate, sound scientifically-based information about this drug, and to launch the stimulant/sedative research program, we shall need seven additional professional and support staff.

Mr. Preyer?

Mr. PREYER. No questions.

Mr. ROGERS. Anything else you can think of that we ought to know about this program?

Mr. BLACK. I think not, Mr. Chairman. We appreciate your interest and we will be glad to provide for the record the material that you requested.

Mr. ROGERS. If you could let us have how many you think each year would be necessary when the staffing would come in, we would like a rundown on that, perhaps in your consultation about the controlled use of funds.

May I commend you for your testimony which is most helpful. We appreciate the cooperation of the Department.

Thank you very much.

Mr. BLACK. Thank you.

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

(Whereupon, at 12:15 p.m., the subcommittee adjourned, to reconvene at 10 a.m., Wednesday, November 19, 1969.)

COMMUNITY MENTAL HEALTH CENTERS ACT EXTENSION

WEDNESDAY, NOVEMBER 19, 1969

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

The subcommittee met at 10 a.m., pursuant to notice, in room 2128, Rayburn House Office Building, Hon. John Jarman (chairman of the subcommittee) presiding.

Mr. JARMAN. The subcommittee will be in order.

As we continue the hearings on H.R. 14617 and other bills proposing to extend the program of matching grants for construction and staffing of community mental health centers and of facilities for the care and treatment of alcoholics and narcotics addicts, our first witness this morning is Mr. Irving Chase, president, Massachusetts Association for Mental Health, representing the National Association for Mental Health.

STATEMENT OF IRVING CHASE, CHAIRMAN, COUNCIL ON LEGISLATION AND PUBLIC POLICY, THE NATIONAL ASSOCIATION FOR MENTAL HEALTH; ACCOMPANIED BY MICHAEL E. FREELUND, ASSOCIATE DIRECTOR

Mr. CHASE. Mr. Chairman and members of the committee—

Mr. JARMAN. Mr. Chase, for the record, would you identify your associate?

Mr. CHASE. He is Mr. Michael E. Freelund, who is the Associate Director of the National Association for Mental Health.

My name is Irving H. Chase. I reside in Concord, Mass., and I am president of Henry Thayer Co. of Cambridge, Mass., engaged in the business of food processing and packaging.

I am Chairman of the Council on Legislation and Public Policy of the National Association for Mental Health in whose behalf I am appearing today.

I am quite sure that most of the members of the committee reside in counties in which there is a mental health association; I know that all but one of your members come from States in which there is an active State mental health association. These county and State mental health associations are among the more than 800 affiliated chapters and divisions of the National Association for Mental Health—a volunteer, non-profit, citizens organization with 1 million members and associated volunteers across the country.

Before these hearings are concluded, you will have heard from the professional societies representing the professional sector and from State and Federal agencies representing the public sector. I speak for yet a third sector, the concerned, informed citizenry in towns and cities across the country, but more importantly, I speak also for the consumers, if you please—the more than 1 million patients confined in our hospitals—both public and private—and the uncounted other millions receiving treatment as outpatients, or receiving no treatment at all.

Mr. Chairman, it is our purpose and our fervent hope that by appearing here today we can help these unfortunate victims of mental illness and also the one in 10 of all of us who, at one time or another in our lives, will fall prey to this serious, incapacitating illness.

I spoke earlier of the volunteer citizen laymen who comprise the membership of the National Association for Mental Health as “concerned informed citizenry.” I know I am such a concerned citizen and I hope my own experience, not unlike that of so many others, will serve as some evidence that I am also informed.

I have been an active citizen volunteer in the field of mental health since 1958, first as president of the Mental Health Association of Central Middlesex in Massachusetts, then as a director and presently as president of the Massachusetts Association for Mental Health, an affiliated division of the national association. I serve also as a member, representing citizen-laymen concerns and interests, on the following bodies:

Advisory Committee to the Commissioner of Mental Health of the Commonwealth of Massachusetts on Construction and Utilization of Community Mental Health Centers.

National Mental Health Advisory Council (as consultant).

Advisory Committee to the Governor of the Commonwealth of Massachusetts on Comprehensive Health Planning.

HEW's Regional Advisory Council on Comprehensive Health Planning for Region I.

HEW's National Advisory Group on Financing Care of the Mentally Ill under medicare and medicaid.

The years I have spent working as a volunteer in this field have taught me one thing above all others—that mental illness remains this Nation's most serious health problem, not only in terms of the gravity of the problem but also in terms of its dimensions.

Conservative estimates indicate that at least one person in every 10—a total of 20 million in the United States—will at some time in his life have some form of mental or emotional illness—from mild to severe—that could be ameliorated with professional help. At least as many people are hospitalized with mental illness today as with all other diseases combined, including cancer, and health disease.

Doctors recognize emotional problems to be an important factor in many physical illnesses, even heart disease. Over 50 percent of all medical and surgical cases have such a complication. In a large number of cases seen by general practitioners, the major problem is an emotional one.

The enactment, in 1963, of the first Community Mental Health Centers Act marked the beginning of a new day for the mentally ill of this Nation—the first truly national mental health program aimed at end-

ing the neglect of the mentally ill. While the development of this program has not kept pace with the original projections, the comprehensive community mental health centers which have been established are fully demonstrating the value of the program and the need for its continuance.

We have seen a steady decline in population of State and county mental hospitals and a progressive reduction in new admissions to those same hospitals.

With the development of the community mental health centers program, an entirely new system for the delivery of comprehensive mental health care to all Americans—we have seen a definite trend toward better utilization and a more equitable distribution of scarce professional manpower. For example, according to a recent compilation showing the relative number of physicians engaged in private and institutional, or public practice, there were, as of June 1969, 9,928 psychiatrists—including 513 child psychiatrists—in private practices and 6,366—including 366 child psychiatrists—in public or institutional practice. The combined total of all other physicians in private practice was 174,785, compared with 48,350 in public practice. (U.S. Distribution of Physicians and Surgeons—June 1969—Fisher-Stevens, Inc.)

In other words, for every three psychiatrists in private practice, there are two in public practice while as to all other physicians combined, there are almost four in private practice for every one in public practice.

I am not a statistician nor a scientific investigator, but what these figures say to me is that imaginative, new programs, housed in decent, modern facilities are able to attract professionals and that is what is being proven by the community mental health centers program.

It is unfortunate that the community mental health centers program, heralded in 1963 as "the bold new approach" in the care and treatment of the mentally ill when first so proclaimed by President Kennedy, has in 6 short years become a halting retreat because the Federal share of funds available for this program have fallen far short of the amounts originally authorized by the Congress. For example, the recent report of the Joint Information Service of the American Psychiatric Association and the National Association for Mental Health reveals that in the first 4 years of the program Congress authorized \$200 million for construction but appropriated only \$180 million, of which only \$135 million became available in the apportionment of NIMH funds, a loss of \$65 million.

Similar reductions in staffing funds began in 1967 when by apportionment \$4 million less than the amount appropriated was made available and again in 1968, when \$30 million was authorized, \$22 million appropriated and only \$15 million was apportioned by the Bureau of the Budget.

If we are ever to come even close to providing enough comprehensive community mental health centers to serve all our people, young and old, rich, and poor—then the basic Federal program must be extended; adequate appropriation ceilings must be authorized; and special consideration must be given to disadvantaged areas.

We therefore applaud the introduction of H.R. 14617 as concrete evidence of this administration's intention and desire to accomplish the

foregoing objectives. However, we must express reservations about certain provisions of the bill because in our opinion they may impede rather than further the attainment of those objectives. As will be noted from the following observations, we favor some of the pertinent provisions of the related bills now before your committee.

STAFFING SUPPORT

One of the lessons we have learned from experience with this program is that longer term Federal assistance is needed toward meeting the operating expenses of new comprehensive community mental health centers starting from scratch. Time after time our own local affiliated mental health associations who have been in the thick of the struggle to launch such a center have reported that the present 51-month period of Federal support for staffing, with the declining share as presently provided, just isn't long enough to bring the center to the point where it can meet its operating costs from patient fees, third party payments and other sources of revenue, such as State and local matching public funds. We believe that extension of the period of Federal sharing to 10 years, with the last 6 years at the level of 30 percent, will enable every such center, once started, to proceed with confidence and with assurance of continuing financial stability.

SPECIAL CONSIDERATION FOR DISADVANTAGED AREAS

Another lesson we have learned is that no plan, however well conceived, is self-executing. We know of no State plan for construction of comprehensive community mental health centers which has not given the highest priority to centers in rural and urban poverty areas. Yet few community mental health centers have been established in those areas of high priority, although some centers located outside these areas are available to low-income groups.

We know there is a desperate need for funds which would enable communities in such areas to assess their mental health needs, develop the necessary resources, and involve their citizens in the development of mental health programs.

These problems are most acute in those regions with fewest resources—the inner city poverty and sparsely populated rural poverty areas, where the need for mental health services is the greatest. The availability of funds for the development of community mental health programs would permit the implementation of services in these areas earlier and to a greater extent that is presently occurring.

The provision of grants to communities to assist in the development of comprehensive mental health services would have immediate and beneficial effects as follows:

Relatively few community organizations or institutions who are potential applicants for community mental health center funds have professional staff with the special knowledge or experience necessary for effective mental health program development on the broad scale necessary for the establishment of truly comprehensive services. The availability of development funds would fill this gap by permitting the employment of experienced personnel and/or providing funds for contract projects and in-depth consultation. This emphasis on program development would make a significant contribution to the emergence

of mental health programs most relevant to the critical needs of a catchment area.

Most potential applicants lack experience in the increasingly important area of community organization—a lack most severely felt when developing community mental health centers are in urban areas. With additional funds, applicants would be able to devote the time, effort, and skill needed for the often difficult task of enlisting citizen involvement and support and thus avoid confrontations and conflicts at later and perhaps crucial stages in the center's growth.

Our experience indicates that the more organizations there are involved in a community mental health center program, the more difficult the development process. Similarly the more diverse the interests represented, the greater the need for sound, well-thought-out operational arrangements.

In such situations, development responsibilities are fragmented by becoming the part-time responsibility of staff in a number of different agencies. This negates important opportunities for developing continuity between services. Additional funds would provide the resources for a centralized evaluation of these disparate inputs and would also mitigate against having the major development responsibility go, by default, to the most affluent organization represented.

Development funds could free many professionals from tasks for which they are not well equipped—a clinical psychologist or psychiatrist may spend many man hours on the development of demographic data and organizational structure and thus diverting his full energies from organizing the treatment aspects of the program in which they are expert. Professionals would also be able to devote more time and resources to recruiting new staff—often an arduous and time-consuming task particularly in rural and smaller urban communities.

With the proliferation of federal "human services" programs, these funds would be a significant impetus to the development of community mental health centers by new kinds of applicants. It is unwise to presume that the only institutions that can organize an effective community mental health center program are those for example, that are already "in the mental health business". Groups within a neighborhood health or service center should have the available seed money to develop a mental health center. Likewise, the funds could enable a community to plan for mental health services as a component part of other developing service entities.

Development grants will enable community mental health centers to utilize a higher percentage of their initial staffing grants than is now possible. Almost without exception currently funded community mental health centers have not been able to fully utilize these grants. Every day after his starting date that the grantee does not operate his funded services at full capacity, Federal funds to which he is entitled are lost to him and his community receives fewer mental health services as a result. The development grant mechanism may have the effect of shortening this tooling-up period and thereby allowing more complete utilization of grant funds.

We favor the provisions of related bills H.R. 13163 and H.R. 14086 which provide that "up to a maximum of 5 percent of the appropriations authorized for each year (for staffing)" be available for this purpose. We believe that the larger sum possibly available under this

provision is required. H.R. 14617 would provide that up to a maximum of 5 percent of annual appropriations of "new" staffing be made available which would obviously reduce the available amount.

The case for a higher Federal sharing of construction costs and a higher Federal percentage for staffing costs in poverty areas rests on substantially the same grounds.

It goes without saying that urban and rural poverty areas do, in fact, need a larger measure of Federal assistance to develop and operate their mental health services.

In respect to construction grants for poverty areas, we favor the provisions of H.R. 13163 and H.R. 14086 which do not limit the percentage of sums appropriated for construction grants which shall be available for poverty areas. H.R. 14617 would limit the sum so available to 20 percent of the annual appropriation for construction. Moreover, H.R. 14617 would make these funds available for projects designated by the Secretary as of special significance because they will "demonstrate new or particularly effective or efficient methods of delivery of mental health services." We strongly oppose making these funds available for this purpose.

The very intent and purpose of the provisions for the benefit of disadvantaged areas would be frustrated and defeated. First, the amount available for all projects of "special significance"—poverty and "new methods"—is to be limited to 20 percent. Then that limited amount is to be competed for by the poverty areas and the others. Our experience tells us only too well who will be the winners in that competition because the applications for construction grants that will "demonstrate new and particularly effective or efficient methods" are bound to come from the sophisticated areas, where expertise is in good supply. It is precisely to make up for this disparity in resources available to the poverty areas that the so-called "poverty provisions" are so vitally needed and it would be unfair to make it even remotely possible for funds intended for that purpose to find their way into other channels.

AUTHORIZATION LEVELS

We strongly favor the establishing of appropriations ceilings in precise dollar amounts instead of leaving this for future determination on a year-by-year basis. We realize that the fixing of dollar ceilings does not constitute a guaranty of availability of funds, nevertheless it does represent a declaration of congressional purpose and intent and as such is extremely helpful in at least defining the outside limits of possible Federal support.

CHILDREN'S SERVICES

We note the absence in H.R. 14617 of any provision for special consideration for children's services. We favor the provisions of H.R. 13163 in this regard and urge their inclusion.

We regard it as a matter of critical importance that community mental health centers be encouraged, stimulated and helped to develop more and better mental health services for children. Unhappily for one reason or another only a few of the federally funded comprehensive community mental health centers have been able to mount meaningful programs for children. They should be helped to do this,

particularly in the light of the recently issued report of the Joint Commission on Mental Health of Children. While the provisions of H.R. 13163 are obviously not intended to deal with all the recommendations of the Joint Commission, the bill's provisions would constitute an initial response to those recommendations and would be an encouraging measure of progress toward ultimately achieving comprehensive community-based mental health services for children.

I spoke earlier of lessons we have learned since the inauguration of Federal community mental health centers program. There is yet another lesson we have learned. There is just plain inertia to 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, or in other rural areas, and often in the heart of a metropolitan ghetto, 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 population 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 an active and aggressive mental health association 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 is convinced, by steady reports from its affiliated associations that more and more the people of this country want and are willing to support this program.

It is deeply gratifying to know that your Chairman and his distinguished colleagues on this committee are resolved not to allow the Federal community mental health program to die out with the existing authorization. They know that to do so 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.

Mr. Chairman, and members of the committee, we are mindful of the financial stringencies created by the grave problems confronting our Nation. No one can ignore the fact that there are many pressing demands upon the Federal budget dollar, and we citizens, comprising the membership and associated volunteers of the National Association for Mental Health, have considered carefully the position we ought to take regarding this bill in the face of the current situations. We have concluded that our primary responsibilities is not to assess relative

priorities among those many demands but rather to present, in behalf of the mentally ill of this country, our views as to the present unmet needs of these afflicted citizens among us, and our best judgment as to the Federal Government's role in relation thereto. The Federal dollars necessary to support this program are few indeed measured against that program's importance to the long-term health of the people of our Nation—surely its most critical source of strength and vitality.

The National Association for Mental Health urges this committee to favorably report H.R. 14617, with the modifications we have proposed.

Thank you.

Mr. JARMAN. Thank you, Mr. Chase. I think you have given an excellent statement on a tremendously important program. We were interested in your comment on page 10 indicating that you strongly favor the establishing of appropriations ceilings in precise dollar amounts instead of leaving this for future determination on a year-to-year basis.

It has been the approach of this subcommittee and of the Interstate and Foreign Commerce Committee, to try to be as specific as possible in planning for the future, and I can assure you that it will be an objective of ours on this bill.

Mr. CHASE. That is good news, Mr. Chairman.

Mr. JARMAN. You made reference, also on page 10, to H.R. 14671, which would limit the sum available for preferential matching to 20 percent of the annual appropriation for construction. I wonder what your reaction would be to an approach that might place a limitation of 20 percent on each State's appropriation for money used in the individual State.

Mr. CHASE. My reaction, Mr. Chairman, would be that this would not be wise. We are undertaking a new approach to a solution to a problem. We see the problem. The solution we don't see so clearly as the problem. I would think it wiser to leave the options open so that—there wouldn't be a stricture which might be unrealistic.

The demands for this poverty money could start out being only 10 percent, but could move to 50 percent, and if there were a 20-percent limit in the middle, there might be matching funds that would be unexpended if the demand were lower, and at a later time a restriction might well slow the development of the poverty program.

Mr. JARMAN. Your position, then, would be in opposition to such a limitation, either on a national basis or on a State basis?

Mr. CHASE. It would, sir.

Mr. JARMAN. Thank you.

Mr. Rogers?

Mr. ROGERS. Mr. Chase, it is good to see you here and hear your statement. Has the association done a study of community mental health centers to know where we are, what kind of a study have you done that you could advise us of the status of community centers and health centers, or has there been any that you know of?

Mr. CHASE. We rely heavily, Mr. Rogers, on statistics generated by the National Institute of Mental Health and the Department of HEW for an overview of the development, but we did, jointly with the American Psychiatric Association last year undertake a study in depth of a number of the community health centers to get a feel for their progress and their problems, and indeed to take as careful a look as we could as

to the validity of the concept, because this is still a very new concept that we are dealing with.

The conclusions were not all black and white, Mr. Rogers. There are problems, as you might guess in an evolution that is as complicated as this, but clearly the conclusion was that the developments are exciting and promise to fulfill most of what we hoped.

Mr. ROGERS. Yes. I wonder if you could supply the committee with a copy of the report?

Mr. CHASE. Yes, sir.

(The report entitled, "The Community Mental Health Center: An Interim Appraisal," may be found in the committee files.)

Mr. ROGERS. What do you see as the major problems. You mentioned the development funds.

Mr. CHASE. Is your question, sir—

Mr. ROGERS. The operations.

Mr. CHASE. Oh, the operations of those which are in existence.

I would say that staffing was the greatest problem. The manpower shortage in the whole field of the social sciences, including medicine is, as you very well know, sir, extremely critical, but the statistics which showed up in my presentation indicate that in the field of mental health an unusual number of the psychiatrists is being attracted into this public scene and this is hopeful.

I think, however, that manpower is the first problem we are going to have to deal with.

Mr. ROGERS. So if there had to be a setting of priority of funds to be expended from the Federal Government, you would set staffing at the top?

Mr. CHASE. I would, sir. Bricks and mortar are definitely in second place, and I see exciting programs evolving without the need for a center construction. We don't have the "Edifice" complex in the National Association for Mental Health.

Mr. ROGERS. Let me ask you this. Do you think it is necessary for us to devote some of these funds to land acquisition?

Mr. CHASE. I do, on the same basis, only because I know that acquisition of land is an essential part of a building process, and it seems logical to me that if the Federal Government is going to share in one part of the cost of construction that there is no reason why it shouldn't share in the whole construction cost.

Mr. ROGERS. Here we get back again to the use of the amount of money we have.

Mr. CHASE. Yes.

Mr. ROGERS. Would you put that at a high priority?

Mr. CHASE. I put the construction priority below the staffing priority. I place the land on the same basis as the bricks.

If the bill says the Government will buy the land and the local guys have to buy the bricks, that is all right with me.

It seems to be part of the same package, and the present ruling which allows for sharing only in the building costs may actually be determining locations of some of these centers in places where they might not best be situated.

In other words, placed in an area where the land is cheap, or where somebody, perhaps a hospital or university, is ready to give it, and maybe this isn't the best place for it. Maybe we are arguing that we

are setting up conditions that are resulting in an undesirable development. I have no information to back this up.

Mr. ROGERS. I am concerned about our getting into new areas in the division of funds where we are still short on staffing and actual construction funds as such but, more importantly, staffing.

Mr. CHASE. Yes, sir. Well, I would not want to see staffing funds deducted in order to pay for construction funds. I want to make myself very clear on that.

But I would also like to make myself equally clear that our Nation must change its priorities in the way it spends public moneys in all levels, and until we undertake a serious commitment to the health of our people, I think it is inappropriate to talk in terms of the few dollars that we are concerned about here.

I am glad to see somebody on the moon now, but consider the cost of that in relation to what we are talking about.

Mr. ROGERS. I agree that we are not meeting the health crisis.

Mr. CHASE. Indeed we are not, sir.

Mr. ROGERS. You speak about the poverty areas, both urban and rural. What study has the association done to know what the Appalachia program is doing in some of the rural areas, the OEO neighborhood programs and the model cities programs. They do have programs that can go up to 100 percent.

Have you made a study of this?

Mr. CHASE. We have no formal study of it, sir.

Mr. ROGERS. Because I wonder if, here, again, we should get into changing the formula or approach when we have existing programs where these needs can be met, through OEO, Appalachia, and the model cities program.

Mr. CHASE. I believe that these are for the community health centers which are essentially outpatient services for physical illnesses, Mr. Rogers, and this is a different concept from what we are talking about here.

The concept of the community mental health center is not that it is essentially a treatment facility for sick people. It is a program within an area which is intended to reach out to every citizen in that area and deal with his mental health problems as they arise, and deal with preventive work and educational work and consultation work.

I see these as quite different programs.

Mr. ROGERS. We operate in five areas in the mental health center, inpatient, outpatient, and so forth. There were five of those authorized, as I recall, in the mental health centers, and that is the thrust of the program.

Mr. CHASE. It is.

Mr. ROGERS. I have some concern about devoting large amounts for this type of program when there may be existing programs that can help fill the need already.

Until this is gone into and consolidated, and I personally think it should be, I think OEO programs should be worked out at HEW so there can be a better coordination, and model cities programs as well, where it affects health, and I hope we will do that, and I would be concerned for us to jump into this until we know exactly what they are doing and what is the approach and how much money is being spent.

Mr. CHASE. I, too, hope we will, and I have personal knowledge of one area in which this is indeed working, Mr. Rogers, and this is my hometown of Boston, where in one area there is a community mental health program, which is one that has not spent 1 cent on construction, but they have a staffing grant and are operating fully.

In the catchment area there are 100,000 people more or less. There are two of the OEO community health centers. They are essentially clinics located in housing projects.

The mental health people have made intimate contact with these community health centers and, indeed, have personnel in those community health centers and are reaching out as a referral linkage back to the community mental health center.

May I say, Mr. Rogers, that you will hear from people later on this morning who are directors of mental health centers to whom these questions could be perhaps more fruitfully addressed.

Mr. ROGERS. Yes. Should the State planning agency have veto power on community mental health centers?

Mr. CHASE. No, sir; I believe they should not, nor is that, in my interpretation of these bills, involved in any of these pieces of legislation.

Mr. ROGERS. I think if you look at the administration proposal you will see that the area wide is simply a review, but a State comprehensive must give approval.

Mr. CHASE. Of the State plan, which is a once a year proposition.

Mr. ROGERS. It still would have a veto of whether you put in a comprehensive health center here or there.

Mr. CHASE. Yes. No, I do not favor that, because I believe the State comprehensive health planning, and I am involved in it at two levels of government, at the State and Federal levels, has not yet reached a state of sophistication that would make this desirable.

Mr. ROGERS. Yes. I would agree. I think we are not quite ready for it. Hopefully we can do it in 2 or 3 years.

Mr. CHASE. This might be a sensible procedure, to give them review power for a stated period.

Mr. ROGERS. Should community mental health centers treat alcoholics and narcotics addicts?

Mr. CHASE. This is a question I feel a little uneasy about answering, Mr. Rogers.

Mr. ROGERS. I can ask that of someone else.

Mr. CHASE. I am a lay businessman. I am in the grocery business, and that is a pretty professional kind of question.

Mr. ROGERS. You mention that there should be extra funds for children. Why can't children be treated right now?

Mr. CHASE. They can, and they should be, and the law requires, the present law says all ages, all conditions.

Mr. ROGERS. This would upset me considerably if I knew that community mental health centers are not giving treatment to children.

Mr. CHASE. This is statistically a fact.

Mr. ROGERS. Why is this so? The law contemplated that anyone could be treated.

Mr. CHASE. I am not able to answer you, sir, I don't know why.

Mr. ROGERS. If you could find out why and let me know for the record.

Mr. CHASE. I will, sir.

(The information requested was not available to the committee at the time of printing.)

Mr. ROGERS. What should the local responsibility be with community mental health centers, pretty much as we have outlined it already?

Mr. CHASE. I believe so, I believe—

Mr. ROGERS. Should there be a maintenance of support level continued?

Mr. CHASE. What do we mean by local, Mr. Rogers? Do we mean local tax funds and voluntary funds combined, patient fees and all these things?

I think they should be used to the maximum extent to which they are available.

Mr. ROGERS. What concerns me is that when we start out with a community mental health center, it may be a nonprofit organization that gets together and forms it. It may have no governmental base there at all.

I wonder if we shouldn't require some local government participation in these centers, because I can foresee the possibility that a nonprofit organization can do an excellent job in getting a community mental health center established, but I can see that it might be a problem to sustain a maximum effort which really is anticipated under the law, and more input as the time goes along.

Mr. CHASE. This may well be so.

Mr. ROGERS. Has your organization given any thought to seeing if we could tie in local governments with community mental health centers?

Mr. CHASE. Indeed, sir. Our organization at all levels has worked hard for the passage of State community mental health center acts which provide for funding by a combination of State and local authorities.

Mr. ROGERS. Shouldn't we require it in the Federal law that the local governmental body is a cosponsor?

Mr. CHASE. I believe, sir, that you might find some situations in which there was no local government money available, in which case the citizens are denied anything. There might be private money available.

Mr. ROGERS. Suppose you could have a combination as long as the local government helped sustain it and had some responsibility in it.

Mr. CHASE. I would be troubled by a situation in which the local government in effect had veto power over—complete veto power.

Mr. ROGERS. I am not saying veto power.

Mr. CHASE. Well, no money.

Mr. ROGERS. Perhaps the local organization could get the government to cosponsor, but still have an official sanction, and an understanding that they will be called on eventually.

Mr. CHASE. To the extent that medicaid funds will flow and are flowing to these, there are, of course, State dollars involved, and we are now in the process of taking—

Mr. ROGERS. That is, if the State has participated in medicaid.

Mr. CHASE. That is right. We are now taking a hard look at the national health insurance proposal, and who knows how this is going to affect the long-term financing of these operations?

It could be that the greatest source of funds for these centers could be patient fees based on health insurance of one kind or another.

Mr. ROGERS. Thank you, sir.

Mr. JARMAN. Mr. Nelsen.

Mr. NELSEN. Thank you, Mr. Chairman.

I wish to comment on your observation about the contribution that the mental health centers make. Years ago in our State of Minnesota when I was then a member of the State legislature we set up community mental health centers.

Recently I was at a meeting and made inquiry as to the number of inmates in the State mental hospital as compared to years ago, and it is way, way down. Community mental health centers have made a tremendous contribution, not only as to costs, but as to the agony to families involved.

Speaking of staffing, is there an availability of skilled persons in this field? Isn't this a great problem? Are we neglecting one phase, that of educating people who will be able to move into this field?

Mr. CHASE. Mr. Nelsen, you have indeed identified the most serious problem in this whole picture and one which is in my opinion the true regulator of how fast we can make this program unfold.

The hope is for 2,000 of these centers in the United States. By June 30 it is estimated 200 of those will have been partially organized.

The NIMH regards the training and development of manpower programs as one of their three principal program areas, and we are constantly urging the Appropriations Committee to appropriate more money for these purposes.

Mr. NELSEN. I noted that some of the States were unable to avail themselves of Federal funds because of factors involved, and I assume manpower would be one of them.

Mr. CHASE. Matching funds is another one.

Mr. NELSEN. Right. Also, you indicated on page 6 that in many cases the State plan indicated a plan for setting up centers in poverty areas, and yet, the implementation of the State plan did not fulfill this pattern.

Mr. CHASE. Yes, sir.

Mr. NELSEN. Of course, this could be the fault of the States in a way, could it not?

Mr. CHASE. The fault would have to be shared, I think, with the local government bodies as well, Mr. Nelsen, because frequently the matching funds which are what prevents this from happening must be local tax funds, and if those funds are not available, then it does not occur.

Mr. NELSEN. You mention local involvement on page 7. We are learning fast, whether it be in welfare or foreign aid that in our generosity we must never overlook the fact that you must stimulate local responsibility and involvement in order to make our generosity pay off. I am happy to see the trend toward more flexibility in allowing the States to put their money where it is most needed in many programs, and also to involve local citizen concern.

We must never adopt the attitude that the Federal Government will solve everything, because we have pretty well proven that it can't.

So, I think your statement on page 7 is very important.

Mr. CHASE. Mr. Nelsen, your comments fall on exactly the right ears, because there is the highest duty of the national association, to involve the citizens in mental health.

Mr. NELSEN. Thank you very much.

Mr. JARMAN. Mr. Preyer.

Mr. PREYER. I have no questions.

Mr. JARMAN. Mr. Hastings.

Mr. HASTINGS. I think I had better yield to Mr. Skubitz.

Mr. SKUBITZ. Mr. Chairman, I have no questions. I yield my time to Mr. Hastings.

Mr. HASTINGS. I would like to question you on one thing that the gentleman from Florida, Mr. Rogers, already talked about, and that is this. The administration's proposal, which includes the approval by State planning agencies and a review by the areawide planning agency—you say you are opposed to this?

Mr. CHASE. Yes, sir.

Mr. HASTINGS. Are you opposed in concept, or are you opposed because you don't think most of these States have a sophisticated enough group so that they could involve themselves.

Mr. CHASE. Your second question represents my feeling.

Mr. HASTINGS. I don't lay claim to the fact that New York has the end-all, of course, in this area, but having been a member of the State legislature there for several years, and having had an interest in this problem, I think New York has come a long way, and I think there are other States that have.

Have you read the testimony of Mr. Black, submitted yesterday?

Mr. CHASE. Yes, I have.

Mr. HASTINGS. He feels strongly that the administration advocate the reviewing and approval by these two respective groups.

I am interested at some time in the future having the States take over this responsibility. I think it is important from the planning point of view, and if I interpret correctly what you say, that there are just too many States that are not prepared to meaningfully accept this responsibility—

Mr. CHASE. That is correct, Mr. Hastings, and we would agree entirely with your statement, and with Dr. Black. It is a question of timing. We do believe in comprehensive health planning. It needs to be done, there needs to be an avoidance of duplication. It is very, very important.

On the other hand, I believe from my own personal experience that all three levels of the comprehensive health planning process, that they are not yet ready.

With respect to the review of the individual grant application which is required under the administration's bill, the administration has recently published Circular A-95, Bureau of the Budget, which requires that every grant be given a 60-day review at the State house.

I am concerned about this review process on top of that review process, and we are going to be so bogged down in review processes that we are not going to get anything done. That is why I think that provision is unwise.

Mr. HASTINGS. I appreciate your testimony, but I more appreciate the interest of people like yourself in this program which is awfully good news people like myself, to see such as you involved deeply in this program.

Mr. CHASE. Thank you. I must confess that I wonder from time to time the state of my mental health on the amount of time I put in this.

Mr. HASTINGS. I might say the same thing about myself as a Member of Congress, Mr. Chase. [Laughter.]

Mr. JARMAN. If there are no further questions, Mr. Chase, we are grateful to you and Mr. Freeland for taking the time to help make an effective record on this subject.

Mr. CHASE. We are grateful to you, sir, for the hearings.

Mr. JARMAN. Our next witness this morning is Dr. James N. Sussex, representing the American Psychiatric Association.

STATEMENT OF DR. JAMES N. SUSSEX ON BEHALF OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Dr. SUSSEX. Mr. Chairman and members of the subcommittee, it is a privilege to meet with you as representative of the American Psychiatric Association and in representing that organization's views.

A prepared statement has been made available to the subcommittee, and I will try to avoid going through this statement word for word, but I do want to touch on the several points that are made therein.

Mr. JARMAN. Doctor, the entire statement will be received for the record.

Dr. SUSSEX. I would like to invite the subcommittee's attention to the fact that this is the oldest national medical society in the United States, with a membership of 17,000 psychiatrists, a membership which has tripled in the last 20 years, which gives you some idea, perhaps of the expansion of manpower in one of the mental health disciplines, and I will have a little bit more to say about the manpower in a moment.

I would like to point out that our association has been involved at all levels, National, State, and certainly at the local community level in mental health activities generally and particularly with respect to the development of the community mental health center program.

We have been very interested in its progress. We have recognized that there are many questions that have not yet been answered, in the brief time the centers program has been in existence, only some 6 years on paper, but in actual operation for most centers for not more than 2 or 3, or almost a maximum of 4 years of actual operational life.

As I mentioned, I would like to stress several of the points that the American Psychiatric Association would like to make. As a matter of principle, that is, feeling that these principles should be incorporated into whatever amendments are finally adopted.

I might add parenthetically a point that is made on page 2 of the prepared statement that partly I speak not only from the text here as representative of an organizational view, but partly from personal experience that I was privileged to have as a member of a survey team a year ago which studied several mental health centers under the auspices of the National Association for Mental Health and the American Psychiatric Association, the so-called Joint Information Service, the report of which I think Mr. Rogers earlier asked be provided to him.

In addition to this, I have been privileged to see a number of other centers in a consultant capacity and know quite a few of them in depth.

Point 1 I would like to make: I think there is not a doubt that many community mental health centers will flounder badly and perhaps go under because of inadequate financial resources in the future unless there is continued Federal participation in their financial support.

The length of time that each center has to develop support at a local and a State level is simply too short as it presently exists, to allow them to find the sources of support necessary to make up the decreasing amounts lost through the decreasing Federal participation.

Some centers, to be sure, will survive regardless of whether or not Federal participation continues, but many programs, and some programs which are imposing in terms of what they have been able to accomplish so far will almost certainly go under.

I think you will hear more of this from some of the center directors you will be listening to later.

The prepared text mentions the sources of support. You have already heard some of these talked about by Mr. Chase, and I won't belabor the point, except to say that, again, it is unlikely that the combination of all sources other than Federal support will be sufficient to keep these programs going.

As is mentioned here on page 3, I won't comment on dollar figures. I would like to underline what Mr. Chase said, however, that having actual dollar figures in any legislation that may be passed seems to us to be particularly important.

Merely authorizing expenditures seems somehow or other to have little relationship in the real world between what was contemplated in the Congress and what is actually available for implementation of a program ultimately at the local community level.

Too many various points exist at which the presumed amount of money can be lessened.

Point 2: The provision for giving preferential funding for existing and proposed centers in poverty areas is certainly desirable. It is certainly a matter of common knowledge, I think, to most of us that the resources are slimmest in the problem areas where the need is greatest.

Any assumption that centers in those areas can become self-supporting is probably an illusion.

The more subsidy these programs have, the better chance they will have to survive at all. It will help to make contributions in the crowded ghetto areas, as well as in the sparsely populated rural areas.

Point 3: The American Psychiatric Association is understandably leery about provisions in some of the amendments which require approval for center applications, particularly by area planning councils. We are in favor of integration of mental health care delivery systems with health care delivery systems generally, and believe that integration of these systems can ultimately be in the best interests of the people.

The problem, however, in accomplishing this across the board now, as proposed in some of the amendments, lies in the uneven development of mental health facilities in some of the States. Some States have incorporated these within the total health and welfare systems, but many, and perhaps most, I think, have not.

There is a vital need, it seems to us, to continue to maintain separate visibility of health components in total health planning and delivery systems, and we think that perhaps the idea that this integration would take place now is a good one in principle, but premature in time.

Certainly, in our view, it should be postponed until we can be confident that mental health interest is strong enough in all States that its ability to compete with other health interests is good.

Point 4: Initial planning and development funds will certainly be helpful. Mr. Chase has made this point, and I will emphasize it, that special funding in the early months can save a great deal of money in terms of effectiveness and early and effective staffing, as contrasted to those programs which have had to have their applications literally approved before such development took place, and then had several months during which they were unable to use the funds that were allocated to them.

Certainly this is doubly important in poverty areas, where such programs can hardly be gotten off the ground without an initial special development fund period of funding support.

Point 5: The American Psychiatric Association agrees that proposals to allow funds for the purchase of lands and for the payment of architect's fees, also, are most desirable, as included in some of the amendments.

Point 6: We favor the elimination of the distinction between professional and technical and other personnel eligible for staffing support. The distinction that was somehow or other incorporated into the initial legislation. Obviously not only professional and technical personnel, but also various supporting personnel are essential if a program is to operate the way it is planned to operate. We hope that this distinction will be eliminated once and for all in whatever final amendments are adopted.

Point 7: A few words about the special provisions for supporting mental health services for children and those with alcoholic and other drug problems. We hope these will be included in the final amendments.

They are massive problems.

One recalls philosophically that it was fundamental to the idea of a community mental health center that it be comprehensive, in the sense that it treat all comers, without discrimination as to diagnosis, as well as other things. This I feel is far from being realized at this point in time. The centers as now funded cannot cope with massive problems such as alcoholism and drug abuse, or with large numbers of children, who sometimes present unique types of problems.

I would like to respond to a question that was put to Mr. Chase, I think by Mr. Rogers, concerning why children seem to be forgotten people in the mental health centers—in many of them, not all of them to be sure.

Work with children takes a particular type of training over and beyond that which is necessary for work with adults. The mental health centers have been amazingly successful so far in staffing themselves after they have been successful in achieving Federal support, but the staff they get are those usually not trained for specific work with children.

Once they are there in the community mental health centers, therefore, they begin to do what they are comfortable doing, trained and competent to do, and these things are not with children. Children tend to be dropped out because staff is not available to work with this particular group of our population.

As a child psychiatrist I am particularly concerned with this phenomenon. We are hopeful that the report of the Joint Commission on Mental Health for Children which will be the basis for further recommendations to the Congress in the future, will be successful in closing the very wide gap between what is necessary or indeed desirable, and what we now have.

However, I would like to reverse the emphasis that is in the prepared statement of the American Psychiatric Association and say this, that regardless of what is done as a consequence of the report of the Joint Commission on Mental Health of Children, we still need to provide services for the emotionally disturbed and mentally ill child in the community mental health center. This is badly needed, and the Joint Commission report should not, in my judgment, be regarded as solving the problem, so to speak.

The problem is with us, and will not be solved except in the context we are now looking at this problem.

In this connection, I understand, I heard this morning something I hadn't known, that the Senate subcommittee added more than \$200 million for children services in its particular proposal for the community mental health center renewal, with preferential matching at a 90 percent level. This would be a tremendous advance with specifically earmarked funds for work with children.

I would like to point out that that \$200 million, I think, should be regarded as a floor and not a ceiling. I think the same remarks I have made with children could apply equally well in the context of alcoholism and other drug abuse problems.

I would also like to mention briefly that the American Psychiatric Association believes that the five services regarded as essential in the original legislation are indeed essential, that also essential will be diagnostic services, with others, and most specifically, training and evaluation.

We very much hope that these are not lost sight of in the final amendments that are passed. Only if evaluation is built into and required in a center program can we expect it to function. When the budgets get tight, evaluation of the program is the first thing that drops out, usually, anyway.

I think I will not dwell on the remarks in the prepared statement on pages 7 and 8 any further, except to say that the model provided by the community mental health center may indeed become a model ultimately for the development of comprehensive health care delivery systems generally in this country.

At least it is one pattern of health care delivery that will increasingly be considered by those interested in health care generally over and beyond mental health.

So that we are trail blazers in this sense.

One last word. I mentioned I would say something about manpower. Mr. Chase's remarks about manpower were a little discouraging, and indeed this is one area in which we need to devote a great deal of attention.

However, the almost 200 community mental health centers that are now in operation, or beginning operation, some of them in full operation, have had, so far, amazingly little trouble staffing, provided they have had enough time to plan and develop their program before their Federal money actually became available.

Mike Gorman just told me that they trained some 65,000 persons in the mental health disciplines in the last 20 years. I think this is probably a far lower figure than we could say about the next 5 or so years in the programs that are now engaged in training mental health personnel at various levels ranging from the highly trained people who take several years to complete their training to those whose functions are just as important in these programs but who can be trained in a couple of years at junior college level or some times in on-the-job training.

With this paraphrasing of our prepared report, Mr. Chairman, I would like to thank the subcommittee for listening to the American Psychiatric Association's view, and I would be happy to answer any questions that I may be able to answer.

(Dr. Sussex's prepared statement follows:)

STATEMENT OF JAMES N. SUSSEX, M.D.,¹ ON BEHALF OF THE AMERICAN
PSYCHIATRIC ASSOCIATION

Mr. Chairman and Members of the Subcommittee, we are privileged to appear before you today, representing the American Psychiatric Association, to plead the critical need for extending federal support of the national community mental health centers program. Our Association is the oldest national medical society in the United States. Its membership, now 17,000, has tripled within the last 20 years. Its structure encompasses 60 district branches providing it with organizational ties to the development of community mental health services in every state, region, and the major communities of the country. From the beginning our Association has been a foremost proponent of the community mental health center concept and of the federal support which has made its implementation possible since 1963.

For several reasons we find the circumstances under which we make our plea today exceptionally gratifying. For one thing, it appears that all concerned are "sold" on the potential of the community mental health centers for bringing the right kind of treatment and care, at the right time, and at the right place—in their own community—to all mentally troubled citizens of our country. We shall not take time, therefore, to review the history and development of the centers or the efforts of our own profession and citizen sympathizers that convinced the Congress it should inaugurate the program in 1963, only six years ago. It is not their essential merit, but rather how the centers are doing, how many of them there are, how far they have come towards realizing their potential that now concerns us.

It is also gratifying today to find ourselves speaking to several legislative proposals before the Congress to extend support for the centers for several more years. There is much bipartisan support for these proposals. All of them are good. None of them contain provisions to which we take significant exception. Our plea, therefore, is a simple one: Let us ensure that the final bill that is passed will incorporate all of the good features of all of the proposals and adequate authorizations to ensure their realization.

Accordingly, I should like to make several points about the principles that should be incorporated into the final amendments. I may say at this point that I was recently privileged to be a member of a survey team to evaluate the present status of representative federally-funded community mental health centers across the country. The study was carried out by the Joint Information Service of the American Psychiatric Association and the National Association for Mental Health

¹ Professor and Chairman, Department of Psychiatry, University of Miami School of Medicine, Miami, Florida; Diplomate in *Psychiatry* and *Child Psychiatry*, American Board of Psychiatry and Neurology; Chairman, Task Force on Childhood and Adolescence, American Psychiatric Association; Member, Executive Committee Joint Information Service of the American Psychiatric Association and the National Association for Mental Health; and Co-Author: *The Community Mental Health Center—An Interim Appraisal*, Joint Information Service, Washington, D.C., 1969.

under a contract with the National Institute of Mental Health.² If the subcommittee wishes, later, to question me about our team's findings I shall be happy to reply. For the record, however, I should like to make seven major points about the amendments and add some brief general remarks about the stake our country has in furthering the community mental health center as an innovative device for delivering health services.

1. THE CENTERS WILL FLOUNDER WITHOUT FEDERAL SUPPORT

There is not the slightest doubt but that the community mental health center movement will flounder badly and that the intent of the Congress in launching the program will wither beyond recognition if extended and expanded support is not forthcoming. My experience as a member of the survey team referred to above supports the contention, and while, as a professor of psychiatry, I am not directly involved in the operation of a center, the intelligence I glean from colleagues in Florida who are, strikingly reinforces the contention. Also, you will hear from several directors of centers later in these hearings; they are on the firing line and I am confident will convince you that their prospects are dim if federal support is not extended. In general, our centers are dependent in the main for income from fees for service to patients, from third-party payments under health insurance programs, from state government subsidization, and from miscellaneous and sporadic support from public and private community agencies. The total of their income is not sufficient to maintain even the five essential services, in sufficient quantity, they are supposed to offer, let alone other services which should be added to provide a truly adequate and comprehensive program. The growth of health insurance coverage of the mental illnesses in the past decade has been most encouraging; but it is primarily geared to cover inpatient hospital expense, whereas the centers, by design, are intended to keep people functioning in their communities through a range of outpatient services and supports. The state governments, in spite of pressing demands on their budgets, have provided liberal monetary support for the centers program. In the period 1964-1969 the states contributed \$310 million to community services compared with \$282 million by the federal government. But it is a moot question how much further they can go. One thing seems certain: The willingness of the state legislatures to appropriate monies for centers will depend in important measure on the certainty of federal matching support. The National Governors Conference last summer adopted resolutions which left no doubt of their position in this matter, as you know.

Since I am not expert in such matters, I cannot venture estimates as to what specific amounts of money should be authorized in the final bill that evolves. I can only plea that they be ample to support the intent of the legislation. All of us, I fear, have become somewhat jaded about what is likely to happen to us as governmental budgetary processes work themselves out. First, one must clear the Bureau of the Budget which has its own set of priorities, and sometimes we are not among them. Then we turn to our friends on this Subcommittee, for example, and more often than not you listen to us, for which we are deeply grateful. After that we must hope that Congressional finance committees will be disposed to appropriate the funds you have authorized. Sometimes they wound us deeply. But even when they prove generous, there is yet another peril along the path: The President may prohibit his departments from expending the funds that have actually been appropriated! And this, as you know, has actually happened in the funding of community mental health centers. Thus life's path is full of pitfalls. But at least in stipulating rational authorizations to support a program, one has a realistic basis on which to urge one's needs throughout the process. Please make them adequate.

2. PREFERENTIAL FUNDING FOR POVERTY AREAS DESPERATELY NEEDED

Provision for giving preferential funding for existing and proposed centers in poverty areas is altogether to be desired. It is almost a truism in our society that the resources are slimmest in those problem areas where the need is greatest. Any supposition that mental health centers in poverty areas can become self-supporting through patients' fees and third-party payments at the moment is illusory. The more generous the subsidy the better chance we will have of maxi-

² Glasscote, Raymond M., Sussex, James M., Cumming, Elaine, and Smith, Lauren H., *The Community Mental Health Center: An Interim Appraisal*, Joint Information Service of APA and NAMH, Washington, D.C. 1969.

mizing the contribution community mental health centers can make to calm the seething emotional disorders spawned in the crowded ghettos and the sparse rural areas of our country.

3. COMPREHENSIVE HEALTH PLANNING IS GOOD, BUT...

We are understandably leery of some of the amendments proposed which provide for approval of community mental health center applications by the states, comprehensive planning agencies and for review by area health planning agencies. Our objection is not to the goal, the ideal, or the principle involved. We are very much for the integration of mental health with total health planning. We are moving forward as rapidly as we can under the slogan "Bring the mentally ill back into the mainstream of medicine."

The problem, however, in attempting to legislate the slogan across the board as here proposed lies in the uneven development of health planning operations among the several states. Some states have achieved a commendable incorporation of mental health services within their total health and welfare systems. But many have not, and in these circumstances there is continuing need to maintain a separate visibility for the mental health component of total health planning.

In sum, the goal is a worthy one. The sooner we can integrate mental health with total health planning everywhere, the better. But the timing of this legislative proposal is, we think, premature. It should be postponed until we can be confident that the mental health interest is sufficiently strong in all states that it can compete on an equal footing with all other health interests.

4. INITIAL PLANNING AND DEVELOPMENTS WILL PROVE PRODUCTIVE

Amendments provision for funds for initial planning and development of community services is especially helpful and much to be desired. We recall that the federal program in the first place was preceded by a federally-supported state planning program. In retrospect it is difficult to see how we ever would have gotten the program under way without that planning stage. But the same principle is just as applicable at a more microcosmic level in every catchment area of our country. It is extremely difficult and complex to start a new center from scratch. One must first have support of the idea by a great many leading citizens. The one must assess the need in relation to the area to be served. The cooperation of a range of community agencies and personnel and the people to be served must be enlisted. There must be agreement on the site of the center. The potential case load and the range of services to be offered must be estimated as carefully as possible. Applications for funding must be drafted and "cleared." I don't suppose that it is quite so difficult to muster community consensus about a new center as it is to get agreement on the course of a new thruway in a city, but the challenge is comparable in some measure. To provide funds for initial planning and development will give the movement a tremendous boost, and most especially in poverty areas where the problems are the most difficult to cope with.

5. USE OF FUNDS TO PURCHASE CENTER SITES MOST HELPFUL

Proposals to allow funds for the purchase of land for construction of centers and the payment of architects' fees are also most welcome. We hope such provision will be included in the final bill.

6. NO POINT IN DISTINGUISHING ONE KIND OF ESSENTIAL PERSONNEL FROM ANOTHER

We very much like the elimination of the distinction between professional and technical and other personnel eligible for staffing support that somehow was incorporated into the initial legislation. One wonders why it was ever formulated. Obviously, a janitor or a secretary is just as vital to the functioning of a center as psychiatrist or nurse. We hope the distinction will be eliminated once and for all in the final amendments this year.

7. SPECIAL SUPPORT IS NEEDED FOR CHILDREN, ALCOHOLICS AND DRUG PROBLEMS

Now a few words about special provisions for supporting extended community mental health center services for children and those with alcoholic and other drug problems. The American Psychiatric Association certainly applauds these measures and hopes that they will be included in the amendments. I need not

dwell on the size of the problems to which they are addressed. One recalls that, philosophically, it is fundamental to the idea of a center that it will treat all comers with any kind of mental disorder without discrimination. But, of course, the ideal is far from reality. They simply cannot cope in a massive and effective way with such gross national problems as alcoholism and other drug problems, and emotionally handicapped children.

As a child psychiatrist, I am, of course, especially concerned with the paucity of our nation's services for helping troubled children. Last summer the Congress received the final report of the Joint Commission on Mental Health of Children which delineated our deficiencies for the first time in comprehensive and stark detail. In the coming year it shall be our purpose to urge upon the Congress that it enact basic legislation to begin the implementation of the Joint Commission's recommendations. Proposals at this time to include in the amendments we are considering special support for child mental health services in community mental health are praiseworthy, but in no wise should be taken as substitutes for the more basic legislation that will be needed soon to launch the Joint Commission's program. It is a discouraging fact, of course, that very few of our new mental health centers have been able to provide significant service to emotionally disturbed young people. They would do more if they had the wherewithal. Indeed, it is our judgment that provision for child mental health services in the centers should be made one of the essential requirements for approval of their funding. The same principle applies to alcoholism and other drug problems.

In sum, we approve these proposals to extend center services to help meet the desperate needs of children and people with alcoholic and other drug problems. By the same token we hope the time will come when, with federal support, the five essential services will be expanded to include all ten services adjudged to be necessary if we are to consider the range of services truly adequate. Thus, to inpatient, outpatient, partial hospitalization, emergency, and consultation services, we would add diagnostic, rehabilitative, precare and aftercare, training and evaluation. Speaking of training and evaluation, it is gratifying that proposals in the amendments have made some provision for special support of this function. We very much hope it will not be lost sight of in the final amendments that are passed. Only if evaluation mechanisms are built into a center's structure and functioning can we hope to assess where we stand, what progress we are making, and what future directions we should follow. It also goes without saying that "training and evaluation" is the first function to be dropped when the budget strings are tightened.

THE NATIONAL STAKE IN FLOURISHING CENTERS

So much for some comments on specific proposals for the community mental health centers amendments of 1969.

I should like to conclude my prepared testimony with some more general but vitally related comments about our national stake in a flourishing community mental health center movement.

We are all very much alert to the heady ferment throughout our society about how we shall deliver and finance health services for all citizens. As a people, we are sick and tired of worrying ourselves into an anxiety state about how we are going to get a doctor in the middle of the night, of how we can manage a bus trip to a clinic six miles away in the morning, of how we are going to pay for hospital care that costs \$75 to \$100 a day, and how we are going to protect ourselves with adequate health insurance coverage; and if we are poor, our anxiety is quadrupled. Manifestly, we as a nation must conjure drastically improved methods of the financing and delivery of services, and soon.

In this context I want to suggest to the Congress that the community mental health center has gone far already to establish the validity of one new modality for the delivery of health services. It is very much a product of community planning. It provides for continuity of care. It is intended to keep people upright and walking about, not prone in expensive hospital beds. It is dedicated to the concept of prevention. It relies importantly on third-party payments for support. It is theoretically available to all citizens in its predetermined catchment areas. It is in short delivering services to citizens where the citizens are. It has established one nuclear pattern which should offer much to total health planning in our country.

By no means would we venture that the mental health center pattern is a final answer; but we would stress the importance of nurturing it as one newly evolving delivery pattern. We need other patterns too. For example, we in child psychiatry

are painfully dissatisfied with the limited capacity of our present well-baby clinics to meet the needs of the child in his first five critical years of development. The well-baby clinic does quite well in caring for mother and child in the first year. But that's about it. We need a new "thing," something that might be titled a "child and family development center," a facility that will bring comprehensive health services to the child and his family in the first five years and including not only prenatal care, pediatric care, but also genetic counselling, child neurology, child psychiatry, obstetrics, gynecology, and related services. All of this is implicit in the report of the Joint Commission on Mental Health of Children and we hope we can delineate the concept with greater precision in the next few years. But in the meantime it will be a great advance to build effective child mental health services into our community mental health centers.

In sum, the community mental health center is one of the nation's best hopes for showing the way to more effective delivery systems. It is obvious, of course, that one cannot divorce organizing the delivery of services from the financing thereof. We are still a long way from having all the answers. But the federal funding of the community mental health centers is most certainly taking us in a constructive direction.

We urge your most generous support of all of the proposals that have been set forth for incorporation into the community mental health centers amendments of 1969.

Mr. JARMAN. Thank you very much, Dr. Sussex. Your comments will be of assistance to the subcommittee in our analysis of the various bills we have before us.

Mr. ROGERS?

Mr. ROGERS. Doctor, we are delighted to have you here. We know of your work, and we appreciate your testimony.

How many centers were studied in the evaluation?

Dr. SUSSEX. The particular survey that was referred to here included eight centers that were studied in depth. I participated in others in which four or five more were visited. I have seen quite a few more in the early operational stages.

So, I am fairly familiar, at least, with about 30 or 35 mental health centers, which represent about one-sixth of the ones operating. I think just about 200 are regarded as operational.

It is difficult sometimes to say, because once a clinic becomes operational and opens its doors, it may be several months before it is really toolled up to do the full job. This points up the importance of funding in the developmental period, the initial developmental period.

Mr. ROGERS. And the major problem you see is staffing?

Dr. SUSSEX. Staffing will certainly be a problem, but I would like to say that even the centers that are staffed now and have had no problem with staffing because they were in an area where staff liked to come, or where they could offer a particularly gratifying professional experience, the question is still whether they can get the dollars to continue when the Federal funding percentage goes down. Many of these centers could continue to function if they could see Federal participation at somewhere around a one-third level, but most of them, to my knowledge, have no idea how they are going to fund everything from sources other than Federal.

Mr. ROGERS. Are all of these nonprofit groups that you looked at?

Dr. SUSSEX. Mental health centers fall under the sponsorship of State hospitals, private nonprofit hospitals, general hospitals in the community, public hospitals, predecessor community mental health clinics, and a couple of others, but these are the main ones.

Mr. ROGERS. Are all of these providing the five services?

Dr. SUSSEX. Yes, sir, technically at least. They have to.

Mr. ROGERS. I understand they have to technically.

Dr. SUSSEX. Some provide little in one or another of the service areas. Some of the services are so new in our country in concept that again the manpower question gets into it, but in a different way. For example, we have little manpower in this country trained in the particular approaches represented by partial hospitalization, day hospital programs. We have had to develop this manpower as the centers themselves were opened.

The existing programs did not train people to run these types of services.

Therefore, of the five essential services the one that has gotten off the ground the least well is the day hospital component.

Mr. ROGERS. Is the American Psychiatric Association doing any research, or have they recommended training programs to any medical schools for particular programs for particular classifications of personnel that would be used in mental health centers?

Dr. SUSSEX. I hesitate to say there have been any firm recommendations in one, two, three kinds of things, but there has been a continuing dialogue between the American Psychiatric Association and various of its committees that are concerned with community mental health and the centers, and with the chairmen of university departments of psychiatry, and also with the training institutions that concern themselves with producing social workers, psychiatric nurses, and so on.

Mr. ROGERS. I hear how we are going to need so many new classifications of personnel, and I believe this to be true, but I haven't seen any concrete suggestions coming forth or any concentrated program to produce these, and if you have any information on this, I think the committee would be glad to see this, because we would like to follow up.

We have training programs, as you know, which this committee has authorized, and it seems to me that we are not getting the response from the professional organizations that we should in helping to direct these programs.

Dr. SUSSEX. Mr. Chase mentioned that an increasing number of psychiatrists being trained are going into community mental health, and I think this trend will continue as they find it a rewarding and satisfying experience, and this, of course, implies that they will be able to feel that they are doing some good for the mentally ill people in this country.

I will acknowledge though, Mr. Rogers, that the formally organized training programs, for example, the residency training programs for psychiatrists are behind the times with respect to the community mental health concept.

Mr. ROGERS. Yes, and I think we need to make some progress here, because that affects so vitally the personnel that is going to run these, and if you could give us some suggestion on this, I think it would be helpful.

(The information requested was not available to the committee at the time of printing.)

Mr. ROGERS. Would you recommend that this committee require 10 services now, into the law?

Dr. SUSSEX. I think it might well consider writing this into the law, and I think that you might gain more specifically helpful information, the best evidence, so to speak, from the people who have been

on the firing line with these mental health centers, and I suggest that perhaps they can answer this better than I can.

Mr. ROGERS. But perhaps concentrating on child mental health, which they should give anyhow, but which you say they are not doing in many instances, alcoholism and drug abuse problems. Should that be tied into required services?

Dr. SUSSEX. I would predict, without knowing what they are going to say, I would predict that the directors you are going to listen to will tell you that there are innumerable problems with respect to developing meaningful and effective programs for alcoholics and for drug abusers within the framework of the mental health centers as they now exist.

I think, however, with funds specifically set aside and allocated for this purpose, where the treatment of an alcoholic or a drug abuser doesn't have to compete with treatment of someone who is not an alcoholic or drug abuser—right now the centers have to make a choice between someone who is an alcoholic and this is going to be difficult—or someone who is not and with whom they can anticipate a great deal more success.

Mr. ROGERS. Thank you, Mr. Chairman.

Mr. JARMAN. Mr. Springer.

Mr. SPRINGER. I take it from what you have said here, then, that you are not in favor of section 314(a). Is that correct?

Dr. SUSSEX. As I understand 314(a) that is the one with reference to the State review.

I am not sure I read it correctly. If this is an annual review of the State mental health plan, I see no objection. If it is a review of every individual application with the power of veto, I would have objection.

Mr. SPRINGER. Why would you object?

Dr. SUSSEX. I have seen instances where such reviews got short shrift, because it didn't fit into a particular preconceived format on the part of the State review body.

I think the operation of these centers has to be in accordance with a generalized and overall State approach. But there is too much variation from community to community to make this effective at this time, in my judgment. Maybe at some future date this would be appropriate. I don't know.

I don't believe myself competent to say more on that.

Mr. SPRINGER. I am glad you say that. Under Hill-Burton, we have built a lot of hospitals that weren't needed. Because they didn't have comprehensive planning, they got the hospitals located in places they were not needed, largely because they lacked this particular section right here.

Now, in my own State, I know that we would want to follow a planning agency to determine where these are going to go, and also get the general approval of where they are going to be in order that we can have a balanced program for the entire State.

But I am never going back to the Federal grant, just because a community rushes in and wants it. I have found too much politics in that.

The first thing I want to know is does the State agency want to know if one should be there, as a sort of a buffer between me and the local community.

Generally, I have taken a position in my own district that if it is not needed this agency is going to pretty well give me a good reason, or know why that they are not going to locate one there when there is a petition to have one and when the money is available.

I take it that in this your experience has been that you found some communities couldn't get it that you thought ought to have it.

Dr. SUSSEX. I think that would be accurate.

Mr. SPRINGER. It took us a long time to come up with 314(a), and if anybody has done more thinking about this than this subcommittee has under this able chairman, I don't know who it is. Because this has been our big bugaboo, getting a State agency enacted and the Governor to appoint someone, and for someone to do thinking about how to spread this around.

In my State it has worked well, and we are pleased with it. But it is my understanding that there are State agencies now in all 50 States, so that the Federal Government at least has somebody they can talk to about it.

This is just my experience, and I thought you ought to have the benefit of it.

Thank you, Mr. Chairman.

Mr. JARMAN. Mr. Preyer.

Mr. PREYER. Thank you, Mr. Chairman.

Dr. SUSSEX, you mentioned that you visited eight centers and studied them in depth. Were those centers in large cities, rural areas, or what?

Dr. SUSSEX. These hopefully were a mixed bag, but it was hard 2 years ago to get a random sample, so to speak. But they represented centers in a large metropolitan area. At least one of those centers was in a relatively suburban area; one was in a central city ghetto; another was in the middle of the central United States in an area where its community was 22 counties, comprising one-fifth of the total State of Kansas, and so on.

Mr. PREYER. It would be difficult, I believe, to arrive at some mean, but what I was wondering is whether you could give us some idea in an average center as to how many patients, how many people were handled in this center in a year.

Dr. SUSSEX. Might I beg off, again with the idea that you will get your best evidence from the people who are operating centers, and I think that your time and the subcommittee's time would be better spent with them in that particular area than with me.

Mr. PREYER. Fine. What I was trying to get at was some information on the number of persons coming through centers, and the length of treatment and the cost per person.

Thank you very much, Dr. Sussex, for your testimony.

Mr. JARMAN. Dr. Carter.

Mr. CARTER. Thank you, Mr. Chairman.

I have read with interest your presentation, and I think it is quite good. I notice that on page 2 that you feel sure that centers will flounder without Federal support, and as it happens I am in agreement with that, because in the poor areas we must continue Federal health assistance as I see it.

I notice, too, that you are very much for the integration of mental health with total health planning, and yet I believe you favor direct

grants from the Federal Government bypassing the States. Is that true, or did I misunderstand you?

Dr. SUSSEX. I think I will try to interpret what I understand to be the organization view on this and I think my personal experience tends to reflect this, too; that the needs of mental health programs, if they are integrated with a program which has as its area of concern total health needs, tend to be granted priorities low enough that they cannot mount effective services.

I am most familiar with medical schools, and I know the difficulty, for example, that psychiatry has in arguing toe to toe with the department of surgery for funds for its educational and training programs.

I submit that although surgery and psychiatry are related in the sense that they both are concerned with treating people who are disabled or nonfunctional or partially functional and so on, that the basic approaches are different enough that they need to be considered almost from two separate approaches and should be funded accordingly.

They should not be made competitive, and I think that I would personally have a fear that if mental health planning were integrated too early and too completely with health planning generally that mental health programs would suffer.

Mr. CARTER. I certainly would agree with you. Of course, there is very little correlation between surgery and psychiatry as I see it, and certainly I feel that your mental health centers should be separated.

But the idea I believe we were discussing is whether the grant should go directly to a mental health center, or should it first go through the State and an area planning agency, something to that effect.

I believe that we must plan, because, as has been brought out previously, we could have a whole host of mental health centers which would overlap.

Planning is essential, but we strongly support the centers, and separate centers at that, and certainly we recognize that in that we have this separate mental health bill to provide the systems you want, and I didn't read about any surgeons or surgery within this bill.

I notice you are a child psychiatrist, and I am interested in that field. We see so many more emotionally disturbed children today than formerly, and is it not true that teenagers who are victims of schizophrenia, are often very difficult to treat?

Dr. SUSSEX. Yes, indeed, they are.

Mr. CARTER. Oftentimes intractable?

Dr. SUSSEX. Yes, in certain instances they are intractable and become in a sense chronically ill.

Mr. CARTER. It is important for us to have these centers so that we can get them early, isn't that true?

Dr. SUSSEX. Early treatment can at least contribute to the prevention of chronicity. I would like to add parenthetically that the emotional illnesses that seem to be seriously disruptive of the youngster's developmental process include a great many more disorders than schizophrenia itself, and although this is perhaps the most severe of such orders it probably represents a relatively small percentage of the number of children who have major emotional problems and need professional treatment.

Mr. CARTER. As it happens, I have seen a few of these youngsters, and to me it is extremely sad to see a teenager who is out of contact with reality.

Dr. SUSSEX. Indeed it is.

Mr. CARTER. And we want to do everything we can to be of help. I notice on page 8 you mention that we as a nation must devise drastically improved methods of financing and delivering services. Would you elucidate on that a little bit, please, sir?

Dr. SUSSEX. Again I must apologize. This is an organizational viewpoint, and I need to speak to this point from personal experience as well as knowing the organizational view.

I think that the American Psychiatric Association believes that there will be over the next few years significantly new and innovative methods of getting health care generally to the population, particularly certain portions of the population which heretofore have had difficulty in getting such care under the private system entirely. Third party payment plans, health insurance will itself contribute to this shifting of health care delivery patterns.

The comprehensive health planning, not mental health, but health generally, planning groups that have been formed—I don't know whether they have been formed in all States or not—but they are looking carefully at the community mental health care model in developing their own thinking about how health care generally can be brought to the public more effectively and more efficiently.

Mr. CARTER. Of course, it is important that we do deliver good health care to the poor people who are unable to pay for it in many cases, and strangely enough, this is where most pathology is and for a few physicians, these actually constitute the most interesting cases and are most helpful to him in the learning process, I would think.

Thank you so much, Doctor. I appreciate your testimony.

Mr. JARMAN. Mr. Hastings.

Mr. HASTINGS. Thank you, Mr. Chairman. I would just like to briefly question you on the drug abuse relationship.

On page 7 you mention in relation to child mental health services, you mention that, and you say the same principle applies to alcoholism and drug problems. You talk about lack of funding needed to treat these problems.

I am a little apprehensive as to whether the total answer to the treatment of drug addiction, if that is what we are talking about, that the solution, if there is a solution to that problem, really rests with the community mental health centers.

I had some discussion yesterday with Mr. Black from HEW on this question. New York State recently has gone into a very extensive narcotic rehabilitation center approach. Involuntary confinement is part of it, and it is a massive problem in New York particularly.

I guess they figure anywhere from 80,000 to 200,000 hard core addicts.

In fact, is there enough money that is going to be made available to this program to really solve that problem within the concept of what you are trying to do?

Dr. SUSSEX. I would presume you are speaking to what would certainly be a very valid point. The problem of drug abuse transcends

the boundaries of mental health, and involves a good many other things than we could possibly call mental health services.

Programs for drug abuse which have seemed to be recognized as essential at one point or another, particularly in rehabilitating drug abusers, are services which are very similar to and comparable to those which are traditional mental health services.

We might use counseling as a generic term to describe some of these, group therapy kinds of approaches, without drug abuse programs have not by and large been successful at all.

Drug abuse programs do require some things not traditionally regarded as being connected with mental health at all. For example, the so-called Methadon detoxification programs. That could be run exclusive of a mental health program.

The fact of the matter is, perhaps New York State can change this trend if Elaine Cummings is successful in selling her view that mental health workers have nothing to do with drug abuse.

Until that time comes, where drug abuse comes on the horizon, the mental health people are the ones that are asked to do something about it. This occurred in Miami in the middle of August with some 400 hard core heroine addicts dumped on the street from a very controversial Methadon program, and the country was told it had to do something about it.

Jackson Memorial Hospital, the county hospital, had to assume this duty by mandate, so to speak, and the Department of Psychiatry got the job of devising a program for these hard core narcotics addicts.

In other counties, the community mental health center has been the service agency to which the drug abuser, his family, and even the law enforcement agencies, when they have decided that a treatment approach is preferable to a punitive one, have gone to.

Mr. HASTINGS. Don't misunderstand me, Doctor. I am not suggesting that mental health does not have a rightful place in the concern over drug abuse and drug addiction. My question really is, aren't most mental health agencies only funded enough to be able to act as a corollary agency to somebody, either State or Federal combined, to really zero in on the problem of drug addiction?

Dr. SUSSEX. I think unless there are specific funds allocated to and earmarked for a drug abuse component in a community mental health program, that drug abuse is unlikely to be dealt with any more than peripherally.

Mr. HASTINGS. Thank you, Doctor.

Mr. JARMAN. Are there other questions?

We appreciate your being with us, Dr. Sussex.

Dr. SUSSEX. Thank you, Mr. Chairman.

Mr. JARMAN. Our next witness is Dr. Donald Weston, accompanied by several witnesses who will sit as a panel, and I will ask Dr. Weston to introduce his associates on the panel for the record.

STATEMENT OF DR. W. DONALD WESTON, ASSOCIATE PROFESSOR OF PSYCHIATRY AND HUMAN DEVELOPMENT, MICHIGAN STATE UNIVERSITY; DR. ALEX. T. PORTZ, DIRECTOR, APPALACHIAN MENTAL HEALTH CENTER, ELKINS, W. VA.; RAYMOND RAMIREZ, DIRECTOR, MENTAL HEALTH AUTHORITY FOR WEST CENTRAL ILLINOIS, QUINCY, ILL.; DR. FRANK CREEL, COMMUNITY PSYCHIATRIST, COMMUNITY MENTAL HEALTH CENTER OF ESCAMBIA COUNTY (FLA.), INC.; DR. DONALD MORRISON, DIRECTOR, NORTHERN WYOMING MENTAL HEALTH CENTER, SHERIDAN, WYO.; AND DR. HIAWATHA HARRIS, LOS ANGELES, CALIF., REPRESENTING THE NATIONAL COUNCIL OF COMMUNITY HEALTH CENTERS

Dr. WESTON. Thank you, Mr. Chairman. We have chosen to appear as a group before you for two basic reasons. We represent the National Council of Community Health Centers which recently was organized in Denver that came out of an acute awareness of many centers that were in their third and fourth year planning that were heading for disaster unless we started to talking to and have some say so about what kind of funding and planning was going to go into the new Mental Health Center Act.

I am pleased to be able to inform the committee, and it has been submitted to you, a resolution that was unanimously passed at our first meeting, concerning issues we feel are critical in any bill.

Mr. JARMAN. The committee will be pleased to receive it for the record.

(The resolution referred to follows:)

CMHC ACT RESOLUTION

Whereas, the National Community Mental Health Center Program has initiated the provision of comprehensive mental health services and,

Whereas, a substantial portion of these serves are preventive and educational, and

Whereas, state and local governments do not have the tax base, together with fees, service contracts and local philanthropy to wholly support the programs, and

Whereas, the survival of some centers is now threatened for lack of adequate funding: Now, therefore, the National Conference of Federally Funded Comprehensive Community Mental Health Centers does hereby

Resolve, That—

1. The Community Mental Health Center legislation (Public Law 88-164 as amended) should be extended five (5) years.

2. Increased levels of fiscal authorization be supported.

3. The centers' programs receive full funding; i.e., the appropriation matching the authorization.

4. The period of support for all centers (old and new) be extended from fifty-one (51) months to ten (10) years.

5. Support levels in poverty areas be increased to ninety (90) percent during the first two years and seventy-five (75) percent for years three through ten.

6. The support levels in non-poverty areas be no less than seventy-five (75) percent during years one and two, sixty (60) percent for year three, forty-five (45) percent for year four, and thirty (30) percent for the years five through ten.

7. Full cost grants of one year duration be made available for initiating and developing mental health center programs.

8. Special programs in alcoholism and drug addiction be supported at no less than ninety (90) percent for the first two years and seventy-five (75) percent thereafter.

9. Training and evaluation grants for alcoholism programs be supported at levels indicated above.

10. All personnel working in community mental health centers be eligible for federal support.

11. Children's programs be encouraged with federal support and integrated into community mental health centers as appropriate.

12. Indirect services of consultation and education be funded at a higher federal participation percentage than direct services in any given support year.

13. Research and evaluation be funded at the ninety (90) percent level for the duration of the grant period.

14. The acquisition of land for community mental health centers and architects' fees be included in eligible construction costs.

15. The level of the states' allotment for administering community mental health center construction plans be increased from two (2) to five (5) percent.

Unanimously adopted, October 25, 1969, Denver, Colorado.

Dr. WESTON. I would like to stress three points. One was in the area of continued substance funding for centers that are in existence. There has to be at least a minimum level of around a third if many centers are not going to go down the drain, and we would be unrealistic if we said we needed only 2 or 3 years more of that. We are going to need that until some other funding comes along, whether it is national health insurance, or whatever.

Secondly was the acute awareness of the poverty areas and the need for them to have special preferential treatment.

Mr. JARMAN. Doctor, may I ask at that point, do you mean one-third of total expenses, or one-third of staffing costs?

Dr. WESTON. One-third of total expenses. It is unrealistic for us to think that our total major costs are just professional staff. You have to have an office, transportation and other things.

The second reason we are presenting ourselves as a group is that we think we represent a cross section of various types of mental health centers. They can answer questions you might have on problems unique to one area.

I would like to have each one of our members here, if it is agreeable to the committee, briefly speak and then open up questions to any of us, and we will try to deal with them.

Many of the members have submitted prepared statements. They also will not read these.

Our next speaker will be Dr. Donald Morrison, of Sheridan, Wyo. He is head of the community health center there. It covers an enormous geographical space and has its own unique problems. Dr. Morrison was the driving force that got us all together in Denver, and thank God he did, because it helps us realize where we are and where we need to go.

STATEMENT OF DR. DONALD MORRISON

Dr. MORRISON. I am a psychiatrist and director of a mental health center, as Dr. Weston indicated.

Ours is truly a rural mental health center. We cover an area of 20,000 square miles.

At the present time, we have a staffing grant that provides us with 39 percent of our operating budget. I would like to refer you to my prepared statement, and on the third page of that statement there is a

graph which shows our financial experience with the first 3 years of the Federal staffing grant.

Based on this experience we projected our budget into the future last spring and concluded that we had been successful in using Federal money to generate local money. By the end of the second year, we had doubled the amount of State and local money being supplied for these services.

At our present rate, we will have tripled it by next year.

We also concluded after we had spent a great deal of time with Governor Stan Hathaway and our local county commissioners that we would never be able to meet the full cost of running a mental health center with State and local funds.

We feel that we probably can continue to exist as we now function, with a minimum of about 30 percent of the money coming from Federal sources.

This feeling led us to survey last spring those centers that were operational for a year or more, and there were 131 such centers at that time. As we felt these people would know firsthand what some of the problems were in maintaining financial support.

One hundred and two centers responded. That is 78 percent.

Two-thirds of those that responded felt that they could continue to function if they had 30 percent support indefinitely. One-third felt they would need at least 50 percent support to continue to function.

Four centers we contacted said they thought they could go it on their own.

Interesting enough, one of the members of our panel, Dr. Portz, originally reported that he could survive with 30 percent funding. He no longer feels that way, and others have also indicated that they are changing their minds as they get deeper and deeper into this.

This survey led us to feel that we must call a national meeting. We did so, and met last month in Denver.

At that meeting, we developed a resolution which Dr. Weston has already submitted. In addition to that, we have organized so that we can begin to speak for ourselves. For a long time, people have been talking for us, and we feel it is high time that we say what our experience has in fact been.

From the beginning of my program, the Federal share was less than 50 percent, and it is now down to 39 percent. If it ever drops below 30 percent, our program will be badly crippled.

That is all I care to say at this point.

(Dr. Morrison's prepared statement follows:)

STATEMENT OF DR. DONALD MORRISON, DIRECTOR, NORTHERN WYOMING MENTAL HEALTH CENTER

A RURAL MENTAL HEALTH CENTER'S EXPERIENCE WITH THE FEDERAL COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTER LEGISLATION AND OUR VIEW OF THE FUTURE

Thank you for giving me this opportunity to address the group. I am Dr. Donald Morrison, a psychiatrist and director of the Northern Wyoming Mental Health Center. As you are no doubt aware, Wyoming has no standard metropolitan areas. Our center covers the 5-county area of Northeastern Wyoming, which is

an area of approximately 20,000 square miles. The total population of this area may be approaching 50,000 people, so that you can readily see we have a population density of just a little more than 2 per square mile. To make our mental health services readily available to the residents we established offices at the county seats. Since our personnel live in the various communities, they are readily available to the population on an informal on-going basis. All of our population is within 30 or 40 minutes drive of one of our offices.

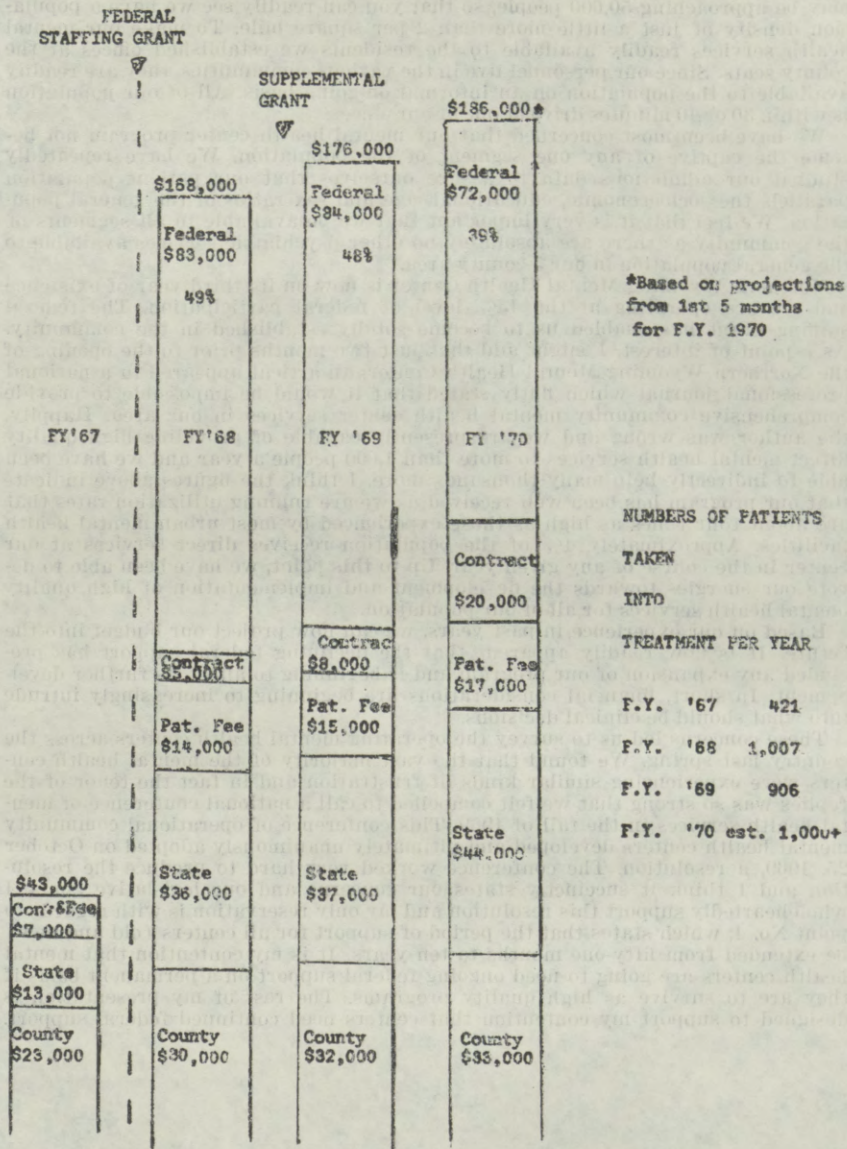
We have been most concerned that our mental health center program not become the captive of any one segment of the population. We have repeatedly studied our admissions data to assure ourselves that our patient population parallels the socioeconomic, educational, age and sex ratios of the general population. We feel that it is very important that we be available to all segments of the community as there are absolutely no other psychiatric services available to the general population in our 5-county area.

Northern Wyoming Mental Health Center is now on its third year of existence and we are operating at the 45% level of federal participation. The federal staffing grant has enabled us to become solidly established in the community. As a point of interest, I might add that just two months prior to the opening of the Northern Wyoming Mental Health Center, an article appeared in a national professional journal which flatly stated that it would be impossible to provide comprehensive community mental health center services in our area. Happily, the author was wrong and we are presently capable of providing high quality direct mental health services to more than 1,000 people a year and we have been able to indirectly help many thousands more. I think the figures above indicate that our program has been well received as we are running utilization rates that are about four times as high as those experienced by most urban mental health facilities. Approximately 4% of the population receives direct services at our center in the course of any given year. Up to this point, we have been able to devote our energies towards the development and implementation of high quality mental health services for all of our population.

Based on our experience in past years, we can now project our budget into the future. It is now readily apparent that the declining federal support has precluded any expansion of our program and is beginning to affect its further development. In short, financial considerations are beginning to increasingly intrude into what should be clinical decisions.

These concerns led us to survey the operating mental health centers across the country last spring. We found that the vast majority of the mental health centers were experiencing similar kinds of frustration and in fact the tenor of the replies was so strong that we felt compelled to call a national conference of mental health services in the fall of 1969. This conference of operational community mental health centers developed and ultimately unanimously adopted on October 25, 1969, a resolution. The conference worked very hard to produce the resolution and I think it succinctly states our concerns and our legislative goals. I wholeheartedly support this resolution and my only reservation is with regards to point No. 4, which states that the period of support for all centers (old and new) be extended from fifty-one months to ten years. It is my contention that mental health centers are going to need ongoing federal support on a permanent basis if they are to survive as high quality programs. The rest of my presentation is designed to support my contention that centers need continued federal support.

The following bar graph summarizes our financial experience to date:



A dramatic increase in the program was seen with the advent of the federal staffing grant on July 1, 1967. The staffing grant enabled us to obtain a full complement of mental health professionals by late September of 1967, and this is reflected in the numbers of patients admitted for services each fiscal year. In addition to these figures, it should be kept in mind that about one-third of the professional staff's time is devoted to indirect services such as consultation-educational programs. These services have also increased over the years. The graphs certainly tend to support the idea that federal seed money can generate a great deal of state and local support for mental health programming. As the overall program has grown, its federal participation has dropped from 49% in 1967 to 48% last

year and we project that it will be 39% for this fiscal year. The other sources of funding have steadily grown to supplant the declining federal share. Frankly, however, the situation appears to be better than it is. As the federal money declines, we are experiencing rather rapid inflation which increases our operating expenses. We also find ourselves faced with annual pay increments for our staff, increasing social security taxes, and a variety of miscellaneous expenses, all of which are constantly increasing. You may note that we actually received more federal money last year than we did during the previous year. This occurred because we hedged and submitted a supplemental staffing grant that became effective in Fiscal '69. This supplemental grant helped offset some of the factors mentioned above but it actually was merely a way of forestalling the inevitable.

The hard facts of life are that state and local funds are limited. Since Fiscal '68, the 5-counties have increased their support to our program at the rate of 5% per year. They feel that this is justifiable so that we can in some measure keep pace with our rising costs. The counties in Wyoming operate under a tax structure elaborated in the last century which clearly states that they may not levy more than 12 mills. Since funds for the mental health center come from the general revenue, there is a definite limitation as to how much fiscal support the counties can lend our program. We agree with the county commissioners that they have been carrying their share of the burden. It should be noted that the county government has not been held responsible for providing mental health services in the past. The counties have voluntarily assumed this responsibility with the advent of the community program. Likewise, the state government is now in the position of having to support the State Hospital and in addition, support community mental health programs. Initially, there was some hope that community mental health programs would reduce the admission rate at the State Hospital and thereby offset the added cost of providing community based programs. This has not in fact been the case and a study that we recently concluded of the State Hospital admission characteristics documents this fact. Our center has been providing *new* services and is not in the business of supplanting old services. In fact, we are doing a considerable amount of case finding and to the extent that we are successful in this area, we may substantially increase the state hospital's burden.

For example, our program has caused the number of alcoholics and drug addicts, referred to the State Hospital from this 5-county area, to triple in the past few years. The overall admission rate to the State Hospital from our area has actually been rather constant and this is attributable to the fact that we've been able to treat a great number of schizophrenic patients in the community and in fact, we have cut their admission rate to the State Hospital to about $\frac{1}{3}$ of what it formerly was. The important fact, is that our center has provided a wide range of new services to the community, such as marital counseling; children's programs; after-care for ex-State Hospital patients; locally based consultation and educational programs such as in-service training programs for school teachers; and a long list of other services that were previously just not available to the community. Prior to the development of this mental health center, people from our area had to travel 450 miles to Denver or even greater distances to the State Hospital to receive psychiatric services. Many just went without.

As you can see from the graph, a considerable amount of our income comes from fees and contracts. Almost all of the contract money is in affect county tax money as it is derived from contracts with local school districts, welfare departments, vocational rehabilitation, the local legal-judicial-penal systems, etc. In summary, the state and county monies outweigh the federal support for our program. Our governor, the Honorable Stan Hathaway, is well aware of these facts and has repeatedly voiced his concern whenever the federal government initiates programs which produce more tax burdens for the state and its counties. We all know that these governmental bodies simply do not have the tax base to fully support mental health programs.

As we attempt to project our experience into the future and determine how continued decreasing federal funds will affect our program, we are forced to conclude that we will be ultimately placed in the position of doing all or some of the following three things: 1) We will have to decrease the quantity of our services because we are going to be forced to lay off some of our professional staff. 2) We will find it necessary to compromise the quality of our program, in that we will have to stop providing services which are less profitable. In short, we will have to concentrate our efforts in areas that are more lucrative

and abandon some of our preventive mental health programs for which there may be little or no immediate financial return. 3) We will be forced to increase our fees for services, which will ultimately squeeze out the lower and lower-middle class clients as they will be unable to afford our services. Our professional staff and our board of directors unanimously agreed that all of these alternatives are unacceptable.

In summary, I recommend that the Federal Government support comprehensive community based mental health programs indefinitely. This support should never fall below the 30% level and in some poverty areas it will need to be maintained at considerably higher levels.

Dr. WESTON. Our next speaker will be Dr. Alex Portz, who is director of the Appalachian Mental Health Center, and can speak to the problems of rural poverty areas.

STATEMENT OF DR. ALEX PORTZ

Dr. PORTZ. Mr. Chairman, as director of the Appalachian Mental Health Center—first of all, I am a clinical psychologist.

This center is in West Virginia. It serves 10 rural and mountainous counties. It is a widespread area, and we have more than 5,000 square miles, with tremendous problems of transportation and their cost.

We are a small program in budget of about \$250,000, although it would cost \$400,000 to really mount the program we feel is appropriate to the region and realistic for the region considering the fact that it is a poverty area which cannot be flush with expensive programs. It would still cost about \$400,000 to mount a good program.

Let me digress on the philosophy of mental health centers for a moment before going into the problems of financial support. I think the philosophy of locally provided treatment, prevention and rehabilitative services has proved itself, but the hope that this could be done in 51 months has proved unrealistic, for these reasons.

One. Most areas, especially poverty ones, do not have the know-how to develop a program plan and a program adapted to the region even in the first year or two. They flounder around. This is an argument for the initiation and development grant.

Also, achieving or obtaining the appropriate staff is something that takes time, especially in poverty areas. Lay boards are unable to select and screen out staff who can do the job in a year or two.

Thirdly, the development of a realistic level of local and State support, which is naturally related to community education and to appropriate political involvement, cannot be done in a year or two, especially in areas where there were no previous mental health services, as there were not in our area.

These are the tasks, these three things, and I think experience has proved they are not accomplished in 51 months.

In our program, even in the first year, the amount of Federal support was 75 percent of staffing costs, and only 61 percent of total costs. Even at that, we ended up with a \$5,000 deficit of local funds for operation and matching of salaries.

So even in the very first year in the poverty area, we were unable to achieve what we could have done. In the second year, the deficit went to \$16,000, or about 9 percent of the total operating costs, and in the third year it amounted to 23 percent of the total cost, or \$59,000.

We are in the fourth grant year now, and we mounted an intensive campaign to cover the deficit from every local and State source, and

we are on the way to doing so partly through a special grant from the Governor of \$60,000.

The State legislature has not come through with adequate support. County government does not have the tax base to do it. I won't elaborate on this, because it is in my prepared statement, and I don't want to take time on that but the realistic level of support in this area of Appalachia, which I think is duplicated in other areas of Appalachia, requires Federal support in order for the comprehensive program to survive.

At one time I thought 30 percent continuing Federal support will do it, but I have changed my mind because the other resources are not coming through, and will not in the foreseeable future.

So, I think a staffing grant formula for poverty areas needs to be up to 90 percent of first 2 years, 75 percent the next few years. This would give us stability for really accomplishing the realistic level of state and local support, and the next time this comes around for consideration for extension, of course, the Congress will have to judge what is a realistic level for poverty areas.

I do have some comments I would be prepared to make on five or six of the questions previously raised, but I will reserve those so that everybody has a chance to speak.

(Dr. Portz's prepared statement follows:)

STATEMENT OF ALEX T. PORTZ, PH. D., DIRECTOR, APPALACHIAN MENTAL HEALTH CENTER, ELKINS, W. VA.

Mr. Chairman I wish to speak of the program and financial needs of community mental health centers in Appalachia and do so from the vantage point of nearly two years as program director at the Appalachian Mental Health Center in West Virginia and 15 years as educator, staff member, state consultant or board member in community mental health programs in Minnesota and Michigan.

The financial plight of the Appalachian Mental Health Center is an example of problems common to almost the entire state of West Virginia, to many areas of the other ten Appalachian states, and to rural poverty areas in other states.

The Congress based its "bold, new approach" of the Community Mental Health Centers Act of 1963 on hope and on the philosophy that comprehensive services provided locally are a better means of prevention, treatment, and rehabilitation than custodial care in distant institutions. I believe the philosophy has proved itself and is still relevant. However, the hope that this program could be seeded and left on its own after 51 months has proven unrealistic.

Seeding implies three things at least: developing a program plan adapted to the region, finding the proper staff, and achieving a realistic level of local and state support based on community education and appropriate political action.

Now in its fourth grant year the Appalachian Mental Health Center is still in the seeding stage. Even the seeding has been held back by lack of adequate funding. For the past year our Center has been forced to compromise program development for which it was ready to turn away qualified candidates for vacant full-time positions for lack of funds.

I would like to comment on these three seeding tasks briefly. First, a program plan adapted to the region. In many potential catchment areas the know-how for developing a sound plan is lacking. The provision in the proposed legislation for initiation and development grants appears to me to be a sound one.

Secondly, while it has proven true that professional staff can be attracted to rural poverty areas if paid adequately, it is also true that lay boards often lack the skills necessary to evaluate prospective staff. It may take years to screen and find those who can do the job. Here again the proposed initiation and development grant could help reduce costly mistakes.

The third seeding task requires the most consideration, namely the achieving of a realistic level of local and state support based on community education and appropriate political action. What, for example, is a realistic level of local and state support in West Virginia and particularly in the ten counties we serve at this time? Our experience has proved that a realistic level is far below that required by the present staffing grant formula. Let me give some figures and then draw my conclusions.

The Appalachian Mental Health Center serves ten rural mountainous counties. The territory is large, 5,750 square miles or somewhat smaller in size than New Jersey. The 141,000 population is scattered with an average of 24 per square mile compared to New Jersey's 770 per square mile. Our current program costs about \$250,000 although the program we feel is needed and realistic would cost about \$400,000 a year. Thus we are a small program in staff numbers and budget but large in geographic area and problems to be met. When the Center was established 3½ years ago there were no identified mental health services in its service area. Either there were haphazard means of coping with prevention, treatment, and rehabilitation or the drastic step of extruding a person to a state mental hospital as much as 150 miles distant. Our Center has made services accessible locally with resident staff and traveling teams serving each of ten county seats. Several of these local offices are more than 60 miles distant from the central office requiring three hours of staff travel time daily over difficult mountainous roads. It is easy to see that transportation costs and the cost of staff travel time are enormous. This is added reason to consider including total operating expenses in the grant formula.

Let me return to the question of what is a realistic expectation for local and state financial support.

In the 1st grant year there was only 42.3% utilization of the staffing grant award, the low utilization due more to lack of staff than to lack of funds. Nevertheless, there was a \$5,616 deficit which was 4% of the \$161,000 program cost. The staffing grant formula was of course 75% of eligible salaries and fringe benefits. That 75% shrunk to 61% of the total operating cost.

In the 2nd grant year there was 71.7% utilization of the staffing grant award but the deficit for the year increased to \$16,719 or 6.9% of the \$245,665 program cost. State Department of Mental Health efforts to obtain legislative appropriations for community mental health programs failed and the future looked bleak. The staffing grant formula of 63.75% ended up as 55.0% of program costs. Philanthropic foundations were not interested in supporting an on-going program.

The 3rd grant year was bleak. Staffing grant utilization dropped to 66.3% in a \$265,506 program. A \$59,719 deficit or 23.0% of operating costs became an emergency issue. The staffing grant formula of 48.75% reimbursement was only 34.1% of program costs. State legislative support was again denied.

We are in the fourth grant year now and have made valiant efforts to maximize local and state support including a substantial one-time grant from the Governor. Nevertheless, we have had to cut program drastically in order to have operating cash. The staffing grant formula of 33.75% is expected to yield no more than 22.1% of operating costs. A staff of 35 in April, 1968 had to be reduced to 23 by September, 1969. The legislature came through with token support for community programs from which we were initially allocated \$53,838 or 20.0% of anticipated costs in our drastically reduced program.

What are the possibilities for developing non-federal support? First, can fee income be increased? When this Center was in its organizational state (March 1968), program planners estimated that private pay revenue in the first year of operation would be \$184,457. Even a year later fee collections were projected to be \$45,244, \$80,595, and \$93,132 for the first three years. In reality they were \$6,330, \$11,920, and \$16,006 or only 15% of what was projected. Fee income from all sources (patient, insurance, welfare, vocational rehabilitation, medicare) was 4.5%, 4.9%, and 6.2% of program costs in these three years. How do we explain this? There are many reasons for this minimal support from fees.

(1) Insurance companies in West Virginia generally exclude mental health services except inpatient care from their coverage.

(2) Although medical assistance is supposed to be included for families receiving welfare assistance the vast majority of our mental health services to welfare families is in practice excluded from reimbursement, probably reflecting the same attitudes as are evident in insurance exclusions. In Fiscal Year 1968-69 20% of our referrals for direct service were welfare clients. Yet we received only \$2,416 from welfare payments or less than 10% of the cost of service given.

This occurred despite the fact that in other circumstances there is sometimes overutilization of medication and doctor visits by medical assistance clients.

(3) A large percentage of community services are being given for which no fees are assessed. In the six month period January through June 1969, 8,777 service contacts were recorded, over half of these being in the areas of consultation and education where no fees are charged. Generally people expect charges only for psychotherapy and psychiatric or psychological evaluations. These are the minority of direct services rendered to families by the Center.

(4) A large number of medically or psychiatrically indigent persons are served by the Center. (See Table I). They are therefore charged a minimal fee if any at all under our sliding fee scale system. We checked the distribution of gross family income for the first 50 cases opened after July 1, 1969. One half or 25, including 14 clients on welfare or social security, had gross family incomes of less than \$200 per month; 21 had incomes between \$200 and \$500 per month. Only 4 had incomes between \$500 and \$1,000 per month. If they had families even these four might not be able to pay the full cost of service. Thus 46 out of 50 cases fall into the indigent or medically indigent categories. West Virginia has no Medicaid plan except for welfare clients.

Another source of non-federal support is philanthropic giving. Our region does not have a tradition of philanthropic giving. The two united funds located totally within our ten counties are struggling to survive on budgets of less than \$50,000. The Center initiated fund raising efforts in October, 1968. Donations were meagre. Fund raising efforts continue but will not establish a tradition of giving soon enough to solve the financial problem of mental health support.

A final source of non-federal support is tax monies from local and state governments. Local governments do not have the potential for much more than the \$56,900 now appropriated for the Center program. This limitation is due to restricted taxing power and to a small tax base related to the existence of extensive national forest lands in the area, to the relative absence of industry, and to the poverty of the region.

Until there is extensive revision of the constitution and tax structure in West Virginia it is unlikely that the state legislature can provide more than \$1.00 per capita to community mental health programs. In the current year the state provides 16.6 cents per capita statewide. Even \$1.00 per capita would be inadequate support of a comprehensive program without continuing and increased federal staffing support.

All of these non-federal sources add up to inadequate matching monies for the federally sponsored comprehensive community mental health program. What is to happen in West Virginia and in the nation if the staffing grant formula is not increased for poverty areas?

Will those areas most in need of community mental health services be effectively frozen out because they know they cannot afford them?

Where programs have been established are we to revert to a system of state hospitals for the poor and high priced clinics for the upper classes?

Will we see an increase in avoidable family tragedies wherein a person deteriorates and has to be hospitalized because he cannot afford the \$20 to \$30 per month which psychotherapeutic drugs cost?

Will we see other persons deteriorate because the cost of transportation to a weekly day care program is not available?

Will we see the readmission rate to state mental hospitals soar?

Will we see preventive educational and consultative program elements throttled and choked because they are not fee producing and cannot support themselves?

This brings me to some recommendations which I respectfully make to this Committee:

(1) Extend the staffing grant period for all Centers to at least 8 years. More seeding time is needed.

(2) Extend the staffing grant coverage to all personnel and in poverty areas to total operating costs.

(3) Authorize full cost grants of one years duration for initiation and development of a mental health center program in poverty areas.

(4) And most importantly, provide preferential matching in poverty areas for both existing and new centers. Whatever formula is adopted our experience would indicate that the first two years should be at the 90% level. Seventy-five percent for the next eight years would provide stability but there is a good deal to be said for a gradual reduction. It is a legitimate expectation that the level of local and state support will build up.

In summary, my testimony has documented the claim that poverty areas are extremely unlikely to be able to achieve the level of local and state financial support required by the present staffing grant formula. We believe in the goals of comprehensive community services for all Americans. Therefore we urge the Congress to extend the basic law, to provide for initiation and developmental grants to launch a new center in a rural or urban poverty area, and especially to establish a higher matching formula for staffing grants to centers serving poverty areas.

I thank you for hearing me and will be pleased to answer any questions from the Committee.

APPALACHIAN MENTAL HEALTH CENTER, ELKINS, W. VA.

TABLE I.—GROSS FAMILY INCOME OF 50 PATIENTS ADMITTED SINCE JULY 1, 1969

Monthly gross family income	Number of cases	Employment	Sources of income				None
			Farm	Social security or pension	Child support or alimony	Welfare	
None	5						5
Under \$50	7	1		2	1	3	
\$50 to \$99	5	1		3		1	
\$100 to \$149	3	1		1		1	
\$150 to \$199	5	1	1	1		2	
\$200 to \$249	7	3	1	1	1	1	
\$250 to \$299	1	1					
\$300 to \$399	5	5					
\$400 to \$499	8	6	1		1		
\$500 to \$599	0						
\$600 to \$699	2	2					
\$700 to \$799	1	1					
\$800 to \$899	0						
\$900 to \$999	1	1					
Over \$1,000	0						
Total	50	23	3	8	3	8	5

Source of referrals:	
Welfare	13
Family	11
Self	5
Physician	5
Vocational rehabilitation	4
Schools	4
Ministers	2
Friends	2
Courts and law	2
State hospital	1
Community action	1
Total	50

Dr. WESTON. Our next speaker is Dr. Hiawatha Harris, from the Watts area of Los Angeles. He can speak quite specifically to the problems of ghetto type centers.

STATEMENT OF DR. HIAWATHA HARRIS

Dr. HARRIS. Thank you. Mr. Chairman, I am also the chairman of the American Psychiatric Association's task force on poverty, so I am your poverty man.

I think that perhaps the one thing that should be emphasized as far as urban and rural poor areas is the question of survival, and this is a problem that we have had since our inception.

We have been touted by the National Institute of Mental Health as one of the model programs for a community mental health center, but at the same time, we are also in danger of going under because we cannot find operational funds to continue at a certain level, and this is our major problem.

Everybody else is talking about 30 percent support, but I am for 100 percent support if necessary in order to keep a meaningful program going.

Prior to the area in which we operate, there were no health services of a different sort, run by the county, with more emphasis on indirect services rather than direct services, and since we have been in there, we have been able to stimulate the county to change their treatment policies and at the same time continue to allow us to do the treatment.

I think I can answer a lot of the questions that Mr. Rogers had concerning the coordination of OEO programs and Model Cities programs, and I would be glad to do that.

The other things is, as you know, especially in areas like Detroit and Watts where there have been no mental health services, and where there have been major uprisings, the land valuation has gone up, so land becomes a prohibitive factor as far as being able to develop construction of community mental health centers.

The matching funds I have already spoken to, and I will answer questions to that.

I think the other things we are particularly concerned about are the evaluation aspects of the program, which have not been spoken to, evaluation, research, whatever.

We feel some applied research funds or money should be set aside so we can get a better idea of what we are doing and what our services are.

We serve some 300 outpatients a month, and I think that sort of speaks for the acceptance as far as the community is concerned of community mental health centers.

I am also from a State where we have the largest number of community health centers, and a city which has 12 and in which we banded together in a council to try to talk to new ideas concerning our work.

Dr. WESTON. Mr. Raymond Ramirez is from Illinois and will be our next speaker. He is from Quincy, Ill., and his operation covers an area of five counties.

STATEMENT OF RAYMOND RAMIREZ

Mr. RAMIREZ. Mr. Chairman, my name is Raymond Ramirez. I am a social worker.

We have one large city of over 50,000, and yet the entire five-county population is 128,000. We serve an area of 3,233 square miles.

I would like to make several important points. Number one, we have completed recently our second year in this program. It is my feeling that the extension of the grant should be continued at a 30 percent level, and this should be at the total budget of the program.

To give you some example, in terms of our present financial picture 34 percent of the budget comes from Federal funds, and this is at a time when we are receiving 60 percent of staffing costs through the Federal grant.

You can see that, as we phase out the end of the 5-year period we will be receiving somewhere around 18 to 20 percent of our total budget.

Two other points I would like to make are that with our particular area the idea of providing patients with continuity of care is a particular issue. In order to do so, we have five clinics in operation, one

in each county, which must be operated and staffed. Travel distances are between 120 miles to 75 miles to provide services to patients who are at State hospitals or who are at our community hospital.

We believe strongly that this is an important facet of our program to provide patients with contact from the community and keeping relatives informed as to the condition of patients at State hospitals, and to plan for their return to the community at the earliest possible date.

We have seen a drastic reduction in the number of days of hospitalization within a State hospital as a result, not only of our program, but as a result of our programs contact with the State hospital superintendent and in planning for programs at the State hospital system.

Again, I would like to refer to a point made earlier about services to children. Forty percent of the patients served in our comprehensive center within the five counties are children under the age of 21.

I have also submitted for your committee's review a copy of testimony concerning our program.

Thank you very much, Mr. Chairman.

(Mr. Ramirez's prepared statement follows:)

STATEMENT OF RAYMOND RAMIREZ, DIRECTOR, MENTAL HEALTH AUTHORITY FOR WEST CENTRAL ILLINOIS

Mr. Chairman and members of the committee, the mental health authority for west central Illinois opened on December 1, 1967, is a comprehensive center compact serving five counties, Adams, Brown, Hancock, Pike, and Schuyler. We are bordered by two rivers, the Mississippi and the Illinois Rivers, by two States, Missouri and Iowa. The area is primarily rural with the exception of Quincy, which has a population of 50,000. The population of the entire five counties is 128,000. (1950). The five county area consists of 3,233 square miles. The longest distance between two points of service is 120 miles. (Carthage-Springfield). Our area is a dichotomy in the large city of Quincy with more than 40 industries (more than in the other four-counties combined) and the high rate of public assistance in the other four counties. The percentage of unsound housing for the five-counties ranges from 30.2 percent to 49.2% (state average 22%). (1) Population for the aged is significant ranging from 13.9% to 15.6%, well above the State and National averages of 9.7%.

Families with income under \$3,000, ranges from 24.5% in Adams, to 49.2% in Brown.

The suicide rate in Adams County is (21) per 100,000 population in Adams, and 20.2 in Pike. Total eight homicides, four occurred in Hancock County. Yet the difference between our area and urban America is that the poverty is more difficult to notice, the poor do not live in close proximity to each other and in general provide little or no leadership of their own. These are some of the factors under consideration in planning the comprehensive community mental health center.

THE COMPREHENSIVE COMPACT SERVICES

The comprehensive compact made up initially of four (4) major agencies—the Mental Health Center of Quincy, St. Mary Hospital of Quincy, Jacksonville State Hospital, and the Andrew Macfarland zone center

Before describing the existing services let me briefly review services prior to the comprehensive center. Services were very limited.

Outpatient services

Consisted of the two part-time psychiatrists, whose treatment philosophy was long term psychotherapy aimed at changing personality. Two social workers, one full time psychologist, working primarily in Adams County. Brown, Hancock, Pike and Schuyler counties had no services.

Inpatient services

Consisted of long term care to adult patients at Jacksonville State Hospital, primarily a custodial institution with an average length of stay over 2 years. There were no 24 hour emergency programs. No inpatient services for children, or adolescents. Limited consultation and educational programs.

AFTER TWO YEARS OF OPERATION WE HAVE THE FOLLOWING SERVICES

Outpatient—Adams County

The Adams County mental health services are located in a two story building owned by the local mental health association—A donation by local citizens. Two part-time psychiatrists (Recruiting for a third). Three full time, and one half-time social workers. Two full time psychologists. One full time and one half-time nurses. One full time educator. The philosophy of service has changed to short-term crisis intervention and groups which include group work for children, adolescents, adults, and those for relatives in various other parts of the compacts services.

Brown County

Services are located in the educational building of the 1st Christian Church in Mount Sterling.

Part-time clinic consisting of a half-time psychologist, psychiatric nurse, and mental health worker with nursing background. Services include socialization groups for elderly patients and community people (the elders consist of more than 16% of the population), in addition to the usual groups and individual treatment available.

Hancock County

Initial services were provided out of an extra room at the hospital in Carthage, with the secretary out in the hall. Present services are located in a group of offices newly refurbished.

Program consists of full-time social worker, R.N., part-time psychologists, and psychiatrists, and a community worker. Specialized services include services of a pediatric neurologist on a monthly basis.

Pike County

Services are located in offices above two local physicians in Pittsfield which are donated rent free by the two local physicians. Services are offered by a full time psychologist, part-time social worker and part time psychiatrist, part-time nurse, providing short-term treatment, group and family therapy.

Schuyler County

Services are located in Culbertson Hospital in Rushville. The team of psychologist, nurse, and mental health worker serving Brown County also serve Schuyler County. Culbertson Hospital in Rushville also provides services to the General Hospital.

Inpatient services—Community services

At St. Mary Hospital, Quincy—A 20 bed psychiatric unit, provides emergency and short-term treatment for patients from the five county area—our first line of defense in hospitalization. Most hospitalizations occur at St. Mary. Average length of stay has varied between 15–17 days, provides better contact with relatives, community, and despite our educational efforts much easier for the patient to have been at St. Mary than at "The State Hospital."

Adolescent unit at Jacksonville State Hospital

Staff made possible through the comprehensive compact has provided an educational milieu with specific emphasis on problems of the teenager and a program designed to meet the individual needs with a daily activity program.

This has also reaped other benefits as we became more involved in the State hospital programs we have been able to effectively change the philosophy of the program and provide more professional services to the programs.

Children's inpatient services

Special services for children at the Macfarland Zone Center. A program designed for young children up to age 13. The program serves more than our five county area.

(1) We have had some particular problems in the overall program. One, distance from each of the five mental health centers range from 120 from Carthage (Hancock) to 75 miles from Mount Sterling in Brown. Thus a communications gap occurs. We have attempted to deal with this by telephone conferences between staffs, a costly operational expense but vital to our program as well as regular visits on a monthly basis.

Partial hospitalization services

A day care program serving 30 patients daily with a time limit of 90 days with emphasis on occupational therapy, group therapy. A rehabilitation workshop serves 100 daily. Provides a variety of work-like experiences, the emphasis on helping the patient relate to a work setting designed to help him with his problems, we work closely with local industry to provide on the-job-training and during the past year placed 24 in responsible and self-supporting positions.

Adult long-term care at Jacksonville State Hospital has changed greatly—enhanced by its involvement with the center.

(2) An example is that the board of the mental health authority and the director meet with State hospital superintendent and staff to review programs, procedures, and planning on a regular basis bring greater community involvement and program planning relating to community needs.

The average length of stay during our 2 years of operation is 60 days for new patients. Treatment and planning for patients from our area has been made more effective. As the out-patient staff from each county visits the hospital on a weekly basis to review new admissions, treatment, discharge planning, keep families in touch and provide avenues for continuity of service.

The 24 hour emergency program is built on a suicide prevention service as the rate of suicide in the area is extremely high more than twice the national average in two counties (Adams, Pike) the service is a basic telephone answering program utilizing the mental health professionals in our program and also other professionals from the community. During the last year of operation 136 telephone calls were received: 41 had their chief problem a suicide threat, 56 had another type of psychiatric emergency, 13 had alcoholic problems, 13 needed other social service information, 9 information only, and 4 prank calls. While in only two cases are we sure we have prevented deaths, the major purpose of the program is to provide another avenue for people to receive service in a crisis situation. Consultation and educational programs have grown most in our short span of operation, but also requires the most difficulty, as most agencies and individual professionals such as doctors, teachers, and ministers would prefer to simply "refer" the patient to mental health for services. However, through education programs, regular seminars with ministers, guidance counselors and other agency staffs, this requires a great deal of staff time and incidentally does not produce very much if any revenue.

Educational services are changing initially and on a continuing basis we will tell about services and how to reach them. One additional emphasis is on changing the concept of mental health treatment and awareness of stressful period in a lifetime and to prepare oneself for problem-solving situations.

FUNDING A COMPREHENSIVE MENTAL HEALTH PROGRAM

The funding of a comprehensive mental health center is as complex as the services we offer. During the first critical years of the program financial stability is very important. Yet when we received 75% during the first year of funds for professional and technical staff this amounted to only 34% of our actual expenditures. 27% came from State and local government funds. (In each county local governmental bodies contributed to the center); 36% came from fees for services with more than 25 percent coming as a result of in-patient service; only 11% coming from out-patient and education and consultation services; 3% of cost came from fund raising agencies such as united fund and county wide drives (Pike) to support local services. This was a year when we anticipated the highest federal support. During the second year the program grew and we have hired additional staff, the result was a one-third growth in professional and technical staff (from \$214,769 to \$344,870). In the second year during which the federal share of staffing is at the 63.75 percent. We found tremendous increase in the program due to: 1) a better evaluation of the services, more demand for specific services, better organization, planning, and recruitment. The overall budget for the year 1968-1969 was \$649,710, with \$344,870 for staffing of which

we are receiving: \$219,853 through the grant (63.75%). This represents 34% of the total budget; 27% of budget comes from State and local government sources and a decrease in funds from services to 33%, a loss of 3% or (\$19,000). Funding drives, united fund, etc., were able to pick up differential cost.

RESOURCES FOR FUTURE FUNDING IN ILLINOIS

In Illinois we have two basic means of future support.

(1) State grant-in-aid, a program of the department of mental health to help local communities provide mental health services by matching local funds.

(2) Permissive legislation. Illinois H.B. 708, community mental health facilities and services act, permits that counties may tax themselves up to 1% for mental health purposes, but it is permissive and a referendum must be passed in order to receive these funds. Thus far in Illinois 31 referendums have been successful, 11 failed providing tax monies to 28 counties, 2 cities, and 1 township.

In our area during our two years of operation we have conducted 3 referendums, and successfully passed two. (Hancock and Brown passed, failed in Adams).

PROGRAMS FOR OUR FUTURE

The future of the mental health authority in west central Illinois is marginal. We recognize that without firm financial support we cannot grow to meet new demands for services to the alcoholic or mentally retarded, nor in fact can we survive. We have successfully passed two referendums but need to pass three more. Time is an important factor. Will we have time to successfully pass new referendum in the other counties? (Scheduled for 1970) And even if successful funds will not be available for another year. We are currently entering our third year. Funds will be even less available. Can our program make sufficient impact within order to survive? Even so with the current attitude on taxes, can we base our hopes on successful passage? With continued help from the Federal Government we can have adequate time to both provide services and to plan in a realistic manner to provide new services.

RECOMMENDATIONS

ALL AREA CHECKED

1. Higher funding rates for the first two years of operation, based on our experience, operating expenses in rural areas are higher, salaries, fringe benefits must attract competent personnel. Mobility is important and costly, communications is expensive. The need for funding of full programs should be considered.

2. Special non-revenue producing services (education and consultation) should be funded at a higher rate.

3. Research and in-service training are essential. If we are to know why we are successful or have failed, and to effectively evaluate services—these are most difficult to provide in a semi-rural area. Monies must be spent on services.

RESOLUTION

1. The support levels in non-poverty areas be no less than seventy-five (75) percent during years one and two, sixty (60) percent for year three, forty-five (45) percent for year four, and thirty (30) percent for the years five through ten.

2. Full cost grants of one year duration be made available for initiating and developing mental health center programs.

3. Support levels in poverty urban and rural areas be increased to ninety (90) percent during the first two years and seventy-five (75) percent for years three through ten.

4. The period of support for all centers (old and new) be extended from fifty-one (51) months to ten (10) years.

5. All personnel working in community mental health centers be eligible for federal support.

6. Indirect services of consultation and education be funded at a higher Federal participation percentage than direct services in any given support year.

7. Research and evaluation be funded at the 90 percent level for the duration of the grant period.

8. The community mental health center legislation (Public Law 88-164 as amended) should be extended 5 years.

9. Increase levels of fiscal authorization be supported.

10. The centers' programs receive full funding: i.e., the appropriation matching the authorization.

11. Special programs in alcoholism and drug addiction be supported at no less than ninety (90) percent for the first 2 years and 75 percent thereafter.

12. Training and evaluation grants for alcoholism programs be supported at levels indicated above.

13. Children's programs be encouraged with Federal support and integrated into community mental health centers as appropriate.

14. The acquisition of land for community mental health centers and architects' fees be included in eligible construction costs.

15. The level of the states' allotment for administering community mental health center construction plans be increased from 2 to 5 percent.

FINANCIAL STATEMENT, MENTAL HEALTH AUTHORITY, WEST CENTRAL ILLINOIS, DEC. 1, 1967-NOV. 30, 1969

Service	1967-68	1968-69
Inpatient.....	\$106,154	\$132,644
Outpatient.....	53,128	44,945
Partial hospitalization.....	25,188	46,559
Emergency.....	7,918	31,661
Education and consultation.....	12,155	57,709
Total, plus 10 percent fringe.....	214,769	344,870
Other personnel and operating expenditure.....	262,513	304,840
Total budget.....	477,282	649,710
Federal grant 89-105 (34 percent).....	161,077	219,853
State and local grant (27 percent).....	128,866	175,421
Services.....	¹ 171,821	² 214,404
Fund raising.....	³ 15,518	⁴ 40,043
Total (100 percent).....	477,282	649,710

¹ 36 percent.

² 33 percent.

³ 3 percent.

⁴ 6 percent.

STATISTICAL REPORT, MENTAL HEALTH AUTHORITY FOR WEST CENTRAL ILLINOIS, DEC. 1, 1967-AUG. 31, 1969

I. OUTPATIENT

	Number of patients	Interviews	Collaterals	Consultation	Educational
Adams.....	3,456	31,376	-----	600	-----
Brown.....	42	502	-----	190	-----
Hancock.....	200	806	-----	400	-----
Pike.....	215	864	-----	75	-----
Schuyler.....	48	470	-----	216	-----

II. INPATIENT

Children:	
Andrew McFarland Zone Center admissions.....	18
Average length of stay (months).....	4
Discharged.....	12
Adolescents and adults:	
Jacksonville admissions.....	276
Average length of stay per admission (days).....	60
St. Mary Hospital admissions.....	590
Average length of stay (days).....	16.7
Discharges.....	570

III. PARTIAL HOSPITALIZATION

Day program—workshop:	
Admitted.....	250
Discharged.....	150
Average length of stay:	
Days (day care).....	80
Months (workshop).....	5
Placed in productive employment.....	71

JACKSONVILLE STATE HOSPITAL

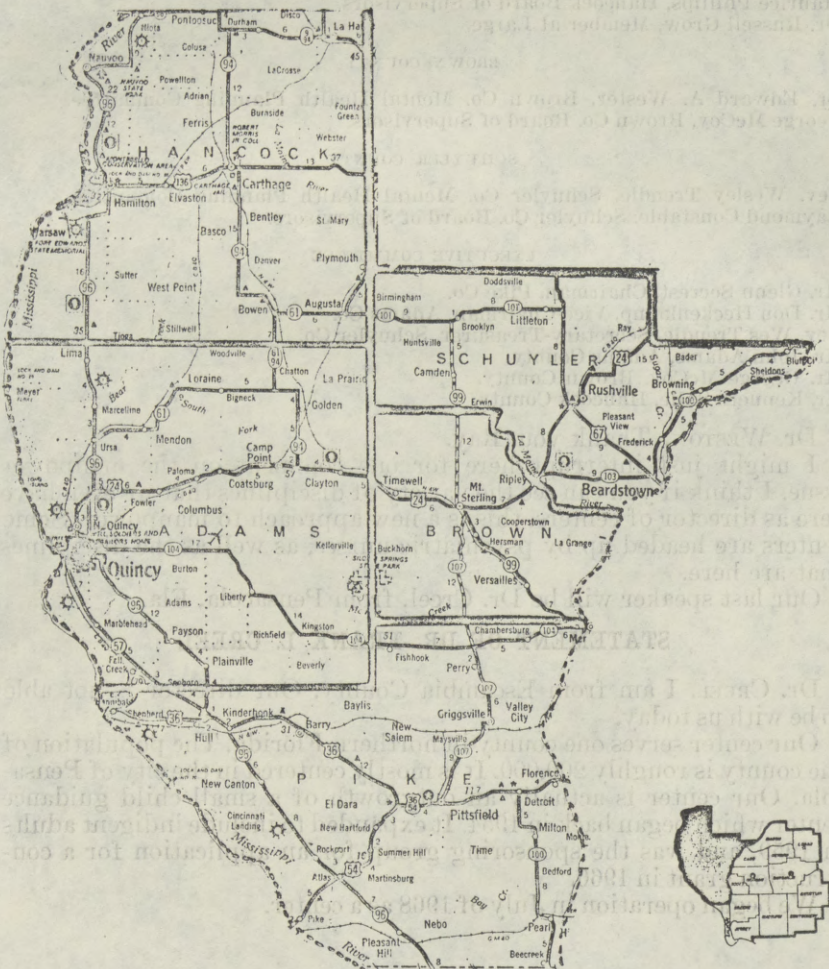
Population by county	1966	1969
Adams.....	190	123
Brown.....	14	7
Hancock.....	66	21
Pike.....	58	26
Schuyler.....	22	4
Total.....	350	181

Emergency services:	Total calls
Suicide related calls.....	41
Other psychiatric crisis.....	56
Alcoholics.....	13
Other social service.....	13
Information.....	9
Prank.....	4
Total.....	136

MENTAL HEALTH AUTHORITY

FOR

WEST CENTRAL ILLINOIS



LIST OF BOARD OF DIRECTORS OF MENTAL HEALTH AUTHORITY FOR WEST CENTRAL
ILLINOIS

ADAMS COUNTY

Vic Cory, Adams County Mental Health Assn.
Judge J. Ross Pool, Magistrate Judge Family Court.
Earl Hudson, County Superintendent of Schools.
John Mast, Board of Supervisors.
Don Heckenkamp, Quincy City Council.
John Norris, Industry.
James Nauert, Labor Relations Machinist Local.
John Adams, Attorney.

PIKE COUNTY

Thomas Hillebrenner, President Pike Co. Mental Health Assn.
Dr. Myer Schulman, Physician.
A. W. Schimmel, Jr., Attorney.
Glenn Secrest, Board of Supervisors.

HANCOCK COUNTY

Jerry Nutt, Sr., Hancock Mental Health Assn.
Kenneth Sallee, Special education Hancock County.
Maurice Phillips, Hancock Board of Supervisors.
Dr. Russell Grow, Member at Large.

BROWN COUNTY

Dr. Edward A. Wester, Brown Co. Mental Health Planning Committee.
George McCoy, Brown Co. Board of Supervisors.

SCHUYLER COUNTY

Rev. Wesley Trendle, Schuyler Co. Mental Health Planning Committee.
Raymond Constable, Schuyler Co. Board of Supervisors.

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Dr. WESTON. Thank you, Ray.

I might just interrupt here for one comment on the manpower issue. I think if you can see the variety of disciplines that we even have here as director of centers, this is a new approach to manpower. Some centers are headed up by psychiatric nurses, as well as the disciplines that are here.

Our last speaker will be Dr. Creel, from Pensacola, Fla.

STATEMENT OF DR. FRANK L. CREEL

Dr. CREEL. I am from Escambia County. Our director is not able to be with us today.

Our center serves one county in northern Florida. The population of the county is roughly 200,000. It is mostly centered in the city of Pensacola. Our center is actually an outgrowth of a small child guidance center which began back in 1954. It expanded to include indigent adults in 1959, and was the sponsoring group for an application for a construction grant in 1966.

We began operation in July of 1968 as a center.

I won't go into all the statistics, but a few, I think, are pertinent. In the first year, we served 1,105 families. 10,508 outpatient appointments, and of these, 27 percent of the cases were people who paid no fees for the services they received. Seventy-seven percent came from families who made less than \$6,000 a year.

We do care mostly for people who couldn't afford private care.

There are several points I would like to make. One is the tremendous variation in centers across the country, which is more and more apparent to me as I have visited other centers, and as I have got together with some of the directors from other centers, and this makes a tremendous difference when you consider financial support.

Many centers started from scratch, and this makes a lot of difference in that regard. My center, with this background, has what I think is a reasonably healthy local support, but even so we would find ourselves in a very difficult situation indeed if the Federal support was phased out entirely at the end of a 51-month period.

In line with our present need for Federal assistance, if we were to continue to use the innovative services that we offer, or to expand these services, Federal support would be an absolute necessity.

Our projected part of the Federal part of operating expenses for this year is 37 percent.

So, it seems to me that a 30-percent minimum level as a continued Federal level for funding of total operations would be adequate.

I do want to make a brief pitch here for a particular problem we have, and that is a matter of consultation and education, and the problem is this: In our community, we do a tremendous amount of this, and 1,531 hours were spent last year in this endeavor. The reason I am speaking for it is that by getting more involved in it we see an even greater need for it.

We help people, but we still are missing a large number of what we consider high-risk groups. In our county we are still not touching a large number of the very poor people. Very few of the drug abuse population. We haven't, even though we do a lot of consultation work with the schools, we have not begun to dent the number of disabled children who come in as behavioral disturbances of one sort or another. These groups are not adequately served.

The consultation program in many ways approaches the same importance as do direct services. This is particularly true, I think, as we are all aware of the acute shortage of mental health professionals.

We do reach a lot of children, but the many we don't reach is substantial.

It is obvious to me without some continued Federal support we couldn't expand and in some areas couldn't provide the services we should to a significant degree.

(Dr. Creel's prepared statement follows:)

STATEMENT OF FRANK L. CREEL, M.D., COMMUNITY PSYCHIATRIST, COMMUNITY MENTAL HEALTH CENTER OF ESCAMBIA COUNTY, INC., PENSACOLA, FLORIDA

Gentlemen: I recognize the importance of the mental health legislation which has been introduced and the profound effect it can have on both existing and planned community mental health center programs. I appreciate the opportunity to be with you. I do regret that Dr. Morris Eaddy, Director of our Center, is not able to testify. Other matters related to our Center program made it impossible for him to come and he has asked that I present to you our view of the pending legislation (and most probably the viewpoint of most other directors of com-

munity mental health centers in the State of Florida). Both Dr. Eaddy and I have had frequent opportunity to talk to other Directors in Florida concerning the mental health programs in various communities and share experiences in program development. We have found that we have many areas of mutual concern.

Let me preface my remarks by stating that it is my observation that community mental health programs—while attempting to accomplish essentially similar goals—differ markedly from one community to the next. Some communities started their programs from scratch. They recognized the enormous need for mental health services and initiated these services with the assistance of Public Law 88-164 and Public Law 89-105. In many cases these new programs have developed rapidly and somewhat on the basis of faith—a faith that adequate local and state funds could be cultivated in the first few years to permit the program to continue as federal funding phased out. Other programs have developed from the expansion of previous mental health programs which had existed for a number of years but offered limited and traditional services. Such was true in the case of Pensacola.

I will tell you a little bit about our particular program, for I feel our Center has developed under quite favorable circumstances and our experiences in our new program have thus far been quite positive and reassuring. In 1954, a very small child guidance clinic was begun in Pensacola and provided outpatient evaluation and treatment services for children experiencing problems of emotional or social adjustment. In 1959 the clinic expanded to provide services to psychiatrically indigent adult patients also. The clinic was operated on funds obtained from the State, United Fund, the City Council, County Commissioners, the Board of Public Instruction, and fees. For the most part, only traditional mental health services were offered with little time spent in the area of consultation and education, training, or emergency services. There was no partial hospitalization facility available. Pensacola does have three hospitals and each of these hospitals has an inpatient psychiatric unit.

In 1966, meetings were held with representatives from the Guidance Clinic, Alcoholic Rehabilitation Clinic, Vocational Rehabilitation, privately practicing psychiatrists and psychologists, administrators of the three hospitals, the Mental Health Association and other interested persons to plan toward the development of a community mental health center. The Guidance Clinic applied for a federal construction grant under Public Law 88-164 and the grant was approved. Baptist Hospital donated a city block of land for the building site. We began operation in the center in July of 1968. We obtained cooperative agreements with each of the three hospitals assuring continuity of patient care. We have had excellent cooperation with the hospitals and with the privately practicing psychiatrists in the community. In the new Center program we initiated a crisis intervention service (suicide prevention), partial hospitalization (day treatment), a consultation and educational program, and were able to provide training experiences for students interested in the area of mental health.

In our first year of operation we saw 1105 families and provided 10,808 outpatient appointments. 27% of the "cases" seen during the first year were totally non-pay. That is, these were people who paid no fee for service. 77% were in the lower income bracket. They made below \$6,000 annually. These are people who would in most part have been unable to afford private psychiatric care. We feel that the center program has been effectively utilized in providing services to the low income groups. In addition to this, 1531 hours were spent in providing mental health consultation to other agencies and individuals. We have come to feel that the consultation program of the Mental Health Center is certainly as important as the direct services which are offered to patients. The funds made available by the Federal government for staffing new programs has made it possible to offer this broad range of services.

We see in our center a large number of people who, without the mental health services provided locally, would require some type of institutional care. At the present time we are following over 360 psychiatric patients returned from our nearest State Hospital. Approximately 80% of the patients we are now seeing in our day treatment program have had previous hospital or institutional care, and our impression is that this program is helping to prevent many of these people from having to return to an institutional setting. We feel basically that our program has met with an exceptionally good response from the general public and from the professional community. We feel our services are being utilized. We feel that due to the increased support which was made available through

Community Mental Health legislation, we have been able to initiate a good program and we hope, of course, to be able to continue in this direction and to plan additional programs in the future to reach a larger number of our population requiring mental health services. We are interested in developing a meaningful program for drug abuse. We are interested in the possibility of planning a day treatment program geared to the needs of the school-age child, emphasizing a remedial education approach as well as psychotherapeutic services. We are interested in providing mental health services for the elderly. We are interested in broadening our consultative efforts in the schools, in the hope of preventing some mental health problems from occurring. We are very interested in looking further into the area of prevention through education and consultation. We are interested in providing a training ground for future mental health professionals. We are interested in the possibility of satellite clinics in outlying regions of our catchment area.

I would think that all centers have these same interests as well as others. We all hope to develop a sound program for prevention, early detection, treatment of emotional problems, and rehabilitation. We feel that what we are doing now is helpful to many people. We realize that what we are doing is inadequate to meet the needs of our communities. We realize that there are population groups—"high risk groups"—that are not being adequately served. We realize that our consultative efforts need to be greatly increased.

As I said earlier, some center programs began from scratch. We were in the fortunate position of having had a limited mental health service in existence for a period of 14 years prior to the beginning of our center program. Because of this we started operation with what I consider reasonably healthy local financial support. In our center in Pensacola, we receive financial support from the County Commissioners, United Fund and schools. We obtain funds from a grant-in-aid agreement with the State of Florida Division of Mental Health. We have been fortunate in our ability to obtain a substantial portion of our operating income from fees which are based on a sliding fee scale. A large proportion of our fee income is from third party payments, primarily, Vocational Rehabilitation. We have recently been approved for military medicare (CHAMPUS). We recognize the importance of third party payments such as these for the successful operation of a Community Mental Health Center program.

I feel, therefore, that our center is fortunate from the standpoint of having been able to obtain financial support from the local community, State government and from fees for service. Other centers have not been so fortunate. Many centers—even after several years of operation—have not been able to work out arrangements whereby third party payment of fees has led to a substantial contribution to the total budget. Many centers that have started from scratch have not yet been able to nurture adequate local financial support of their programs.

Even with the financial support for our center that I have mentioned, we will find our program in a very difficult situation if federal financial support phases out entirely at the end of the 51 month period of the staffing grant. It is true that as the percentage of federal participation is reduced, the relative contribution of the State will increase. In our State, the probable matching formula will be 50-50. Projecting our program several years in the future, and taking into consideration probable increases in operating expenditures (anticipated increase in professional salaries, annual cost of living increases, etc.) if our program were to remain essentially static—with no increase in services and no further attempt made at innovative programs—just maintaining the status quo—we can anticipate an annual operating budget of close to \$400,000.00. Assuming that the State will be able to provide up to 50% of the cost of the operating budget, this would leave \$200,000.00 to be raised from other sources. Assuming that our local financial support continues and is not reduced, and assuming that we are able to generate a substantial sum from fees, we would estimate that we would be able to raise perhaps \$150,000.00 locally. If all these assumptions can indeed be met, we would still be lacking approximately \$50,000.00 to continue the same program we are now offering the community. Without additional funds, we certainly cannot think of expanding our services into any of the other areas I mentioned earlier.

There are many other communities, however, who may well be in a less fortunate position. That is, there will be other communities that have initiated meaningful community mental health programs that will not be able to obtain even this degree of local financial support. Should federal funding phase out at the end of 51 months, we would be able to continue to operate a mental health program

in our community. We would continue to give services to the lower socio-economic groups. We would continue to attempt to provide consultative and educational services to the extent we are now offering these services. I do not see how we would be able to expand these services, however, or how we would be able to plan toward meeting problems in the other areas I have previously described without continued federal financial support. Centers in communities that do not obtain substantial local financial support might well cease to operate.

I say these things only to indicate that the impetus given to mental health services by Public Law 88-164 and Public Law 89-105 has been extremely important in making it possible to look toward new approaches in the area of mental health, to reach new population groups and to attempt preventive approaches to mental health problems. It appears to me that if it is possible to continue federal funding—perhaps at a 30% level—and not have it phase out completely—that these new programs will be able to continue in their attempts to meet the needs of communities. Without this support, many centers will be unable to provide essential services and many other centers—such as ours—will not be able to grow and explore new ways of meeting the mental health needs of the various target groups in our communities. I am therefore pleased that the legislation being considered by your committee does take into consideration the need for continued federal financial support to these new programs. I think there is no question but that this continued support is needed and essential if the mental health needs of people are to be met on a local basis and if a significant preventive effort is to be attempted in the area of mental health.

With regard to the financial picture, I would also like to comment upon the specific coverage of personnel in these centers. It goes without saying that clerical, business, and other “non-professional” personnel are necessary to carry out any of the programs being considered by community mental health centers. Even though many of these people do not have “direct patient contact”, and cannot be considered “therapeutic” from the standpoint of their having a personal association with patients or being part of a planned therapeutic program—these personnel are required in order to administer the program and provide professional personnel with their special skills and contributions toward the total program. Secretaries are needed to type dictation concerning patient contacts; administrators are needed to insure efficient utilization of funds and personnel; janitors and maids are necessary; receptionists and telephone operators are required; someone must be employed to keep track of appointments and insure that professional staff adhere to schedules and make maximum use of clinical time. It is my feeling that all salaries of personnel required to implement a center program should be eligible for federal matching funds. I hope that the new legislation will acknowledge these expenses as being realistic and necessary aspects of any center program and assist the local mental health center by participating in these operating expenses also.

Now let me pass on to several final comments. Many communities throughout the nation will have a great deal of difficulty providing the local matching funds required in present legislation for construction and staffing. It is unfortunate that these very localities which have this difficulty in obtaining the necessary local support *often are most in need of comprehensive mental health services*. I strongly feel that in these instances—in rural areas and in urban areas with high levels of poverty—that federal matching should be on a higher scale for both construction and staffing. I would think that in some areas where there well may be no likelihood of substantial local support, that a provision could be made in the legislation for total funding for a period of time in order to initiate services. Over a period of years these localities could be expected to develop local funding, though perhaps not on the basis of the same grant formula that will be applied to areas more fortunate in their fund-raising potential.

In closing, let me summarize by saying that from my observation of an admittedly small number of community mental health center programs, I feel that they are providing local mental health services that have been long needed. I am convinced that the majority of mental health problems can be diagnosed and treated at the community level. I believe that without the federal assistance provided in Public Law 88-164 and Public Law 89-105, it would not have been possible for these local services to have been initiated. I believe that in order for these programs to continue—and certainly grow—continued federal support will be necessary. I believe that a continuation of federal support at the 30% level would be adequate.

Thank you for permitting me to share my views with you. I will be happy to respond to any questions you may have.

Mr. JARMAN. A quorum call is in progress, and we will make a request of the House that we be permitted to continue the hearings at 2 o'clock. The panel's testimony will continue at that time.

The committee will stand in recess until 2 o'clock.

(Whereupon, at 12:20 p.m., the subcommittee recessed to reconvene at 2 p.m., the same day.)

AFTER RECESS

(The subcommittee reconvened at 2 p.m., Hon. Paul G. Rogers, of Florida, presiding.)

Mr. ROGERS. The committee will come to order, and we will proceed to hear testimony from the panel.

I think we have had each one make a statement now. Are there any other statements to be made, Dr. Weston?

Dr. WESTON. No. We are eager for questions.

Mr. ROGERS. Mr. Preyer?

Mr. PREYER. Dr. Creel gave us some figures, which I missed. You said something about something over 10,000 patients the first year, was it?

Dr. CREEL. Those are individual patient visits that were seen during the first year of operation, from July of 1968 to July of this year.

Mr. PREYER. What was your budget for that year?

Dr. CREEL. I can give it to you. I will have to look it up.

Mr. PREYER. Just roughly.

Dr. CREEL. It was about \$203,000.

Mr. PREYER. You received 37 percent Federal support?

Dr. CREEL. That is a rough figure. Actually, I think they figured that on the basis of not the fiscal year, but 6 months of 1968 and 6 months of 1969. Yes, that would be for the fiscal year.

Mr. PREYER. When you say they were "patient visits," would this mean 10,000 different patients?

Dr. CREEL. No, one patient might be in a number of times. And this included people in day treatment for a number of days, but it still would be one patient rather than a number of different patients.

We haven't gone much into services, but we have a very active day-treatment program there, with a capacity for 30. And many of these people rotate in and out of this program, some of them in as little as 3 weeks. So there is a very rapid turnover with a tremendous toll on the staff. I think staffs in mental health centers, particularly in day-treatment programs—and that is my bailiwick—are really going to get battle fatigue, and we are going to have a turnover in staff because of the tremendous amount of time and effort they have to spend there.

Mr. PREYER. Is there some median figure of how often a patient must visit before that person is discharged, if that is the word you would use?

Dr. CREEL. We try to come up within the first week of a patient's—for instance, in day-treatment, in the first week's time, we try to come up with a firm idea of how long we expect him to stay. Many times, patients who leave day-treatment are followed up in the outpatient department. Hopefully, many of them get back into their homes and jobs and are seen less frequently and less intensively than they are there.

Outpatient treatment is a different thing. We follow a large number of patients from our State hospital, which is about 180 miles away. We

have currently about 350 or 360 patients that we follow through on trial visits that have been discharged from the State hospital and who still require medical supervision, particularly regarding medication. This is another large element of direct service.

Mr. PREYER. As a matter of general interest on the number of patient visits related to the budget, what, for example, in Dr. Morrison's area, what would your budget be and the number of patient visits?

Dr. MORRISON. The graph on page 3 of my prepared statement gives of patients from our State hospital, which is about 180 miles away. We the total budget figures, and in the right-hand corner you will notice the number of patient admissions for each fiscal year. This does not include people who were carried over, of course, from previous years. We see about 2,000 people a year. Of course, some are carried over. The average number of visits per patient is just a little more than $4\frac{1}{2}$.

Now, some people are seen once for a problem that is resolved in one session, and some are carried on for months. But it works out with an average of $4\frac{1}{2}$, and this is because we are a crisis-oriented group. We are geared to short-term intensive treatment.

Mr. PREYER. Thank you. I think those are impressive figures. Some of the OEO programs, for example, come in for considerable criticism, where a substantial amount of money is spent on a relatively few beneficiaries. It brings the whole program under attack. Here, you seem to be able to make a very good argument in the number of people benefitting from the dollars spent.

Dr. PORTZ. I would like to give some figures, too, because I think we had about 16,000 patients, or service contacts, in the last fiscal year. Half of these were what we call "consultation-education services," with agencies, caretakers, physicians, ministers, and so forth, so that the other half were direct-service contacts.

We have some one-shot diagnostic or direct-service kinds of contacts, but I think every center that is trying to be comprehensive has a pretty wide range. And looking at an average might not give you a full picture, because I am sure every center has a number of very marginally adjusted individuals who may require service every week for a year by several different staff members.

But I think what happens in many of these cases is that hospitalization is prevented, and the family may be held together, so that the children don't have to be placed in foster homes and the parents who are still there can be wage earners, or homemakers. And this kind of service never is paid for in fees or third-party payments. This is one place where the public support of a comprehensive mental health center is absolutely necessary if the job is going to be done.

Mr. PREYER. Thank you, Dr. Portz.

Thank you, Mr. Chairman.

Mr. ROGERS. I would like to just go down quickly, if I could, from each one, starting with Mr. Ramirez.

Would you let me know the number of beds you have, inpatient beds, where you treat and actually use the beds for your patients in your installation?

Mr. RAMIREZ. We have three facilities that we will utilize for inpatient services. In the community we have 20 beds in a general hospital, which is in a separate area for psychiatric care.

Mr. ROGERS. That is not in your center?

Mr. RAMIREZ. Yes, it is in our center.

Mr. ROGERS. It is in a general hospital, however?

Mr. RAMIREZ. It is in the confines of a general hospital.

Mr. ROGERS. In other words, you have your facility in connection with a general hospital?

Mr. RAMIREZ. Yes.

Mr. ROGERS. And 20 of those beds are allocated to you?

Mr. RAMIREZ. Yes.

Mr. ROGERS. Are they used for other purposes?

Mr. RAMIREZ. No. They are under our control. We fund this, and it is our operation.

In addition to that, we also utilize a State hospital which has set aside an area for our services, 160 beds.

Mr. ROGERS. For your control?

Mr. RAMIREZ. They are not under our control. The hospital is under the control of the superintendent, but we utilize these hospital beds as a backup service to our program.

Basically, under our control, we have 20 beds, and if you would like some information on these beds, for instance in the last 2 years, we have had 590 admissions in this program, and an average length of stay of 16.7 days during the 2-year period that we have been in operation.

Mr. ROGERS. That is the average stay, 16.7?

Mr. RAMIREZ. Yes.

Mr. ROGERS. Is that in the 20 beds and the 160 beds?

Mr. RAMIREZ. No, in the 20-bed unit.

Mr. ROGERS. These figures are just for the 20-bed unit?

Mr. RAMIREZ. Yes.

Mr. ROGERS. Dr. Harris?

Dr. HARRIS. We don't have an inpatient system. We have affiliation with the Los Angeles County Hospital, and by my being part of the State system at one time, I have telephone contact with the people in the State hospital.

Our philosophy is—and it seems like the philosophy of the Department—is that the length of hospitalization should be as short as possible, and we utilize the day-treatment center more than anything else for those patients who need hospitalization. If someone needs hospitalization right away, I can call the county hospital, and they stay a couple of days and then come back to us.

Mr. ROGERS. Your personnel does not follow them to the hospital?

Dr. HARRIS. No, our personnel is not associated with that.

We have a construction grant which would have 30 beds, 10 children, 10 adolescents and 10 adults. But our program will be affiliated with the day-treatment process, with a maximum amount of day treatment involved.

Mr. ROGERS. Dr. Weston?

Dr. WESTON. We inherited a 45-bed unit that was in the local community. This was primarily all adult beds, and when we were able to attach the continuity of services and have them come under our administrative staff and have our staff follow patients, the occupancy dropped from 45 beds full and a waiting list of 12 people, down to where it is only about 25 beds occupied at any time.

The length of stay has dropped from 17 days down to 8 days. And we feel this is because of the continuity of services and by having our staff follow through.

With respect to manpower, we are designing alternatives, and it is run by the department of psychiatry at the university, which I happen to be a part of. We use non-M.D.'s basically for roles that M.D.'s have handled, whether it is inpatient, outpatient, or whatever.

I will be glad to give you some more information on that.

Mr. ROGERS. What do you do with the rest of the beds that you are not using?

Dr. WESTON. At the present time those beds are vacant, and we are negotiating with the State, because there are people in the State hospital where, with funding, we would get the people back into the beds, in the community.

Mr. ROGERS. Since you have not had to use those beds to give inpatient treatment for the whole 45 beds, has this reduced the cost to your institution?

Dr. WESTON. It has reduced the cost of that aspect of the services. We have increased our outpatient services. That has gone up almost 200 percent.

Mr. ROGERS. Your outpatient has gone up 200 percent?

Dr. WESTON. It is not due just to the drop in inpatient beds. Part of that is because of the programs in the community.

Mr. ROGERS. I understand.

What would the reduction in cost be? Do you have any idea?

Dr. WESTON. The best way I could give you a reduction in cost, figuring part of the change—we figure we saved 1,400 inpatient days in the last 6 months over the previous year.

Mr. ROGERS. 1,400 inpatient days?

Dr. WESTON. Yes, and our average cost per inpatient day is close to \$50. So whether we saved—I don't know whom we saved, but we saved either insurance companies or someone, an individual, the State, that much money.

Mr. ROGERS. That is a significant figure.

Dr. Portz?

Dr. PORTZ. In our center, let me say that we started with agreements with eight hospitals, general hospitals in the area, that they would take inpatients. Obviously—

Mr. ROGERS. Yours is a rural area, as I recall, and spread quite widely.

Dr. PORTZ. Yes.

Obviously, there wasn't the staff to really have an inpatient program, that is, a planned treatment for the patient while he was in the hospital, so we have ended up with only two general hospitals with which we have working agreements.

Mr. ROGERS. How many beds do you have available to you?

Dr. PORTZ. It is two beds in each hospital. These are mixed in with the other kinds of patients. We do have a plan approved whereby there would be an 11-bed unit. We haven't been able to implement that because we didn't have the matching funds.

Most of our inpatient work is at the State hospital, which is 45 miles distant. Two of our staff go there a day a week. We are increasingly involved with the sheriffs, the county clerks, and the judges

in our area, both in hospitalization and in other problems, mental-health problems, so that we are the screening agency, in effect, without any legal requirement that this be so, for admissions to our State hospital. And we plan for their release and the followup program, and the readmission rate has been reduced from 78 to 13 percent in one study several months ago.

We do have a research project organized to really evaluate the effect of the community mental-health services on the state hospital population. But we had to postpone that, too, for lack of staff time to really carry it out.

This is part of the bind we have been in. In a year and a half we have gone down from 35 to 23 full-time staff, because we have had to let people go in order to keep surviving.

Mr. ROGERS. Let me ask you this. Suppose a patient needs hospitalization and you filled up your two beds in each of the two hospitals. Are they ever held over in jail in your area?

Dr. PORTZ. In our area, as in most, the only ones held over in jail are alcoholics. We have been working on that problem.

Mr. ROGERS. But the mentally ill and mentally incompetent have not been held in jail?

Dr. PORTZ. Our local hospitalization with those four beds is primarily emergency and very short-term treatment.

Mr. ROGERS. And if they needed longer term treatment, you would make arrangements with the state hospital?

Dr. PORTZ. Either that, or in some cases, with the psychiatric units outside the area, particularly West Virginia University.

I might say we have developed a part of a training program which would include the West Virginia University and three area colleges. This is for placement of psychology students, and so forth. We believe there is built-in in most centers the possibility of developing the staff as time goes on. But, again, that is one of the programs we have been unable to implement because of our tight money. And we had to lay off staff that would be involved, or we had qualified candidates who would be involved in the training that we couldn't employ.

Mr. ROGERS. So far, the universities really have not come in to assume any of the burden as such, you are saying?

Dr. PORTZ. We work with them.

Mr. ROGERS. But I mean as far as staffing and maybe putting interns in there or anything like that.

Dr. PORTZ. We have definite plans for that. But it is going to require staff on our part to do supervision and training.

Mr. ROGERS. Dr. Morrison?

Dr. MORRISON. In northern Wyoming we have contracts with the five hospitals that are in the county seats of the five counties that we serve, and we are in the fortunate position that none of these county hospitals are ever full. The hospital in Sheridan runs an occupancy rate of 62 percent, and they were very eager to agree to hospitalize our patients.

Mr. ROGERS. How many have you used of those beds?

Dr. MORRISON. I run an inpatient census of from two to five persons. On a few occasions we have actually had no one on inpatient service for a few days at a time.

In the other hospitals we run an average census of one or two persons at a time, and we have staff living in the other towns who work with the general practitioners to take care of these people. And they refer the more difficult cases to Sheridan, where I can work with them.

So I suppose our total patient load on any given day would be somewhere between five and 10 patients in inpatient service.

Mr. ROGERS. Your group was formed in 1967?

Dr. MORRISON. Yes, the first of July 1967 was when we started our grant. We were fully staffed by September of that year, and have been fully staffed to the present time save for one period of 3 or 4 months in 1968.

You may notice in the graph I mentioned earlier that there was a fall in patient population that year, because I fired one man and we had to replace another.

I would like to add, however, that for the one psychiatric social-worker position that I had at that time, we had 34 applicants, and for the psychologist position open at that time, we had seven qualified applicants. And we were in a position of being able to choose people we wanted.

Mr. ROGERS. Have you had a decrease of your inpatient care?

Dr. MORRISON. Population? No, this has been steady.

Mr. ROGERS. You have seen no change?

Dr. MORRISON. No, it has been quite steady right along.

There is one thing I should mention, too. Our psychiatric nurse spends a great deal of time training the nurses in all five of these hospitals in psychiatric-nurse techniques. We are gradually teaching these nurses how to handle people with emotional problems. We are also involved in training programs for physicians in the hospitals, with video tape and various other programs.

Mr. ROGERS. Do you get any funds from a regional medical program for that?

Dr. MORRISON. No, we are doing this on our own. I see two patients in the hospital who are under the care of some other physician for every one of my own, so that I may have two or three patients in the hospital of my own and be calling on four or five who are under some other doctor's care on any given day.

Mr. ROGERS. Are you reimbursed for the consultation work?

Dr. MORRISON. Yes.

Mr. ROGERS. Do you devote full time to the community mental-health center?

Dr. MORRISON. Yes, all our staff are full-time.

Mr. ROGERS. Do the funds go to the community mental-health center?

Dr. MORRISON. Yes, all funds derived from any professional endeavor, save from royalties on books, go to the center.

Mr. ROGERS. I see. Thank you.

Dr. Creel?

Dr. CREEL. Our situation is a little bit different in that we have had a tremendous need for beds in our area for years, even though we have a large number.

We have in Pensacola three hospitals. Each of them have psychiatric units. The county has 28 beds. Sacred Heart Hospital has 16 beds, and

the Baptist Hospital recently came under Hill-Burton funds and was able to expand to a 40-bed area.

Mr. ROGERS. How about the community health center itself?

Dr. CREEL. It has cooperative agreements with all three hospitals.

Mr. ROGERS. Are you actually housed in a hospital?

Dr. CREEL. No, about two blocks from the Baptist Hospital, but in an area that is convenient to all hospitals. This land was given by the Baptist Hospital.

Mr. ROGERS. So there are no beds in your center, but you have a working arrangement with the hospitals?

Dr. CREEL. That is correct.

Mr. ROGERS. Are those beds under your control?

Dr. CREEL. No, not directly. Our personnel do follow patients that they have been seeing, in the hospital. The patients are admitted by the psychiatrist. If the psychiatrist has been seeing them as an outpatient, he continues. It is a responsibility to admit a patient to the hospital. But the staff person who is following them or treating them or counseling with them continues to do so.

Now, we do have one staff position that comes under the center program, a psychiatric in-service nurse, who is paid for in part by each of the three hospitals and in part by the staffing grant. She goes to all three hospitals in a similar fashion as Dr. Morrison's nurse, except that she is funded.

This is a lot of beds for an area our size, but we have a very large referral area. For years we were the only source of care for a 200-mile space, and really many people from further than that.

Panama City now has a center also, but we are still having a hard time keeping up with bed space.

Mr. ROGERS. Thank you very much.

Let me go down the line and ask each of you, let me know how many psychiatrists you have working in your center.

Mr. RAMIREZ. We have two psychiatrists.

Dr. HARRIS. Three.

Dr. WESTON. We have three fulltime psychiatrists, and we have four psychiatrists from the university take night calls and weekend calls.

Mr. ROGERS. Do you have to pay those from the university?

Dr. WESTON. No. The university is actively involved in the center, although the center is off campus.

Mr. ROGERS. Could you let us have those who are paid members of your staff?

Dr. WESTON. Three paid.

Dr. PORTZ. We have had three paid psychiatrists. But now we have only one. We have another candidate whom we couldn't employ, and we really need two for the program we envision.

I might say that in a poverty area like this, 141,000 people in this large territory, 5,750 square miles, two is perhaps a smaller number than one would like. But it is what is a realistic program in a poverty area, and we do need the funds for the second psychiatrist.

Mr. ROGERS. The reason you don't have the second is because you have no funds, is this what you are saying?

Dr. PORTZ. Primarily.

Mr. ROGERS. Or you haven't been able to attract anyone?

Dr. PORTZ. No, we had candidates lined up to come, but when the State legislature didn't come up with funds last year, we had to turn them off.

Dr. MORRISON. I am the only psychiatrist in the State of Wyoming in community practice.

Mr. ROGERS. How many psychiatrists in your State?

Dr. MORRISON. Dr. Carnes is head of the State department, and there are two others in practice.

Mr. ROGERS. You have a lot of healthy people out there.

Dr. MORRISON. No.

Mr. ROGERS. That doesn't follow.

Dr. CREEL. I am half time at our center, and we have four psychiatrists who are on the consulting staff who are paid some from the center. The other three who do have patients do relate to the center, although they are not paid consultants.

Mr. ROGERS. So you have no full-time psychiatrist?

Dr. CREEL. No, we do not. We need one.

Mr. RAMIREZ. May I make an addition? We have one additional psychiatrist from the State department of mental health who consults with our program.

Mr. ROGERS. At no cost to the center?

Mr. RAMIREZ. No cost to the center.

Mr. ROGERS. How many psychologists do you have?

Mr. RAMIREZ. Four full time.

Dr. HARRIS. One full time.

Dr. WESTON. Seven full time.

Mr. ROGERS. These are on the payroll?

Dr. WESTON. Yes. Some State, some center.

Dr. PORTZ. One full time, myself, and three part time, paid positions for two more full-time psychologists, which we haven't been able to employ because of funding.

Mr. ROGERS. Have you had applications for the jobs?

Dr. PORTZ. Yes.

Dr. MORRISON. Two.

Dr. CREEL. Four.

Mr. ROGERS. How many nurses whose specialty is psychiatry?

Mr. RAMIREZ. Well, we have four nurses who work in the community as what we call psychiatric nurses. And in our 20-bed unit we have six nurses on the staff there.

Mr. ROGERS. So that would be 10?

Mr. RAMIREZ. A total of 10.

Dr. HARRIS. We have three full-time nurses in the day-treatment center.

Dr. WESTON. We have three masters in psychiatric nursing on our staff, one paid by the university school of nursing and two by the center.

Then we have 18 bachelor-level nurses, most with psychiatric training, but we have an active training program for nurses both in public health and other hospitals as far as psychiatric training.

Dr. PORTZ. We had two, and now one. We recently turned down a master's level psychiatric nurse because of lack of funds.

Also, the in-patient unit that is in the grant would have five nurses, and that is being held up.

Dr. MORRISON. One.

Dr. CREEL. We have two master's level. The nurses we have in the in-patient units have what I would consider really extensive psychiatric training.

Mr. ROGERS. What other assistance do you have as to technical people?

Mr. RAMIREZ. We have five full-time social workers and one part-time social worker. In addition to that, we also have what is sometimes called community workers. These are people who have no professional training in our situation. These are people with high school educations, who know the area, know their county or community, and work with us very closely.

Mr. ROGERS. And wanting to learn in this field?

Mr. RAMIREZ. Yes.

Dr. HARRIS. We have eight full-time social workers, two of whom are devoted to children, to our child outpatient clinic.

We have approximately four so-called paraprofessional or new careerists, who in some centers might be named mental health aides, counselors, et cetera.

Mr. ROGERS. What do they do?

Dr. HARRIS. It depends. One is working with the welfare agency. One is involved with geriatrics. One is involved with a friendship club, which is really an aftercare situation for the socialization of those patients no longer coming to the clinic. And there is another who is working in the day treatment center as a full-time therapist.

Mr. ROGERS. Do you give treatment at night?

Dr. HARRIS. The facility is open from 9 to 9. We don't have night hospitalization as it is commonly called. We have outpatient treatment at night.

Mr. ROGERS. But you have someone on duty and your facility is open at night?

Dr. HARRIS. Yes. We have 24-hour coverage. We have receptionist-interviewers, which is another way of—maybe I shouldn't say this, but I will—of getting around the funding for certain personnel. And they are directly involved with the treatment of patients.

I think this is one of our pleas for full funding of all personnel.

Mr. ROGERS. Thank you.

Mr. RAMIREZ. May I make a couple of additions? Your mentioning the day program reminded me of ours. We have two staff on our day program, which serves about 30 patients each day. One is an activity person, and a secretary is a bachelors trained person with a degree in psychology. They man this particular program.

In addition to this, we have a large workshop program which has a daily census of about 100.

We have six people who are running the workshop program. These are individuals, again, with no formal "mental health" education, but they are work-oriented. And their particular task is to help our patients in the rehabilitation process, and they work with former State hospital patients as well as former patients out of our psychiatric unit.

Mr. ROGERS. Thank you.

Dr. WESTON. We have, in addition to 10 full-time masters level social workers, eight part-time, and two B.A. workers.

Mr. ROGERS. Are they paid for by your service?

Dr. WESTON. Yes. They also operate 24-hour emergency service, and after they participate in student teaching programs, they come from both the University of Michigan as well as Michigan State University.

We also have 20 psychiatric technicians, which would be the para-professional. We have an active training program for them, although they work in day-care and some of our outreach programs.

We have two part-time people whose sole responsibility in research in the center. That is important to answer some of the questions you are asking, to know what we are doing, and how much it costs.

Dr. PORTZ. We have two masters level social workers, two bachelors level, and two alcoholism counselors.

We have nine professional aides, primarily active in aftercare and some of the basic social work in the various county seats.

The professional aides were trained on the job in the last 2 years in a combined program with the West Virginia Department of Mental Health and ourselves.

Dr. MORRISON. We have two masters level psychiatric social workers, a mental health educator, and then three different volunteer groups that add up to about 100 people.

Of those, one of them are social workers, psychiatric workers and aides, who volunteer their work on a part-time basis.

Dr. CREEL. In our outpatient department, we have five masters level social workers, one masters level psychologist.

In the day treatment program we have one psychiatric nurse. That was one of the two I mentioned when you asked about nurses earlier.

We have two teachers with backgrounds conducive to this work. Another has a sociology-psychology background.

We have a therapist who is a former Navy commander with some training and experience with us.

I couldn't give you the statistics, but we have a heavy dependency on volunteer services.

Mr. ROGERS. I think it would be helpful to the committee, if it would not be too difficult, for each of you to just give us a little chart on basically what we have been going into, the number of personnel, and so forth, the number of patients, inpatients, outpatients, or however you may categorize them, the funding, where you get your funds in each institution.

I know we have gone over some of this, but if we could have it in chart form for the record, it could be helpful to us.

Dr. WESTON. Could we mail this to you?

Mr. ROGERS. Yes.

Mr. RAMIREZ. Some of that you will find in my statement at the rear. However, we do not have the staffing, and I will mail that to you.

(The information requested was not available to the committee at the time of printing.)

Mr. ROGERS. I think we know how you feel on funding, that it should be an overall funding, that it should not go less than funding. And in your area, I think 100 percent.

Do you get any funds from OEO or any funds from HUD?

Dr. HARRIS. No.

Mr. ROGERS. Have you tried?

Dr. HARRIS. We haven't tried. We have a unique situation in Los Angeles, where the local health director was opposed to the community mental health centers concept. Hence, the funding through of State funds into community mental health centers was not possible, as it is in the northern part of the State, where the local mental health director was in direct agreement with the aims and thus used his office to get the funds.

We have been working, and now we have some contractual agreements with the county for those funds.

Mr. ROGERS. If this can be furnished for the record, would you let us know the extent of that funding?

Dr. HARRIS. Yes.

(The information requested was not available to the committee at the time of printing.)

Mr. ROGERS. There is an automatic vote on the floor now, which we will have to go to.

Dr. WESTON. We would like to go back to the child psychiatry area. We are going to have under our new unit that is under construction, six child beds and 12 adolescent beds. I need the ancillary services to back them up. If we are really going to make a dent, it is in staffing. To separate them from the mental health center, where you have the rest of the family, doesn't make much sense to me, either.

So I would like to support that aspect.

I was just passed a note, "30 percent for 10 years."

I think, to be perfectly honest, unless some alternative funding is available, I don't know where it is going to come from.

Mr. ROGERS. I think we might as well be realistic and say what you are asking for is Federal funding at a certain level.

Mr. RAMIREZ. For an indefinite period of time.

Mr. ROGERS. What some of us have proposed is simply a 6-year extension, where we can look this over again, 3 years of the new and 6 years, with the last 3 years at 30.

Dr. MORRISON. Mr. Chairman, I would like to make one other point. We only have two people per square mile where I live. Ten percent of my operating budget goes to pay mileage for my staff just to get around the area, from office to office.

Mr. ROGERS. Is this realistic to try to have a center where your operation is so spread? Should it be divided and ancillary to some hospital?

Dr. MORRISON. The center is composed of five clinics banded together. People can get to one of them in 45 minutes' driving. But I am the only psychiatrist, so I have to go to all five offices. The farthest one is 200 miles away.

Mr. ROGERS. You have four psychiatrists in your statement.

Dr. MORRISON. But they are 600 miles away in Evanston or 500 miles away in Cheyenne.

Mr. ROGERS. So you have no programs in those towns?

Dr. MORRISON. Our program covers one-fifth of the State of Wyoming in the northeast corner of the State.

Mr. ROGERS. This is the only health center?

Dr. MORRISON. Yes. The Governor will not let us start another one in the State, because he is fearful that the State and local people have

to pick up the entire tab after the grant runs out, and he said, "No more until we find out what the Federal people are going to do."

There are two other areas in the State that would like to start mental health centers if they could see their way clear, if the Federal funding was going to stay in there.

Dr. WESTON. Thank you, Mr. Chairman, for giving us a hearing.

Dr. HARRIS. In regard to 314(a), I think that if this is going to be included in the bill that the language should be clear that there should be participation from the people in the poverty area. As comprehensive health-planning programs are now, we almost have to fight to even get into the meeting rooms, so this must be very explicit if it is to be added.

Mr. ROGERS. I agree with my colleagues who say we eventually want this done. I think it is too early myself to bring this in. I don't share any view that we should jump into this quite yet.

Dr. WESTON. Thank you, Mr. Chairman.

As you can tell, we are glad to finally have our voice heard.

Mr. ROGERS. The committee is grateful to you all for coming.

We will stand in recess until we can get through this vote.

(Brief recess.)

Mr. ROGERS. The committee will come to order.

Our next witness is Dr. Sheldon S. Steinberg, University Research Corporation, Washington, D.C.

Doctor, it is a pleasure to see you, and we are sorry our proceedings were as interrupted as they have been.

STATEMENT OF SHELDON S. STEINBERG, EXECUTIVE VICE PRESIDENT AND MEMBER, BOARD OF DIRECTORS, UNIVERSITY RESEARCH CORPORATION

Mr. STEINBERG. I appreciate the opportunity to make a statement before the committee, Mr. Rogers.

Mr. ROGERS. If you like, we will make your formal statement a part of the record following your oral statement.

Mr. STEINBERG. I would appreciate it.

Mr. ROGERS. If you could, give us your important points.

Mr. STEINBERG. I will try to be brief.

First of all, I think it might be helpful to identify a little bit about my past experience to, in effect, qualify myself for my appearance before the committee.

For the last 3 years I have been involved in working in a community health center as director of research and training, specifically the Area B Community Health Center here in the District, and for the last 2 years working with the University Research Corporation with a variety of Government agencies—Federal, State, and local—focusing on improving the delivery of human services in the field of mental health, health, education, welfare, day care, and so forth.

First, I would like to support the State plan inclusion in the proposed bill. I think it is critical and necessary to have some coordination of effort and allocation of priority based on need within the State.

Mr. ROGERS. Let me ask you there—I understand eventually all of us would like that. It is my understanding that a number of the

States—and we had testimony during the Hill-Burton bill on this—have not proceeded to the point where they have effective State organizations. Some of them have one or two persons.

Mr. STEINBERG. Yes.

Mr. ROGERS. What would you think if we at this point say it should be reviewed by, and coordinated with, rather than giving an actual veto by the State at this state?

Mr. STEINBERG. I would agree with that. I think the key is coordination within the State.

Mr. ROGERS. I think all of us want that, but to say at this point we should give them a veto, I am not sure that all States are quite ready for this. Some would be, but some would not.

Mr. STEINBERG. That has been our experience. We have been working with some States, particularly with a person who generally would be designated as coordinator of Federal programs. That will relate to the third suggestion that I have in the prepared statement that I will comment on later.

Mr. ROGERS. So then you would have no objection as long as we coordinate them?

Mr. STEINBERG. No. I prefer to use the term I used in the statement, "a better orchestration of Federal funds."

Second, I would like to support the intent to give a higher share of the available funds for the disadvantaged areas. I don't think I need to go into the reasons. That has been adequately covered in previous testimony, I think.

Of course, the continued focus and perhaps an expanded activity in a specific allocation of funds, focusing on the mental health of children and youth, I think this is extremely critical.

I would like briefly to comment on the three suggestions, then.

No. 1, I would urge the committee and those responsible for making these centers and programs operational to develop a systematic effort to recruit local residents as part of the overall treatment staff of the center.

I think there is ample evidence now across the country to demonstrate that there are certain advantages that accrue, not only to the individual recruited from the community, but back into the community itself. And, again, I have summarized some of the advantages in the statement.

Second, I would urge the committee to require in the appropriate sections on training that all training programs funded under this bill, in effect, demonstrate very clearly a career system for all of the staff who are working within the center, so that we at the same time, hopefully, can accomplish two things.

First, we can have people stay within the treatment facility and increase their skills and the recognition with an increased level of responsibility and a title, and so forth.

I have also indicated very briefly some evidence now in one of the programs that we are assisting the U.S. Department of Labor with, the new careers program, the amendment to the Economic Opportunity Act.

We have some experience over about 13 months now of some 17,000 nonprofessionals who have been recruited from the low-income,

under-employed, under-education population, that they can, in fact, provide services and be trained to perform very well.

I also have provided—and I thought you might be interested in seeing some of the kinds of titles for the entry-level positions and second-level positions in which these people have been trained, and they are included on page 5 in the statement, as well as on page—well, the insert between pages 5 and 6, career ladders that are actually operating now in the field of health, and more particularly the middle-career ladder, again indicating some of the potentials for the staffing.

The third, I think—and, again, I am not quite sure whether this is really something that the committee should address itself to. But I think it is increasingly important, particularly in relation to community health-center operations, to consider a requirement of hinging into other available Federal programs in the community. And I would just like to give one example.

If we accept the concept that the community mental health center addresses itself to the community as the patient and that the various human services, the employment opportunities and all of the rest of the things that make up a community, in effect, are the system that keep the patient alive and really are the index of mental health, then I think it is critical that other areas of potential funding be looked at.

For example, one of the prime needs in the country right now is comprehensive day care. The impact and effect of a poor home environment and a lack of the normal process of adapting to our culture in early childhood has very serious implications for the future for the mental health of people—that is success in school and success in a career system.

Right now, for example, it is possible to use supplemental moneys of model cities to match against social security funds to set up comprehensive day-care programs and to train people to work in the provision of services in these programs by using Department of Labor money.

Now, again, I am not sure as to just how that would tie into the amendments before the committee. But I would like to raise that for your consideration.

(Mr. Steinberg's prepared statement follows:)

STATEMENT OF SHELDON S. STEINBERG, ED. D., F.A.P.H.A., EXECUTIVE VICE PRESIDENT; MEMBER, BOARD OF DIRECTORS, UNIVERSITY RESEARCH CORPORATION, WASHINGTON, D.C.

Mr. Chairman, Members of the Committee, I appreciate the opportunity to testify on behalf of the bill. In particular, I would like to focus my remarks on those sections of the bill concerned with training programs for the range of services to meet needs of local residents in a community mental health center and, in particular, training programs for personnel working with alcoholics, narcotic addicts, children and youth.

My professional experience has been in public health and, for the past three years in community mental health and in New Careers training programs for the unemployed, underemployed and undereducated. I have participated in the development of the national demonstration New Careers program operated by the U.S. Department of Labor through technical assistance, consultation, and training. I have prepared a brief statement for the Committee but would appreciate the opportunity of summarizing three key recommendations for the Committee's consideration.

1. I would urge the Committee, and those with responsibility for making these centers and programs operational, to develop systematic efforts to recruit local residents as new careerists (nonprofessionals), including former alcoholics and addicts, as members of the treatment team.

There are significant advantages to the systematic recruitment, training and employment of such persons in the delivery of mental health services.

(a) They increase the effectiveness of services in these communities because of the residents unique backgrounds in connection with the community and direct experience with its problems.

(b) They provide an important link between the professional and the client population, with whom frequently the professional has had little real life experience.

(c) They provide an important vehicle for helping people to help themselves in the community, and they also provide an important potential vehicle in these local health centers for meaningful employment and career development for the poor.

This is true in general for community mental health programs. It is particularly true in addiction and alcoholism where we find that the use of ex-addicts and ex-alcoholics is a potential manpower resource of significant effect.

Because of their previous personal experiences, contact with others in the community, and the knowledge of their own living situation, when community residents are given structured training, employment opportunities and career potential as nonprofessionals in these programs, they give very important, extremely significant assistance to the professional in providing treatment and rehabilitative services for the range of mental health problems including alcoholics and addicts.

In fact, there are some who feel that in many ways you can't run an effective program for alcoholics and addicts without the use of previously "uncredentialed" residents providing a kind of treatment resource.

I would urge you to emphasize this approach for the staffing and organizational patterns for these centers. And, in fact, if it were possible to develop an amendment to the existing legislation for community mental health centers to provide for the development of systematic programs for the use of such nonprofessionals in new careers, I would urge that, too.

(d) It is especially important in developing manpower resources for these centers to recognize that there is an extreme and expanding shortage of trained manpower for all community mental health programs, particular for alcoholism and addiction. A great deal can be gained by considering the use of local residents, employing them, and providing them with nonprofessional careers in these programs.

It gives the nonprofessional and the people in the community a positive way of participating in the development and delivery of services in their own community.

2. I would urge the Committee to require in the appropriate sections on training that all training programs funded under this Bill and other amendments to the Community Mental Health Centers Act include plans to ensure career mobility for all staff, and especially nonprofessionals.

There is ample evidence now that a well-thought through training program which "screens in" uncredentialed local residents is successful in starting people on a career ladder.

This evidence is based on our findings during the provision of technical assistance to the U.S. Department of Labor's New Careers program.¹ Currently, over one hundred projects in various stages of development involve more than 17,000 trainees.²

Briefly, the findings indicate:

(a) A retention rate of 85%.

(b) Average annual salaries of level I jobs is approximately \$4,200. This compares with an average income of \$2,100 for the 12% working prior to involvement and \$1,900 for the 28% who were on welfare only.

¹ Section 205E, Economic Opportunity Act, 1964.

² The data presented is based on our own findings during the course of our technical assistance work and does not represent official Department of Labor data or evaluation. The statistics are based on samples and thus are, in our judgment, fairly accurate approximations.

(c) Forty-eight percent of the trainees had less than a high school diploma prior to the program. Currently, 35% are working toward the diploma or have achieved it, 39% of the sample are receiving college credit. Fifteen percent of the sample can apply this credit to a degree.

D. Career ladders have been established for most New Careerists.

The health services lead the occupational areas both in number of enrollees and in specific job titles. The second category of job titles in the health field is mental health. The first and second level jobs reported include:

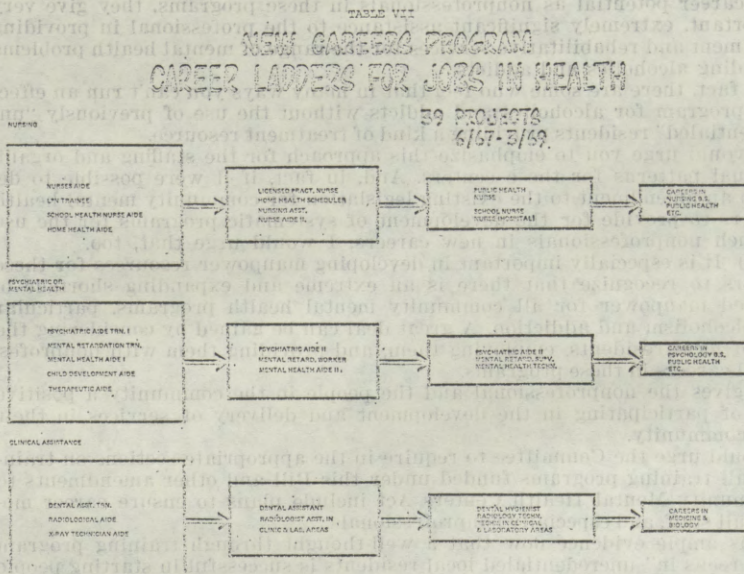
ENTRY-LEVEL POSITIONS

Mental Health Aide
Nurse Aide
Community Health Aide
Psychiatric Aide Trainee
Mental Retardation Aide
Psychiatric Research Aide
Behavioral Science Aide
Psychometrist Aide
Hearing and Speech Therapy Aide

LEVEL II POSITIONS

Psychiatric Aide II
Mental Retardation Aide II
Nursing Assistant
Psychiatric Trainee II
Mental Health Aide II

The following illustration demonstrates "career ladders for jobs in health."



Source: Wilson, Fishman and Mitchell. An Assessment of Technical Assistance and Training Needs in New Careers Projects Being Sponsored by the United States Training and Employment Service, Manpower Administration, U. S. Department of Labor, National Institute for New Careers, University Research Corporation, Washington, D. C.

You will note that the middle career ladder focuses on those jobs which are directly related to the operation of Community Mental Health Centers. It also should be noted that the other career ladders are also applicable for careers where a center is providing a full range of services—in-patient, out-patient, adult day treatment, etc.

I am pleased to provide the Committee with a more detailed description of a mental health aide provided in a community mental health center for further consideration. (See Appendix A)

Therefore, again, I would urge the Committee to consider inclusion in the Bill the framework for developing this New Careers opportunity system for the reasons cited earlier.

3. The last recommendation relates to a more creative orchestration of available federal funds for the educational and training programs which support the career opportunity programs in the community mental health centers.

There are now available a large variety of funds to provide needed services for mental health programs, both directly and indirectly. For example, Model Cities supplemental funds may be used to purchase services directly or as matching local money to apply against Titles IV A or IV B of the Social Security Act for comprehensive day care and/or legal services. More creative use of these funds provides expanded service opportunities and related new careers. Work Incentive Program (WIN) funds then may be used to train AFDC recipients in both the public and private employment sector. As pointed out earlier, some staff, at the entry-level, have been trained in the New Careers program. The vocational Education Amendments of 1968 also provide resources for creative reconstruction of vocational education programs at the secondary level to begin a series of "career sampling" experiences with related academic backup.

I would urge the Committee to consider requiring linkage of available federal funds within those communities in which community health centers currently are operating or where they may be funded in the future. We have learned over the past few years that the continued application of categorical funds in a multiplicity of programs creates, in many instances, not only duplication of effort but competition for community resources. I am not sure whether or not this recommendation falls within the scope of this legislation but I think some guidance is needed in all federally funding programs to effect the best and most creative use of these funds.

Again, may I express my appreciation, Mr. Chairman and Members of the Committee, for the opportunity to testify on behalf of this Bill.

APPENDIX A

MENTAL HEALTH AIDE POSITION DESCRIPTION (COMMUNITY MENTAL HEALTH)

INTRODUCTION

The purpose and work of this position are to provide treatment assistance to a professional team who deal with emotional problems in a community mental health setting. The community mental health aide functions in a variety of community mental health centers and their outreach activities designed to improve the overall mental health of the individuals and communities served by the mental health center.

The primary responsibility of the mental health team, of which the mental health aide is a part, is to return the emotionally disturbed or poorly adjusting and problem client to his societal or community environment in the best physical and emotional condition possible. The aim of the mental health team is to conserve staff strength, provide quality service to the community, and return the client to his environment equipped to handle the stresses of living, and make him a productive member of the overall community in which he lives.

The mental health aide works as a team member in the mental health center and performs work which represents a complete phase of an overall treatment plan for the client. The specific nature of the subject-matter involves out-reach activity in the community, group leadership. These are more clearly indicated in the specific duties and responsibilities described below. He is a special therapeutic agent.

POSITION CONTROLS (SUPERVISORY)

The community mental health aide is supervised by a trained mental health specialist or coordinator in a centralized or decentralized office. The supervisor of this position may be from the specialties of social work, psychology, psychiatry or a related discipline. Supervisory control over the position may be flexible depending upon the level or work being performed. Supervision is lessened as the mental health aide moves into greater skill competence and independence. Supervisor appraises incumbent's performance in terms of his judgment, initiative, and resourcefulness, his expressed qualities of leadership and ability to cope successfully with the job demands.

GENERAL DESCRIPTION OF DUTIES

The community mental health aide functions in a variety of activities in the mental health center. As a member of the treatment team or mental health unit, it is mandatory that the mental health aide assume certain personal responsibilities. He acts as a liaison between the client and the professional staff and carries out assigned roles under supervision.

SPECIFIC DUTIES AND RESPONSIBILITIES

- (a) Assists in referral and intake activity.
- (b) Assists in the arrangements for individual and group interviews; may conduct these under proper supervision.
- (c) Serves as an observer of community mental health problems and makes reports to staff on these observations.
- (d) Assist in crisis situations by helping professional staff resolve difficult situations.
- (e) Compiles survey data on community programs, particularly mental health.
- (f) Participates in agency outreach program through planned program of home visit or school visits.
- (g) Provides limited "maintenance counseling" while a client is waiting to be seen by professional staff.
- (h) Assists in recruiting community residents to participate in special meetings and classes in mental health and the community.
- (i) Supervise activities of children who must wait for parents.
- (j) Conduct small group activity with clients.
- (k) Write progress reports and case history materials on family members.
- (l) Acts as a liaison between the client and the professional staff.
- (m) Observes and reports on individual and group behavior and reactions of the client.

MINIMUM EDUCATIONAL REQUIREMENTS AND OTHER SPECIAL QUALIFICATIONS

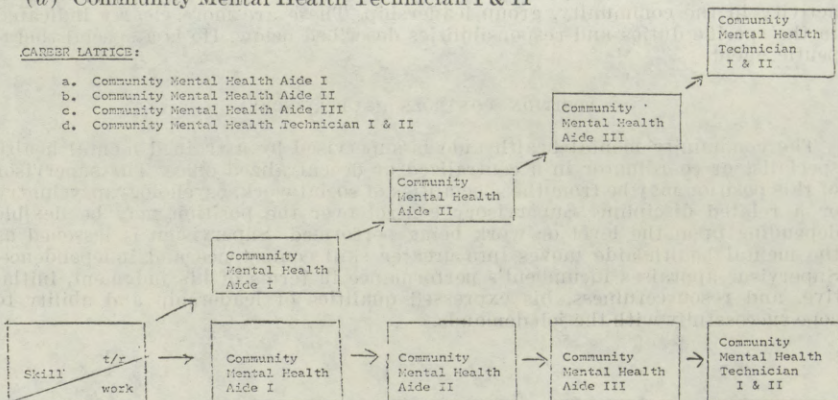
- (a) Fifth grade reading ability
- (b) No current history of mental disorder
- (c) Personal qualities should include:
 1. Attentiveness and patience
 2. Willingness to help client by listening and offering support
 3. Ability to be flexible
 4. Sensitivity to personal needs, but with objectivity
 5. Respect for self and others
 6. Outgoing personality
 7. Good verbal ability (with training)
- (d) Successful completion of designed training in community mental health aide activities as job roles

CAREER LATTICE

- (a) Community Mental Health Aide I
- (b) Community Mental Health Aide II
- (c) Community Mental Health Aide III
- (d) Community Mental Health Technician I & II

CAREER LATTICE:

- a. Community Mental Health Aide I
- b. Community Mental Health Aide II
- c. Community Mental Health Aide III
- d. Community Mental Health Technician I & II



CODE FOR QUALITY CONTROL OVER POSITION OF MENTAL HEALTH AIDE (JOB ELEMENTS)

EXPERIENCE AND/OR EXTENT OF TRAINING

Code 1—Has received training on the subject matter and/or task, but can use the knowledge or skill only if assisted in every step of the operation, with few exceptions. Requires more training (in-service) and experience.

Code 2—Understands the subject matter or task to be done. Has applied part of the knowledge on the job and in a training situation. Can do the job if *closely supervised in the more difficult parts*.

Code 3—Understands the subject matter or task to be done and has done the job enough times to make sure he can do it. Needs more practice under *limited* supervision.

Code 4 (Technician I)—Has a complete understanding of the subject matter or task. Can do the task completely and accurately *without supervision*, though supervisory controls are available.

Code 5 (Technician II)—Has a complete understanding of the subject matter or task. Can do the task completely and accurately without supervision. Can teach others to do it and can apply the techniques and skills to similar situations.

SOME DUTIES AND TASKS ANALYZED

1. Referral and intake for therapeutic activity group. Tasks:
 - (a) Make telephone calls to referral resources
 - (b) Receive referrals from community agencies
 - (c) Set up interview schedules
2. Interview Individual or group members. Tasks:
 - (a) Schedule the interview
 - (b) Meet the client
 - (c) Discuss interview needs (information)
3. Observe and report on client (group or individual). Tasks:
 - (a) Select client to be observed
 - (b) Attend to what the client does (observe)
 - (c) Take notes of meaningful behavior
 - (d) Discuss with supervisor
 - (e) Write up the report (limited)
4. Assist in crisis situations. Tasks:
 - (a) Set up interview appointment for senior staff member
 - (b) Accompany senior staff to investigate crisis
 - (c) Discuss crisis situation with senior staff
 - (d) Help formulate a decision on the problem
5. Participate in individual or group supervision. Tasks:
 - (a) Set up scheduled appointments
 - (b) Discuss job-related problems
 - (c) Analyze or assess the problem
 - (d) Integrate supervisory guidance in the solution of the problem
 - (e) Make some decision concerning the problem (limited)
6. Write up case histories (progress reports on client or family). Tasks:
 - (a) Define the report (purpose)
 - (b) Conduct the interview
 - (c) Record notes on process
 - (d) Integrate information for interpretation
 - (e) Write summary of case history
 - (f) May be called upon to interpret report. Report to supervisor
7. Provide "maintenance counseling" with youth about personal problem (limited). Tasks:
 - (a) Define the problem
 - (b) Set up individual interview
 - (c) Conduct interview. Report to supervisor.
8. Assist in intake procedures. Tasks:
 - (a) Receive telephone referrals
 - (b) Establish intake-referral file
 - (c) Establish intake interview
 - (d) Establish record

Mr. ROGERS. Thank you very much, Doctor. I think your suggestions are excellent. I am delighted to see this ladder of careers, and I see in your statement you have given us a job description.

This will be most helpful, because I want to go into this in depth. We may call you to give advice to the committee later on.

Mr. STEINBERG. I would be delighted to do so.

Thank you for the opportunity to appear.

Mr. ROGERS. Do you have any questions, Mr. Preyer?

Mr. PREYER. No, no questions.

Thank you for coming.

Mr. ROGERS. Our last witness is Dr. John B. Carver, director of the Multi-County Comprehensive Mental Health Center, Tullahoma, Tenn.

Doctor, we are delighted to see you. If you have a prepared statement, we will make it part of the record at this point.

We have another call on, as you see, but you go ahead. And if you would just highlight your statement for us, we will make the statement a part of the record at this point.

STATEMENT OF JOHN B. CARVER, DIRECTOR, MULTI-COUNTY COMPREHENSIVE MENTAL HEALTH CENTER, TULLAHOMA, TENN.

Mr. CARVER. Thank you, Mr. Chairman. I will be happy to do that. How much time do we have?

Mr. ROGERS. We may get the second bell in 5 minutes.

Mr. CARVER. Thank you very much for the opportunity to appear.

My testimony has been submitted. Let me mention to start with that I do support what the other mental-health-center directors have said before you this morning. For reasons that relate to what I have to talk to you about, we decided to sit separately.

I am with the National Council of Comprehensive Centers and serve as a regional coordinator and vice chairman of that body. The national council was formed at a Denver conference last month of federally funded mental health centers. This conference produced the fifteen point resolution attached to my statement. I will confine my remarks to point 12 of that resolution.

We need more money. I think that is evident. But I am not going to make a point of that, because it would be just belaboring the point. So I am here to talk about how we allocate the money.

I am personally quite concerned that it is not enough to maintain or even expand current services, because they are simply too inefficient.

We have no choice but to deliver services more efficiently; failure to do so will see us back before you in 20 years still quoting the same dismal statistics.

More Federal funds will not answer this problem although we have been quite successful at fooling ourselves that it will. Mental health professionals have not come to grips with this issue. We keep acting as if we really can staff those 454 comprehensive centers without depleting still further the manpower of other mental health agencies. Psychiatrists and psychologists are not now walking the streets, gentlemen. They have jobs—jobs that become vacant when we place them into new center positions. The “maintenance of effort” provision may work

very well for any given center but it is almost meaningless when viewed on the national scale.

The preferential funding proposed for children's services, for alcoholism and for addiction is well meant. I had the feeling today listening to these distinguished witnesses that pretty soon there would not be one target group left for whom preferential funding had not been advocated. The witnesses you have heard are not really contradictory; this state of affairs just underscores the dilemma we are in. Every worthwhile area is being inadequately dealt with due to manpower shortage. Mr. Gorman argues brilliantly for children's services, Dr. Knott for alcoholism, and the list can be extended further.

The alarming fact is that if we chose one target group—say, children, for example—and applied all existing professional manpower to it on a direct service basis we would probably still be unable to keep up with the needs. We must produce more public service per man and more service per dollar. This is critical. We are talking about the very potency of mental health systems to deal with this national problem. Right now we are failing; if you only give us more money we'll fail in newer buildings and with better paid staff, but fail we will.

Mental health problems come out in many ways—in psychosis, in law school achievement, in law enforcement problems and a host of other channels. Every school system and police department should have access to a specialist in human behavior, but we cannot help them with our current wasteful use of manpower. We have learned these lessons, but we need your help to correct the situation. A change in how we allocate funds—not necessarily more funds—can do more to raise our services per dollar and public good per professional than any other one step Congress can take.

(Dr. Carver's prepared statement follows:)

STATEMENT OF JOHN B. CARVER, PH. D., DIRECTOR, MULTI-COUNTY COMPREHENSIVE MENTAL HEALTH CENTER, TULLAHOMA, TENN.; VICE CHAIRMAN AND REGIONAL COORDINATOR IV, NATIONAL COUNCIL OF COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTERS

Mr. Chairman, gentlemen of the committee. The encouragement, technical assistance, and the funding made available by the Congress in Community Mental Health Acts and Amendments since 1963 have brought about a significant and powerful reorientation of the mental health professions toward the problems of community mental health. Reputable witnesses can testify to this committee regarding the need for continued assistance from the Department of Health, Education and Welfare so that this nationwide effort to deal effectively with human behavioral and emotional problems at the community level shall not falter at this critical point in its development. These witnesses speak competently regarding the expansion and extension of funding under the Acts. As a center director, I wholeheartedly support them and endorse the resolution adopted unanimously by the National Conference of Federally Funded Mental Health Centers last month. A copy of that resolution is attached to my testimony. But I have not come to Washington to ask specifically for more money, although our needs speak loudly to that point. I am here instead to ask that this subcommittee consider a change in the distribution of funding which holds promise of multiplying many times the amount of public good to be produced from each mental health dollar, specifically, point 12 in the resolution.

You gentlemen have wrestled with many variables in these bills and no doubt for every alternative you have faced there have been those with interests willing to speak long and eloquently upon both sides of any issue. It is not my intention to complicate your task, but it is my aim to bring to your attention one glaring problem in our current approach to community mental health. Like many problems, however, this one inherently carries with it the opportunity to build upon our growing experience in operating community mental health programs. We

must not be content to produce newer buildings and larger staffs without developing more services per dollar and more efficient use of our scarce manpower.

In any given year of federal support under the Comprehensive Centers Acts, staffing costs for all types of mental health services have been funded at the same level. Apparently the Congress has assumed that all elements of mental health service are either equally important to the public good, or it has assumed that local needs, and therefore local decisions, would dictate which elements of service should be emphasized at any given mental health center. Accordingly, inpatient service, diagnostic services, outpatient services, consultation services and the other elements of comprehensive mental health centers receive the same level of support at any given time.

While numerous questions have been raised concerning the inclusion of land costs in the Bill, the length of federal support for centers, inclusion of nontechnical personnel under the grants, and other variables with which we have had to deal, comparatively little has been said about differential funding of the elements of mental health service. Yet, as I wish to point out to you in the next few minutes, this one consideration stands a greater chance of significantly affecting this nation's mental health than any other single move, even more perhaps than the initiation of this entire program itself in the Act of 1963.

Having made these statements, I am now out on a very long limb. I would like to show you how I got there.

THE MANPOWER DILEMMA

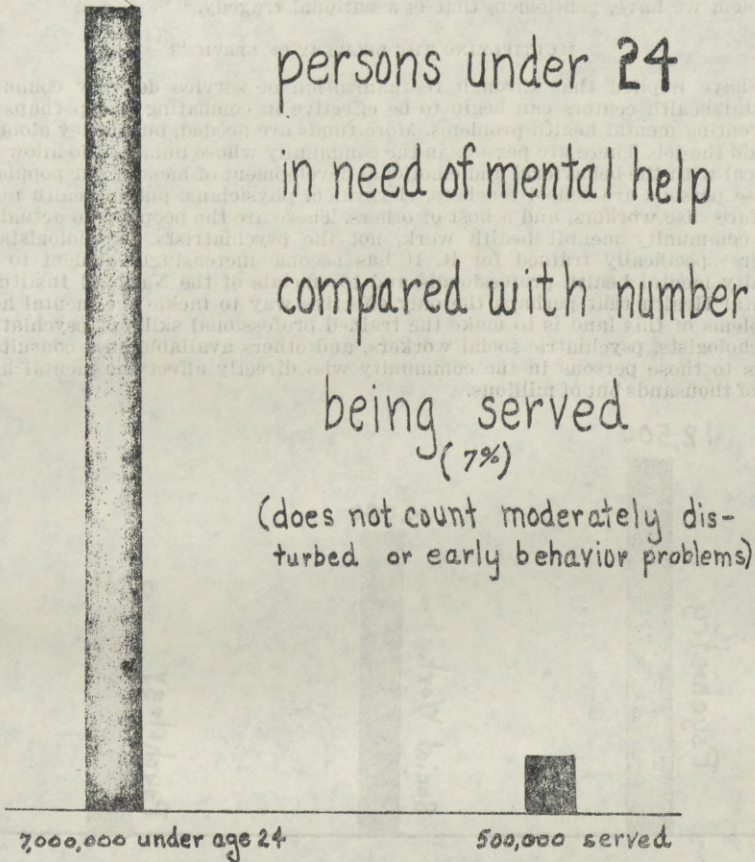
If one word can be said to be descriptive of the mental health problems of this nation, that word might be "overwhelming." Nothing is more blatantly obvious about the problem with which this committee concerns itself today than its sheer size. Incapacities due to emotional or behavioral problems account for the filling of as many hospital beds as all physical diseases and accidents combined. According to the latest figures released by the Joint Commission on the Mental Health of Children approximately 11% of the young people of this country are handicapped with emotional disorders ranging from seriously disturbed to psychotic. This, gentlemen, is 3 children per classroom across the land, and it does not even count the moderately disturbed nor the early behavior problems most susceptible to preventive intervention. Mental hospital statistics reflect only a portion of the outcome of this grave situation. Suicides, attempted suicides, criminality, accident rates, broken homes, the failure to resolve interpersonal and intergroup conflicts that can be seen in riots across our land, all of these are related to difficulties of human adjustment, broadly called mental health problems. Statistics can be quoted endlessly, but they only continue to show that the size of the problem is such that it cannot be effectively dealt with directly by existing manpower. I would like to emphasize my statement once more. The problems of community mental health to which the Congress has addressed itself cannot be effectively prevented or even significantly controlled by the available mental health manpower now or in the foreseeable future given present systems of service delivery. The experience of federally supported comprehensive mental health centers in the past several years has only served to make us more cognizant of this harsh reality.

Figure 1 illustrates the outcome of this situation with just those under the age of 24. The Joint Commission on the Mental Health of Children found that in this age group alone there is at best a 14 to 1 ratio between young people needing service and those receiving it. According to the figures released by the Joint Commission the column of 7 million might even be more, perhaps 10 million, a 20 to 1 ratio. Again, these figures do not include young people who are only moderately disturbed. No one can do more than guess, but it would not be surprising if this number swelled to 20 million if we included the moderately disturbed as well.

That is the situation with children. To conserve your time I will not bother to illustrate the increase in the size of this problem if we include persons over the age of 24.

To say we have a manpower problem in this business is an understatement. The American Psychiatric Association has this year published a manpower analysis which indicates approximately 12,500 full-time equivalent psychiatrists are in clinical practice; that excludes teaching and research. Clinical psychologists and psychiatric social workers who in many cases are also trained as psychotherapists have made their numbers known in nearly so clear a way, but if liberally counted, they might contribute a pool of 17,500 to the psychotherapists manpower, as shown in Figure 2.

JOINT COMMISSION REPORT:



We are short on physicians in this country, being far outstripped in that category by the Soviet Union and others. But mental problems which loom on the whole as numerous as physical ills can boast only 15 professional psychotherapists per 100,000 population compared to approximately 136 physicians per 100,000. The number of law officers, included for comparison, ranges from 90 to 180 per 100,000 in county and city, respectively.

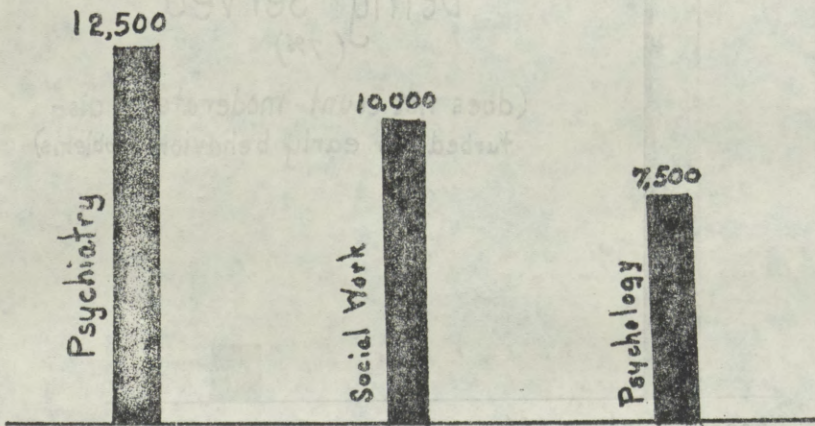
I do not wish to imply that community mental health programs face an unsolvable task. Not at all. It is imperative, however, that community mental health programming reorganize its delivery of services if it is to address itself to the entirety of community mental health problems, rather than to a hopelessly small portion of those problems.

Mental health professionals are trained primarily to deal with individual patients. We generally do this in our office settings where persons in distress are expected to come to us for treatment. While we perform our jobs reputably and even with skill on occasions, these efforts are not effective in combating the mental health problems of the community. The first flaw is that of numbers; there are only enough trained mental health professionals to deal with an insignificant number of human problems. There simply are not enough of us to go around. The second flaw is that of social bias; mental health centers tend to be middle

class institutions and it is only with great effort that we are effective with the economically disadvantaged. The third and perhaps most serious is that we have almost totally overlooked prevention. In a society where departments of public health on every level put great emphasis on the prevention of disease, it is difficult to realize that institutions which address themselves to the emotional health of the nation have only been able to pay lip service to prevention. With the size problem we have, gentlemen, that is a national tragedy.

MULTIPLYING THE DELIVERY OF SERVICES

I have implied that through reorganization of service delivery community mental health centers can begin to be effective in combating and perhaps even preventing mental health problems. More funds are needed, but money alone will not do the job. There are persons in the community whose numbers do allow them to deal with the behavioral and emotional development of most of our population. These persons are school teachers, clergymen, physicians, public health nurses, welfare case workers, and a host of others. These are the people who actually do the community mental health work, not the psychiatrists, psychologists and others specifically trained for it. It has become increasingly evident to community mental health professionals and to officials of the National Institute of Mental Health that perhaps the only effective way to tackle the mental health problems of this land is to make the trained professional skills of psychiatrists, psychologists, psychiatric social workers, and others available on a consultative basis to those persons in the community who directly affect the mental health not of thousands but of millions.



Full-Time Equivalent
Persons in clinical practice
(liberally counted)

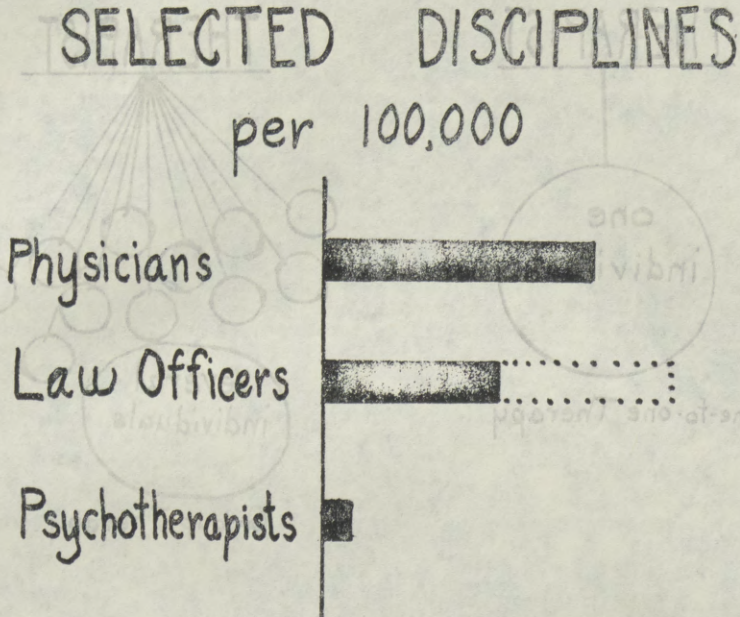
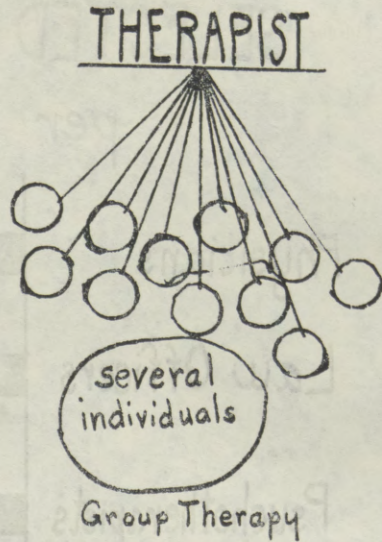
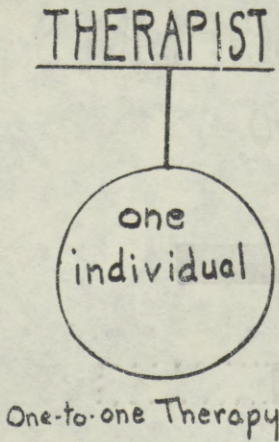


Figure 4 illustrates two ways in current practice of using an hour of a psychotherapist's time. The psychiatrist or other therapist might work with an individual, a couple, or perhaps an entire group of ten people or so. Obviously the group therapy approach has multiplied the number of people we are able to help, but even now with widespread use of group therapy methods the problem is as I have already presented it. The past several years have seen the growth of a new way of using mental health professionals, in the role of mental health consultants. The consultant, a psychiatrist, for example, makes his knowledge and ability available not to dozens per week but to hundreds. In Figure 5 is illustrated the multiplier effect of mental health consultation as it might be seen in a school system. With this approach the young student with disturbed behavior is not referred to the mental health center for treatment by his teacher, but is made the subject of a mental health consultation session between the teacher and her mental health consultant. The child is not seen as a mental patient since the persons, teacher and parents, who were in control of the child's life remain in control. The emphasis is put upon changes in the way parents and teacher behave toward the child, thus forcing the mental health professional to be practical in his recommendations. The teacher is left more competent to effectively deal with the child and confident in her ability to do so, particularly inasmuch as the mental health consultant is at all times as available to her as the nearest telephone.

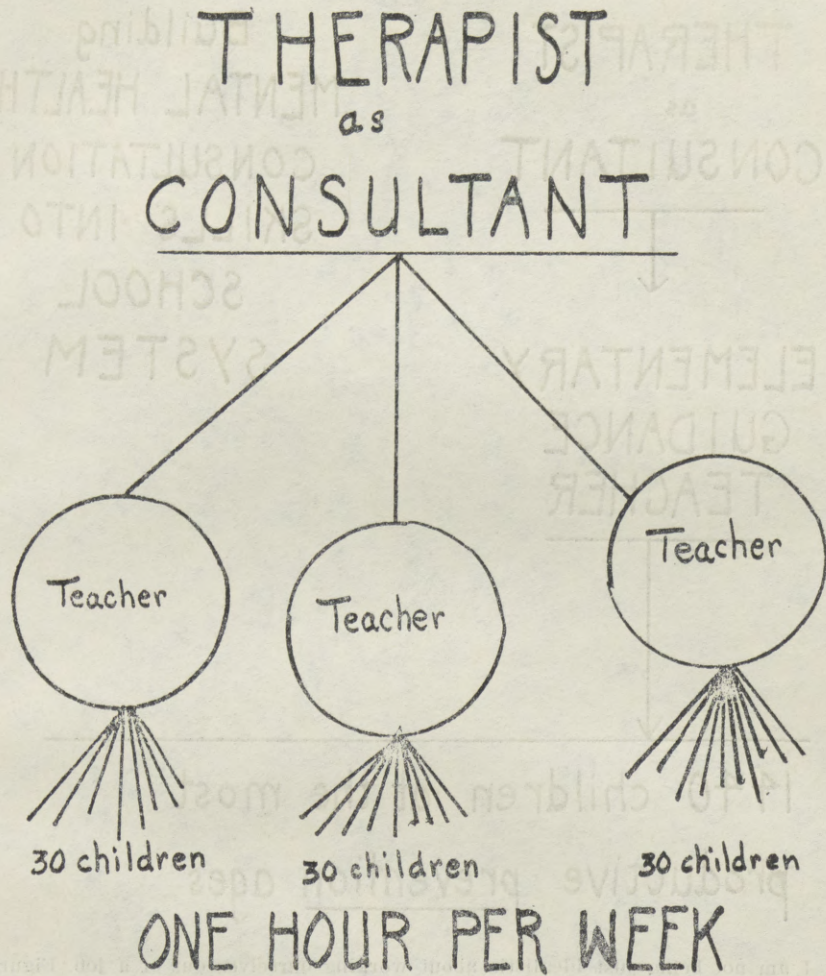
I am currently associated with a federally funded mental health program in Middle Tennessee serving five counties. Our mental health problems of the area served by the Multi-County Comprehensive Mental Health Center are similar to those of the rest of the nation. We have decided that it is an injustice to our taxpayers to run a program of the traditional sort wherein most of our time would be spent with patients. As a result 85% of our service time goes into mental health consultation in every corner of our catchment area. We deal on a regular and systematic basis with school systems, public health nurses, welfare caseworkers, clergymen, and others, imparting our skills and advice to those persons already at work in the community who deal with hundreds of times more people than we could ever hope to help directly. Many of these helping people in the community are serving in tax supported institutions, such as the schools. Our efforts then are bent toward helping these organizations use their tax dollars and more effectively for human adjustment.



Alternate use of one hour per week for one psychotherapist

Mental Health consultation in our area and in more research-oriented settings around the country have broken several myths. One myth is that teachers are not competent to deal with disturbed children in a regular classroom. Another myth is that psychotherapy is the treatment of choice and environmental change in teacher and parent, for example, is a second best approach. There are many misconceptions we have had about mental health for decades which are tumbling; I will mention but one more. It is a myth to assume we are so critically short of professional manpower that we cannot hope to deal with the full blown problems, much less approach effective prevention of these problems. Indeed, the overwhelming lack of mental health services in this country is due as much to inefficient distribution of these services as it is to the critical shortage of professional manpower.

Little Billy is a case which might illustrate the kind of activity which is typical of mental health consultation. Billy is a third grader this year, although it was thought last year that he was too "sick" emotionally to attend regular classes. Billy's parents were fortunate enough to be able to afford private psychotherapy for Billy. This had seemed to help, but Billy was still not in school regularly. The school was at a loss to know how to handle the situation, feeling that to be firm with Billy might cause him to act even more bizarre and to become even more mentally ill. The parents, having exhausted their financial resources for private treatment, applied to the mental health center. Because of the factors I have already mentioned, we tend to limit our outpatient service to emergency situations, leaving more time for mental health consultation in the community. In keeping with this philosophy we asked Billy's parents to put Billy back in school and agreed to work with the teacher and with the parents to reorganize Billy's world.



By concentrating on the practical aspects of his environment and by working not with Billy but with those who knew him better and spend more time with him than could we, we were able to effect a complete change in Billy's approach to school and to life in general. The change in Billy, however, was not more meaningful than the change in his parents and his teacher. The effects of this sort of treatment are numerous. Those whom we serve do not saddle themselves with the incapacitating image of a "mental patient." The school teacher who has learned to deal effectively with one disturbed child by virtue of such consultation cannot help but apply the same skills and approaches to the other children whose problems are equivalent or of less serious nature. She cannot help but apply these principles to the children next year. Early handling of problems become not only possible but probable. I have used a teacher as an example, but I could have used a clergyman or a public health nurse or any one of the hundreds of other community caregivers with whom we work.

Another characteristic of good consultation is that the consultee becomes increasingly less dependent upon the consultant. During the second year of mental health consultation, for example, the teachers should have less need to call in the consultant for the simpler problems. Perhaps if we really did our consultation well, we might work ourselves right out of a job. But we can never hope to approach such a lofty goal so long as we bury ourselves in direct service to the few while the many go unserved.

THERAPIST
as
CONSULTANT

Building
MENTAL HEALTH
CONSULTATION
SKILLS INTO
SCHOOL
SYSTEM

ELEMENTARY
GUIDANCE
TEACHER

1440 children at the most
productive prevention ages

I am not being just idealistic about working ourselves out of a job. Figure 6 shows an approach we have found to be rather efficient in our area. If in visiting with teachers the mental health consultant carried with him some person designated by the school system such as a supervisor, principal, or guidance teacher, even more mileage can be achieved. I am working in one school system currently, for example, in which there are six elementary schools which share an elementary guidance person. This lady accompanies me in my consultative visits with teachers in these schools. I can spend only a few hours a week with this school system, she can spend forty. As we expected would happen, this lady is becoming increasingly able in many areas to deal with mental health and behavior problems encountered by the 48 teachers serving grades 1 through 6. As shown in the diagram the predominant consultation will eventually be with her, rather than with the individual teachers. The possibilities of programming community mental health services so that they become smaller over time rather than continually requiring larger staffs and greater budgets is certainly worth investigation.

Speaking particularly of work with children, this prevention-oriented consultation cuts across a number of later problems. We characteristically build public programs to fight the results of early problems rather than to make concerted efforts to prevent them. Recent legislation aimed at relieving crowded and sub-standard living conditions, poverty, and other social ills are a start in the business of prevention.

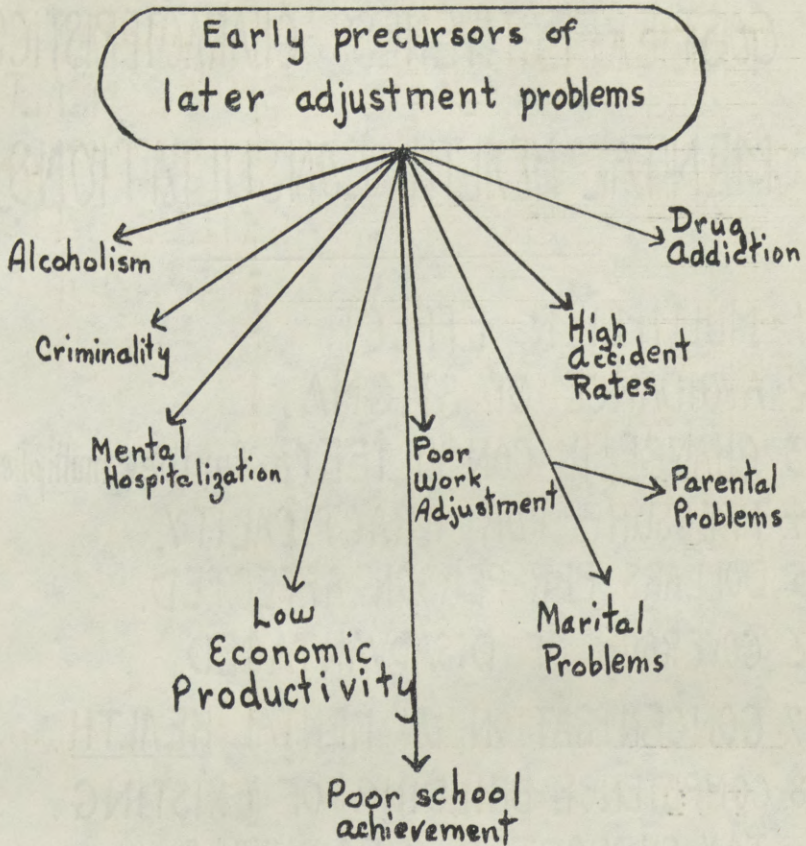


Figure 7 shows some of the resulting problems from early behavioral difficulties. If we can effectively combat them during the ages when they are most easily changed, we might be on the road to prevention. For us in mental health that is an almost unknown road.

The table of characteristics of consultation is presented as a recap of this discussion. The most obvious characteristic is that of the multiplier effect, spreading mental health expertise over a great many more people than can ever be reached as long as we keep our mental health skills inside the therapists' offices. The second point involves the avoidance of stigma. When a person's mental health problems are aided through a teacher or public health nurse or clergyman he does not become labeled a mental patient. Also, getting mental health skills out into the main stream of life will begin to eat away at the popular misconceptions about mental health professionals, their work, and the people with whom they deal. The third point is related to the multiplier effect. Through mental health consultation the teacher learns new attitudes and ways of responding; the clergyman learns new ways of looking at human behavior and new ways of dealing with the problems of his congregation. There is no way to count the numbers of people who can be favorably influenced by this one point alone. Point number four is an interesting challenge for the mental health professions. When we leave our offices and go out where the action is we are called upon to produce, not just to theorize. We find it necessary to talk so that people can understand us. We must make common sense or go back to our drawing boards.

The fifth point is pure economics; no one has computed a figure based on real data, but it would not be beyond reason to expect that mental health programs could reach literally scores of times more people through mental health consul-

COST-EFFECTIVENESS CHARACTERISTICS of MENTAL HEALTH CONSULTATIONS:

1. MULTIPLIER EFFECT.
2. AVOIDANCE OF STIGMA.
3. CHANGE IN CONSULTEE (a further multiplier).
4. PRESSURE FOR PRACTICALITY.
5. DOLLARS PER PERSON AFFECTED.
6. COVERAGE OF DISADVANTAGED.
7. CONCENTRATION ON MENTAL HEALTH.
8. COMPETENCE-BUILDING OF EXISTING.
TAX-SUPPORTED RESOURCES.
9. POSSIBILITY OF PROGRAM SIZE.
REDUCTIONS OVER TIME.

tation than through direct service for the same amount of money. In working through schools and other community caregivers such as public health and welfare, we are serving the disadvantaged just as effectively as the middle class.

With the concentration upon mental health as opposed to mental illness we can aid the moderately disturbed as well as the severely disturbed and we can deal as well with the early behavioral problems which are most susceptible to preventive efforts. This one means very much to me because of my personal concern about the low priority given so far to developing workable prevention programs.

Points 8 and 9 go together in that in building the competence of the existing reservoir of community helping resources, we are operating as a catalyst. Expertise in human behavior is not the exclusive province of psychiatry and psychology; it belongs to the teacher, clergyman, labor leader, corporate manager, lawmaker, economist, physician, law enforcement officer, in short, it belongs to every one whose business it is to deal with human behavior. It is the obligation of mental health professionals to share what they have learned, especially

with those who exert the greatest influence over the development of children. The fact is if we do not make our skills and our concepts available on a wide basis by massive amounts of mental health consultation we will be quoting the same distressing statistics before you in 1980 regardless of whether the Congress appropriates \$70,000,000 or \$700,000,000 for each of the next ten years.

OUR INADEQUATE CONSULTATIVE PROGRAMS

Most socially conscious psychiatrists, psychologists, or psychiatric social workers will agree with the remarks I have made. Yet there is less than a handful of mental health centers, federally funded or otherwise, currently operating which stress consultation and education. Concentration is ordinarily in the areas of direct, face-to-face, fee-producing services. Among the federally funded centers, less than 10% of professional and technical staff time is devoted to consultation and education. It is remarkable that this is true. The National Institute of Mental Health has offered support and encouragement for the development of effective consultative community programs. In training programs across the country the amount of emphasis on skilled consultation methods is increasing each year. Why, then, do federally funded community mental health programs—founded as the “bold, new approach”—fail to be, at least in this one respect, either bold or new?

The most succinct and honest reason for this particular emphasis is expressed not by the psychotherapist but by the accountant. If mental health centers are to live to serve tomorrow they must economically survive today; the most effective way to accomplish that end is to emphasize “paying” services. Consultation efforts in the community—furnishing by far the greatest coverage to the community at large—are difficult to finance except when done in insignificant amounts.

The Joint Information Service which produced the recent Interim Appraisal of community mental health centers found that programs in economic difficulty tended to restrict their consultation-education efforts in favor of fee-producing inpatient and outpatient services. Mental health programs must, in order to remain solvent, go where the money is. It is unfortunate that in order to stay financially alive we must curtail the one service which can actually change community mental health.

CORRECTIVE FUNDING

The Community Mental Health Act of 1963 and subsequent amendments have been effective as a first step toward mobilizing mental health manpower in the direction of community services. As the Congress now considers renewal of these efforts, I respectfully plead with you to provide some help out of our own economic shortsightedness. It is urgent at this point that we learn from the years of federal mental health center funding that neither chance nor professional judgment can be trusted to design our programs in such a way as to serve the greatest public good when we are faced with opposing pressures for economic survival.

Everyone has money problems. I hope we are not so naive as to think we shall ever be without them. But it would be a national tragedy for these problems of money to continue to force us to operate mental health programs for the economic benefit of our own institutions rather than for the greater mental health benefits to the taxpaying public.

Unless mental health consultation is given greater impetus through legislative encouragement, the mental health problems of this nation will not be one whit better in 1989 than they are in 1969. In fact, given the critical and worsening manpower gap and the reversed state of financial incentives, these problems may well get worse.

In order to tap the powerful resources available through mental health consultation, the Congress must provide incentive to offset the existing state of financial forces. Preferential funding will provide this incentive. Specifically, preferential funding for mental health consultation will produce two effects. First, such funding will liberate manpower potential now encumbered by inadequate delivery systems. And second, higher support for consultation will stimulate the development of expanded consultative services and the innovation of increasingly efficient methods.

I am asking this committee to fund the consultation-education element of service at a rate at least 15% higher than the funding of other services in any given

support year. This is the critical point of my testimony. Again, I am requesting that consultation-education be funded preferentially at a federal participation level at least 15% greater than support for direct patient services.

Differentially funding consultation carries with it the opportunity for effecting a significant breakthrough in our nations' primary health problems.

RESOLUTION

NATIONAL CONFERENCE OF FEDERALLY FUNDED COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTERS

Whereas, the National Community Mental Health Centers Program has initiated a provision of comprehensive mental health services and,

Whereas, a substantial portion of these services are preventive and educational, and

Whereas, state and local governments do not have the tax base, together with fees, service contracts and local philanthropy to wholly support the programs, and

Whereas, the survival of some centers is now threatened for lack of adequate funding.

Now, Therefore, the National Conference of Federally Funded Comprehensive Community Mental Health Centers does hereby resolve that

1. the Community Mental Health Center legislation (Public Law 88-164 as amended) should be extended five (5) years.
 2. increased levels of fiscal authorization be supported.
 3. the centers' programs receive full funding, i.e., the appropriation matching the authorization.
 4. the period of support for all centers (old and new) be extended from fifty-one (51) months to ten (10) years.
 5. support levels in poverty areas be increased to ninety (90) percent during the first two years and seventy-five (75) percent for years three through ten.
 6. the support levels in non-poverty areas be no less than seventy-five (75) percent during years one and two, sixty (60) percent for year three, forty-five (45) percent for year four, and thirty (30) percent for the years five through ten.
 7. full cost grants of one year duration be made available for initiating and developing mental health center programs.
 8. special programs in alcoholism and drug addiction be supported at no less than ninety (90) percent for the first two years and seventy-five (75) percent thereafter.
 9. training and evaluation grants for alcoholism programs be supported at levels indicated above.
 10. all personnel working in community mental health centers be eligible for federal support.
 11. childrens' programs be encouraged with federal support and integrated into community mental health centers as appropriate.
 12. indirect services of consultation and education be funded at a higher federal participation percentage than direct services in any given support year.
 13. research and evaluation be funded at the ninety (90) percent level for the duration of the grant period.
 14. the acquisition of land for community mental health centers and architect fees be included in eligible construction costs.
 15. the level of the states' allotment for administering community mental health centers construction plans be increased from two (2) to five (5) percent.
- Unanimously adopted October 25, 1969, Denver, Colorado.

Mr. ROGERS. Are there any suggestions as to changes in the legislation?

Mr. CARVER. Yes, sir; I do have some.

Mr. ROGERS. Would you point that out in your statement to us?

Mr. CARVER. Yes. May I have about two minutes to get to it?

Mr. ROGERS. Are they outlined?

Mr. CARVER. Yes. If you go to the last page, the suggestion that I have for correction of the situation is included. This is based on the fact—when I mentioned efficiency, I am talking about numbers of people served—we have now a situation in this country wherein people

under the age of 24, if we take all the kids in that age group who are seriously disturbed or worse, it amounts to approximately 7 million children.

Now, we are currently serving about one out of 14 of that number. We can multiply the number of people we are serving by 7 and still only be getting to half the number of children who need the services. And that is not counting the moderately disturbed, or the early behavioral problems that are most susceptible to preventive intervention.

In other words, we are not solving the problem. We are working hard, but the delivery of services gets in our way, and the manpower problem, as pointed out yesterday and today.

In the Assistant Secretary's testimony, this was made a point of in the first few pages.

The problem we face with manpower is not going to get a great deal better very fast. There is no way, given current manpower and current systems of service delivery we can prevent, and we can't even significantly control the mental-health problems we have. We just don't get to enough people.

One of the ways that the Congress has suggested earlier, through the earlier legislation, going back to 1963, was the consultation-education part of the service, because through this we can get a tremendous multiplier effect.

If I might refer very quickly to the program we are running in middle Tennessee as a model of this kind of design, we work with schoolteachers, public-health nurses, clergymen, welfare workers, mostly people in tax-supported institutions to effect better early detection and even prevention of mental disorders.

In this way, instead of reaching dozens a week, we reach hundreds a week.

Mr. ROGERS. Is the technique you use outlined in your statement?

Mr. CARVER. Yes. This is all in the prepared statement.

Mr. ROGERS. Good. We will go through this carefully.

What you are saying is that we need to develop a system of consultation to begin to catch these problems quickly.

Mr. CARVER. That is the only way we will not come back to you 20 years from now saying the same things we are saying now.

Mr. ROGERS. To do it in the school system is the best way, and to have your psychotherapists do it with your teachers and ministers, and so forth.

Mr. CARVER. He becomes a mental-health consultant.

Mr. ROGERS. You have given us the technique?

Mr. CARVER. Yes.

If I might add one more point, I have given you the reasons why we don't do more of this. And it is a very simple financial reason. It is that we don't get paid for the work in the same ways we get paid for other things.

Mr. ROGERS. Do you think the law should have specific authorization for this type of work, specifically pointed up?

Mr. CARVER. It is specifically pointed out how the law could be amended to cover this area in my prepared testimony.

Mr. ROGERS. You have done well in 5 minutes. I think we have the gist of what you said, and we will go over your statement.

Do you have questions, Mr. Preyer?

Mr. PREYER. No questions.

Mr. ROGERS. We appreciate your staying so late in the afternoon.

The committee will adjourn until 10 o'clock tomorrow morning.

(Whereupon, at 3:45 p.m. the subcommittee adjourned, to reconvene at 10 a.m. on Thursday, November 20, 1969.)

COMMUNITY MENTAL HEALTH CENTERS ACT EXTENSION

THURSDAY, NOVEMBER 20, 1969

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

The subcommittee met at 10:30 a.m., pursuant to notice, in room 2128, Rayburn House Office Building, Hon. John Jarman (chairman of the subcommittee) presiding.

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

As we continue the hearings on H.R. 14617 and other bills dealing with the community mental health extension program, our first witness will be the Honorable Earl F. Landgrebe, our colleague from the State of Indiana. Mr. Landgrebe has a short statement he would like to present.

STATEMENT OF HON. EARL F. LANDGREBE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF INDIANA

Mr. LANDGREBE. Mr. Chairman, I thank you for this opportunity to present my views for the subcommittee record regarding the Community Mental Health Centers Amendments of 1969.

I have long had an interest in mental health and am a member of the mental health organization back in the second district of Indiana. I have followed and will continue to follow your proceedings in this vital area with great interest. And you can be sure that my vote on the House floor regarding this legislation will be most sympathetic toward the problems of mental health in the United States.

My principal reason for wishing to make a statement for the record, however, is not so much to talk about my own interest in mental health as it is to point out the high quality of mental health centers that would be helped by this bill, particularly in my District.

The Second Congressional District of Indiana is blessed with three community mental health centers of the highest quality. These are located in Lafayette, Michigan City, and Valparaiso and serve Tippecanoe, La Porte, and Porter Counties.

So often we are asked to fund projects which are more equipped to waste money than to put it to responsible use. But in the case of these three mental health centers, which are probably typical of most such centers around the country, I am convinced that every dollar we authorize for them will be put to work 100 cents' worth.

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To illustrate my point, I would like to insert at this point in the record the Proposal for the Establishment of a La Porte County Comprehensive Mental Health Center. This well-planned and coordinated proposal, written in the form of an application for Federal funding, is typical of the high caliber of professionalism and responsible planning and management that is found in all three centers.

(The Proposal for the Establishment of a La Porte County Comprehensive Mental Health Center has been made a part of the file on this legislation and is available to the general public as well as the committee members and staff.)

Mr. JARMAN. Thank you, sir, for your fine statement.

Our next witness this morning is Dr. William E. Schumacher, director, bureau of mental health, department of mental health and corrections, from the State of Maine, who is representing the National Association of State Mental Health Program Directors.

Doctor, it is good to have you with us this morning.

STATEMENT OF DR. WILLIAM E. SCHUMACHER, NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS; ACCOMPANIED BY HARRY C. SCHNIBBE, EXECUTIVE DIRECTOR

Dr. SCHUMACHER. Mr. Chairman, I am Dr. Schumacher, director of the mental health program for the State of Maine. Accompanying me is Mr. Schnibbe, executive director of our national association.

I am here today representing the directors of the mental health programs in the 54 States and territories.

It is important that the members of this committee understand the relationship of the State governments to the community mental health centers program. Mr. Chairman, the largest dollar investment in community mental health centers in this country comes from State government. To date the total Federal investment in the community mental health centers program (through the end of fiscal year 1969) is \$282 million.

The investment by the States in federally funded centers is \$310 million (for support of both construction and staffing). I say "federally funded" for very special reasons. In most States the State mental health agency is also funding "centers" and a variety of other community programs that have no Federal support. These are programs which are not in themselves centers.

For example, in just two States alone (California and New York) the State community mental health support is \$100 million per year. So, Mr. Chairman, I want to repeat for emphasis—more State dollars have gone into the Public Law 88-164 community mental health centers program than from any other single financing source.

It is clear then that the States—as demonstrated by the data I have just cited—are not only wholehearted supporters of the community mental health program concept, but are its principal source of financial underwriting.

As the principal funding source for the monumental nationwide effort to promote treatment of mental illness at the community level, the States welcome and endorse extended Federal support of that portion of the community mental health program called the "centers."

We are anxious for our continued long-term partnership.

You have heard extensive testimony of the many issues that constitute the essential parts of the several bills before your committee.

I will try not to repeat any of that testimony, since we substantially agree with the proposals made to you yesterday by the directors of presently operating community mental health centers in seven different States.

There are several specific issues to which the States wish to address themselves.

However, before I describe them, I think it is important the States at least be on record before this committee as especially endorsing certain provisions which we hope will become part of the new legislation renewing Public Law 88-164 (the Community Mental Health Centers Act, 1963).

We favor:

Federal assistance for the operation of the centers (as distinguished from support of professional and technical staffings). While personnel usually constitutes some 80 percent of the operational costs, a portion of that 80 percent is for clerical, maintenance, accounting and business people. These are not professional and technical persons, and these are essential people to an operation. Psychiatric medication, telephone calls, and many other things are a great financial burden and a great expense. Many States in their own community mental health grant programs use operational costs, and this has been demonstrated to be an effective way of providing grant aid.

Secondly, we favor extension of the period of support of operations of the centers beyond the present 51 months.

Federal support of operations at a level no less than 30 percent in any 1 year. Why 30 percent? It seems as reasonable as the choice of the original percentages. There is no solid reason for a 30-percent figure that I can determine, but it is the lowest level of Federal support in the present program. It is enough to be more than token level of support, and it still leaves the major financial responsibilities for the support of these centers with the localities and with the State, but it does involve the Federal Government on a more extended level.

Federal support of centers in poverty areas at a level of 100 percent for at least an initial period, and in no year less than 75 percent, and I believe the committee heard from Dr. Harris of Los Angeles previously about this particular matter.

We favor preferential matching for stimulation of mental health programs for treatment of children, alcoholics and narcotic addicts. Preferential matching seems a better way to handle this placing of special emphasis on particular problem areas, because it prevents fragmentation and compartmentalization that occurs with earmarking funds for certain specific programs. It does provide incentives for special programs without making these discrete and distinctive, and it permits their function.

Finally, we favor acquisition of land as a cost eligible for Federal support. With the quality of buildings we build using Federal specifications, they will last a long time. There should be no barrier to reasonable site selection, and there is with the limited local funding and State funding for construction.

In particular, the States raise the following additional issues, and I hope if you have questions you will raise them as I mention each point.

The first is that the Federal support of a portion (no less than 30 percent) of the operating costs of CMHC's should be permanent—not 51 months, not 7 years, not 10 years, but permanent.

Mr. ROGERS. Do you mean you want us to start out with a 30 percent level of funding for the operation of a center?

Dr. SCHUMACHER. Not necessarily.

Mr. ROGERS. That is what you are saying here, I believe, that you want us to give 30 percent funding permanently.

Dr. SCHUMACHER. What we had envisioned was a reduction to the 30 percent level under the existing program and a continuation of the 30 percent level on an indefinite basis.

Mr. ROGERS. I don't believe that is what this says. I think you had better clarify that to make sure, because I would think that it should be operating costs, 30 percent.

You say not at 51 months, not 7 years, not 10 years, but permanently, and that would indicate not for 51 months or 7 years, but permanently.

Let me ask you this: Do you think it is well maybe not to say in this legislation "permanently," because we will have to make studies as we go along. Suppose we have medicare and medicaid come in very heavily and this changes the picture entirely. Wouldn't you agree that that ought to be a factor to be considered before we set down any permanent rule?

Dr. SCHUMACHER. I would feel the extension of this should be until a payment method such as national health insurance took over the fee-for-service type of payment.

Mr. ROGERS. I see what you are getting at, but that is why we want to put it on a 3-year basis at a time. Congress needs to look at the program.

Mr. SCHNIBBE. Mr. Chairman, Congressman Rogers, what we want to do is distinguish between renewal of the program and the support of the operations of the centers. I don't think we would argue about renewal of the program every 3 to 5 years.

What Dr. Schumacher is testifying here is that some kind of permanent guarantee is available for operation support if the program is renewed every 3 to 5 years.

Mr. ROGERS. Yes, I understand. You want a base of 30 percent and you would hope that would be continued in the renewal that we would have every 3 years.

Dr. SCHUMACHER. Yes, very much like what is applied to welfare programs and other programs. This is a national problem, and we feel this type of commitment is indicated for a problem of this scope and its influence on the health of the people.

Mr. ROGERS. Yes, I understand.

Dr. SCHUMACHER. Secondly, in the interest of promoting orderly health and mental health planning, the State "mental health authority" should have the authority to approve or disapprove construction applications, but is limited to only "review and comment" on so-called staffing grants.

We do not buy the HEW counter-argument that if a State government "comments" unfavorably, then the grant will not be funded.

First of all, our experience is that this is not true. We have commented unfavorably and grants have been made anyway in at least two States.

Secondly, if it were true in fact that State government's "comments" could determine ultimate Federal approval or disapproval of a grant, then why not write that authority into the law.

We think that it makes sense to place language "approved and recommended" in part B of title II of the act, similar to the existing "approved and recommended" in part A.

This action, we feel, would bring Public Law 88-164 and Public Law 89-105 into consonance with the spirit of Public Law 90-577, the Intergovernmental Cooperation Act of 1968.

We ask the committee to adopt the following amendment, the wording of which follows:

In Part B of Title II of the Community Mental Health Centers Act of 1963 (PL 88-164 as amended by PL 89-105) re-write Section 221(a) to add a paragraph . . . "(6) the application has been approved and recommended by the State agency and is entitled to priority over other projects within the State in accordance with the regulations prescribed pursuant to section 203(2). No application shall be disapproved by the Secretary until he has afforded the State agency an opportunity for a hearing."

Your counsel can probably word an amendment, but any such amendment should require for appeal to higher authority in case of disapproval. The problem, as you can see, is having a mental system inconsistent with the State plan, built and staffed despite the State agency's disapproval, or at least staffed, and then turning to the State agency for its continuing operation and support. This is what has happened in two States that we know of.

Mr. ROGERS. You are saying that you want approval given by the State mental health agency, not by the State comprehensive planning agency?

Dr. SCHUMACHER. No, the State planning agency, the one empowered to administer the State plan.

Mr. ROGERS. What is your feeling, or maybe you could go into it—

Dr. SCHUMACHER. Yes, I will.

Third, the act should be extended for no less than 3 years, but preferably 5 years, in order to allow State legislatures and State executive offices proper leadtime to authorize and fund the State's matching shares of the community programs.

And it is almost like a new ball game. Our State legislatures, many of them, meet biennially, and the first time a matter is presented it does not necessarily receive favorable consideration. You need leadtime for education, for the development of support, and 3 years is too short a time for the duration of a measure of this importance.

Fourth, H.R. 14617 has a feature in its that is unique to that bill (none of the other House bills contain this provision) and I wish to comment for a moment on it. The provision is on page 4 and page 5 of H.R. 14617 and concerns "approval" of State CMHC construction plans and "review and comment" on CMHC project applications.

Sections 2(d) and (3) of H.R. 14617 require that each State construction plan under part A of the Centers Act be approved by the State mental health planning agency and the State comprehensive health planning agency under section 314(a) of the PHS Act. They also require all construction applications to be submitted to the section 314(b) area-wide planning agency for review and comment within 60 days.

Comprehensive health planning as provided in the law is a highly desirable activity, but even more appropriate in service planning is the 314(b) regional health planning. However, these activities in many States are not as established as mental health planning, which preceded them by some 5 years.

To vest in these agencies control of mental health plans and applications, while desirable for future legislative provision, is not appropriate at this time. To put it bluntly, they are in many instances Johnny-come-latelys. They will not be Johnny-come-latelys in the foreseeable future. They will be effective, able agencies, but they are now, in most instances, not.

Some States developed excellent plans under both 314(a) and 314(b), but this is the exception rather than the rule. It seems to me that this measure is one which could be postponed until the 314(a) and (b) agencies are better developed and have better comprehensive and legal health plans.

In our State, these agencies are still—the (b) agencies—are still trying to find money to stay alive week by week.

Mr. ROGERS. May I interrupt, Mr. Chairman?

I think it would be well for you to document this for us if you could. I think your association ought to be able to do this.

Mr. SCHNIBBE. Yes, we can do that.

Mr. ROGERS. Give us the status and ability of each State. I think we need this for the record.

Mr. SCHNIBBE. We will furnish that. (See letter, dated December 12, 1969, below.)

Mr. ROGERS. The States that are able to use a comprehensive agency at this time, and those that are not.

Thank you.

Dr. SCHUMACHER. It is a provision that should be subsequently included in the law.

Mr. ROGERS. I would agree with you. I think in 2 or 3 years we would want to require approval in comprehensive health planning, but I think it would be premature at this time.

Mr. SCHNIBBE. We have heard from a majority of States—not a majority, but 15 or 20—and they feel like you do.

The agencies are not strong enough at the moment to handle these things properly. I think we would all agree with you that eventually all this planning should be coordinated, and I will get the information on all 50 States for you.

Mr. ROGERS. That would be helpful. Thank you.

(The following information was received for the record:)

NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS,
December 12, 1969.

Hon. PAUL G. ROGERS,
Rayburn House Office Building,
Washington, D.C.

DEAR MR. ROGERS: This is in response to a query you made during the hearings, November 20, on HR 14086, (extension of the community mental health centers act).

Our discussion concerned a proposed administration amendment to the act, requiring state community mental health center *plans* to be approved by the 314(a) comprehensive health planning agency; and CMHC *projects* to be reviewed by the 314(b) areawide planning agency.

You asked us to determine whether or not the state mental health authorities thought the 314(a) and (b) agencies were developed enough at this time to assume such responsibility.

We agreed to query the states to determine their positions on this matter.

I am able to report to you now that 40 states and territories have responded.

Of the responding states: 21 said "yes", the 314(a)—state comprehensive health planning agency—is at this time sophisticated enough and knowledgeable enough to be able to approve state CMHC plans; 19 states said "no".

On the question of 314(b) agency (areawide planning) review of CMHC projects: 19 states said "no", the areawide agencies are not yet ready; 11 states said "yes".

Attached to this letter is a list of the states indicating their responses. Many of the states provided remarks explaining their position. I have not enclosed the remarks with this letter but they can be made available to you or the other members of the House Interstate and Foreign Commerce Committee at any time.

Respectfully yours,

HARRY C. SCHNIBBE,
Executive Director.

ATTACHMENT TO DECEMBER 12 LETTER TO CONGRESSMAN PAUL ROGERS

State	Sec. 314(a), State health planning agency, is developed enough to approve State plan for community mental health centers	Sec. 314(b), areawide or regional health planning agencies are developed enough to review project applications for community mental health centers
Alabama.....	No.....	No.....
Alaska.....	Yes.....	No.....
Arizona.....	No.....	No.....
Arkansas.....	Yes.....	No.....
California.....	No.....	Yes.....
Colorado.....	Yes.....	No.....
Connecticut.....	No.....	No.....
Delaware.....	No.....	No.....
Florida.....	No.....	No.....
Georgia.....	Yes.....	No.....
Guam.....	No.....	No.....
Hawaii.....	No.....	No.....
Idaho.....	Yes.....	No.....
Indiana.....	Yes.....	Yes.....
Iowa.....	No.....	No.....
Kansas.....	No.....	No.....
Kentucky.....	Yes.....	No.....
Maryland.....	Yes.....	Yes.....
Massachusetts.....	Yes.....	No.....
Michigan.....	Yes.....	No.....
Minnesota.....	Yes.....	Yes.....
Mississippi.....	Yes.....	Yes.....
Missouri.....	No.....	No.....
Montana.....	Yes.....	No.....
Nevada.....	No.....	No.....
New Hampshire.....	Yes.....	Yes.....
New Jersey.....	Yes.....	Yes.....
New Mexico.....	Yes.....	Yes.....
New York.....	Yes.....	Yes.....
Ohio.....	No.....	No.....
Oklahoma.....	Yes.....	No.....
Oregon.....	No.....	No.....
South Carolina.....	No.....	No.....
Texas.....	No.....	No.....
Utah.....	Yes.....	Yes.....
Vermont.....	No.....	No.....
Virginia.....	Yes.....	Yes.....
Washington.....	No.....	No.....
West Virginia.....	Yes.....	No.....
Wisconsin.....	No.....	No.....

Note.—States not responding: District of Columbia, Illinois, Louisiana, Maine, Nebraska, North Carolina, North Dakota, Pennsylvania, Puerto Rico, Rhode Island, South Dakota, Tennessee, Virgin Islands, Wyoming.

Dr. SCHUMACHER. A fifth concern is that the act should be amended to allow the use of 5 percent of the State construction allotment for administration of "any State plan" (i.e., mental health, mental retardation, alcoholism, narcotic addiction, et cetera). This sum (not to exceed \$50,000) should be made available to the agency administering the CMHC plan.

In regard to the above recommendation, we ask that the allotment for administration of the plan be made available for 1 carryover year. This is an amendment, which, if it had been in force in fiscal year 1969, would have given the States \$690,000 to be used for community mental health center planning.

As it was, without this amendment in fiscal 1969, 45 States lost the money (\$690,000), which meant a severe constriction in mental health center planning. Actually, State agencies not only develop the plans, but they also provide a lot of assistance to grant applicants, and we promote the development of mental health centers, and this, of course, is the operation.

We have amendment language to recommend, Mr. Chairman, and it is attached to this statement. It is our assumption, by the way, that this amendment will also apply to administration of the State mental retardation facilities construction plan.

I should like to express my appreciation to the 88th Congress and those of you who passed the original act. I am sure that each center has had the same experience we have had in Maine, the right people in the right setting eager to reach out and reach those with the needs.

Programs are just exerting a major force to change the way in which care is given. There are improvements that could be made to strengthen the program, and I have mentioned several of them above. There is no question about continuing this, but one problem looms ahead.

Many centers are in financial difficulty, and those that will be funded in the future will experience the same type of support.

Many centers will reduce activities to conform to their reduced financial base.

Actually, some of the activities performed by this center are revenue-producing. The direct services to clients, that is. Some of the services which the centers provide are calculated to provide some preventive mental health activities, such as education and consultation and research and training and program evaluation.

These things do not produce revenue, and consequently, with the reduction in support, the activities which first will be reduced are those activities which don't produce any revenue whatsoever to pay for their continuation, and these are perhaps the most promising portions of the program.

I feel that this is a real threat that might change the community health center to a community mental illness center, where we deal only with people with problems, and we don't try to prevent the development of problems.

Because of this, I feel there is a necessity for a period of extended financial assistance, and we are involved in this deeply as far as the States are concerned through our community mental health grant programs, through our direct assignment of State personnel, through the administrative assistance that we provide, we are committed to this

program. I think there are few States that would find any objection to the actual nature of the centers.

We had some doubts at first, but I think we are convinced that it is good legislation and it produces the desired result, and we heartily endorse its continuation and plead with you for a continued Federal commitment to the existing centers and to the new ones that will be funded under an extension of this program.

Mr. Chairman, I have been asked by two other national organizations to express their interest in the extension and expansion of this legislation. They are National Association of Private Psychiatric Hospitals and National Association of County Officials. Both of these organizations, Mr. Chairman, will submit statements for the record later.

It will be of interest to committee members to know that out of 174 private psychiatric hospitals in this country, 71 have expressed a willingness and intention to participate in the CMHC program. Twenty-six private hospitals are already involved in federally funded center programs, 31 plan to submit applications.

Mr. Chairman, this concludes the testimony of the directors of the State mental health programs. I want to express my thanks to you and the other members of the committee for permitting us to present to you these ideas.

(Proposed amendment follows:)

AMENDMENT TO PUBLIC LAW 88-164 (AS AMENDED), "THE COMMUNITY MENTAL HEALTH CENTERS ACT OF 1963," PROPOSED BY NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS

(a) The first sentence of section 403(c)(1) of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 is amended—

(1) by inserting "for any fiscal year" immediately after "title II";

(2) by striking out "during such year";

(3) by striking out "for a year" and inserting in lieu thereof "for any fiscal year"; and

(4) by striking out "for such year".

(b) Section 403(c)(1) of such Act is further amended by inserting immediately after the first sentence thereof the following new sentence: "Amounts made available to any State under this paragraph from its allotment or allotments under part A of title II for any fiscal year shall be available only for such fiscal year and for the following fiscal year".

Mr. JARMAN. Dr. Schumacher, the subcommittee and the committee are very strongly in favor of the program and appreciate the specific recommendations that you have made to us this morning.

Are there questions?

Mr. ROGERS. Just one or two quickly, Mr. Chairman.

Your testimony is helpful, and I think the material you will furnish us could be helpful on State planning.

What contribution should the State make to poverty areas?

Dr. SCHUMACHER. To poverty areas?

I can only respond to my own State. We differentially favor in our community health grants in aid to those communities with economic difficulties. If they are poverty areas, we fund at a higher level. Our law authorizes funding at 50 percent. Some programs are funded only at 30 percent.

Mr. ROGERS. If the Federal Government should come in with 100-percent funding and no less than 75, shouldn't there be State responsibility there?

Dr. SCHUMACHER. I think there should be. One thing I will say with regard to poverty areas is that people who are involved in poverty are not quite like people out of poverty areas in their utilization of services. They don't tend to attend, except in crisis situations, and of course this becomes, then, the least effective way of helping people, and I do think that they don't support agencies as middle-class, more opulent communities do.

Mr. ROGERS. Yes, I understand.

Should there be a maintenance of support, in other words, where there was a level of the various States supporting a certain level, should we at least maintain that amount of support?

Dr. SCHUMACHER. I think so. I think there should be no diminution of State activity.

Mr. SCHNIBBE. Congressman Rogers, on the poverty issue, did you mean it is likely that you might write in the regulations that the States would be required to match a portion—instead of 100 percent Federal money, 80 percent Federal and 20 percent State or something like that?

Mr. ROGERS. What would be your feeling on that?

Mr. SCHNIBBE. Again, if you wish, I will find out what the prevalent practices in the States in special matching systems into the poverty areas is.

I think probably in many of the States there is not a specific provision. I think, you know, there may be providing money on a per capita basis whether it is in Pasadena or in Watts.

Mr. ROGERS. This would be interesting to know, and as soon as we could get it, it would be helpful.

(The information requested was not available to the committee at the time of printing.)

Dr. SCHUMACHER. We managed to get this in our statute in poverty and rural areas both. We are permitted to fund higher in those areas.

Mr. ROGERS. Thank you, Mr. Chairman.

Mr. JARMAN. Mr. Hastings?

Mr. HASTINGS. Thank you, Mr. Chairman.

Dr. Schumacher, I am somewhat interested in the question of drug addiction and how these centers will ultimately lend to the correction of the problem.

Where do you see—what time in the future do you see—where community health centers will be able to effectively deal with the problem of drug addiction?

Dr. SCHUMACHER. Relative to drug addiction, I think you have to extend this out to the abusive, dangerous drugs. In our State, our center, which is now fully operational, is organizing community drug councils, promoting an educational program within the health education program in the school system. We provide detoxification within the inpatient services of the hospital, we provide group therapy for young adult and adolescent drug users and we do provide extended hospitalization in the State hospital.

So, we do try to provide a range of services, because in Maine at least, we feel that the drug abuse problem is not a case of handling

the individual, but preventing the extension of this problem to other people. To curtail its extension is our biggest problem.

Mr. HASTINGS. I think all the services you mention are important to the relation of the problem, but the real problem of the treatment of the addict—New York State, which I represent, as you know we spent, I believe \$133 million on a program which is almost a failure. It has just not solved the problem. It is a tremendous amount of money.

I don't see yet as a practical matter where we are going to have this kind of funding available within this act, the community health program.

Dr. SCHUMACHER. The handling of drug addiction, I think, is a complex problem which requires continuing research. I think you can fund therapeutic programs to, you know, the limit of our ability to do it, and you are still going to come out with a high failure rate.

We don't know enough about drug abuse and addiction to really do an effective job with whatever tools are given to us.

I think that it is extremely important in this field to insure that there are adequate levels of funding for research and program evaluation.

Mr. HASTINGS. Are you suggesting that all within the Community Mental Health Act?

Dr. SCHUMACHER. I wouldn't say, being unfamiliar with this.

Mr. HASTINGS. I think that is probably my main question, whether the main thrust toward the cure of drug addiction should be within your interests, or whether a separate State agency is going to have to handle the bulk of it.

Dr. SCHUMACHER. I would feel that the service component should be strongly intertwined with the community mental health program. This is the best place to do whatever therapy you have, because you make provision for all services within a health center.

I feel there are needs for additional funds within the area of research and broad program evaluation.

There are provisions in the act for program evaluation by the National Institutes of Mental Health, a 5-percent program evaluation component.

I think that perhaps some special consideration and emphasis should be given to the evaluation of what activities are being done in the drug abuse area.

Needless to say, my experience in Maine is completely different from the experience of people in New York, Washington, and San Francisco. Our problem is distinctly different. I think this is an area of research. Why is it so different?

We had 43 reported usage of drugs—

Mr. HASTINGS. In New York, we have a minimum of 60,000 users.

Dr. SCHUMACHER. Grass grew well in Maine this year, but heroin has been very uncommon in Maine.

Mr. HASTINGS. Thank you very much, Doctor.

Mr. JARMAN. Gentlemen, we appreciate your being with us.

Dr. SCHUMACHER. Thank you.

Mr. JARMAN. The Chair might state we have a time problem in this hearing. We have seven more witnesses listed for today, and the hearing time this afternoon will be difficult because the House will be in session on the foreign aid bill.

It would be very helpful to the committee if the witnesses would submit their statements in full for the record and then comment on any highlights that should be emphasized to the committee.

Our next witness is Dr. David H. Knott, medical director, alcoholic rehabilitation unit, Tennessee Psychiatric Hospital, representing the National Council on Alcoholism.

STATEMENT OF DR. DAVID H. KNOTT, MEDICAL DIRECTOR, ALCOHOLIC REHABILITATION UNIT, TENNESSEE PSYCHIATRIC HOSPITAL, REPRESENTING THE NATIONAL COUNCIL ON ALCOHOLISM; ACCOMPANIED BY MIKE GORMAN, LEGISLATIVE REPRESENTATIVE

Dr. KNOTT. Thank you, Mr. Chairman. I am Dr. Knott, the medical director of the alcoholism clinic in Tennessee.

Accompanying me is Mr. Mike Gorman, who is legislative representative for the National Council on Alcoholism.

I will summarize the first four pages of the testimony and submit it to you. These statements emphasize the problem of alcoholism in this country.

Mr. JARMAN. The statement will be received.

Dr. KNOTT. I would like to go over the material on page 5.

On October 30th of this year, President Nixon forwarded to the Congress the administration's proposals for renewal of the Community Mental Health Centers Act. Included in his message are significant provisions for alcoholism which signify a deep and gratifying commitment on the part of the administration to expanded funding for alcoholism programs within the context of community mental health centers.

We are indebted to Congressman Harley Staggers, chairman of this full committee, and Congressman William Springer, the ranking Republican member of the committee, for the rapid introduction of the administration proposals as H.R. 14617.

The administration bill is quite progressive, going considerably beyond the inadequate provisions of the Alcoholic Rehabilitation Amendments of 1968 (Public Law 90-574).

It incorporates a number of the provisions in S. 1997, introduced by Senator Javits and 44 colleagues on April 29th of this year, and H.R. 11361, introduced by Congressman Hagan of Georgia and several colleagues.

However, in contrast to these earlier bills which provide an authorization of \$206 million over a 5-year period of alcoholism activities, the administration bill covers only 3 years in new authorizations and does not include any specific appropriation request. It asks for "such sums as may be necessary."

The main strength of the administration bill is that it gives preferential Federal construction and matching to community mental health centers which will initiate alcoholism units. Moving the Federal matching percentage for construction of alcoholism units up to 90 percent and providing more realistic Federal matching ratios for staffing, operation, and maintenance of these units—from 90-percent matching during the first 2 years and then dropping by 10 percent a

year until the final 10-percent matching in the 10th year of support—is a considerable improvement over the inadequate provisions contained in the present Alcoholic Rehabilitation Amendments of 1968 (P.L. 90-574).

However, it is our understanding that the Senate Subcommittee on Health on November 12th voted to provide 90-percent matching for the first 2 years, and 75 percent over the next 8 years, for the support of specialized services for alcoholics. Since it takes a long and arduous effort to break down current stigmas and get an alcoholism program going, and since most alcoholics have little or no money to pay for treatment, we heartily endorse and support the higher percentages voted by the Senate subcommittee.

In addition to the level of Federal support, the duration of such support is equally important to avoid unreasonably precipitous demands upon local communities struggling to sustain highly expensive and administratively difficult services for alcoholics.

Because of the stigma still unfortunately surrounding alcoholism, and because of the relatively expensive nature of alcoholism treatment services, only a few community mental health centers have provided services for alcoholics. The administration bill offers a carrot to the centers—in essence it says that if a center will take on the admittedly tough problem of alcoholism, it will receive a higher proportion of Federal funding.

However, preferential matching is meaningless unless sufficient authorizing funds are providing. All of us in the field of alcoholism are deeply indebted to Congressmen Staggers and to Congressman Rogers for the introduction of community mental health center renewal bills earlier this year which include specific funding for alcoholism activities.

Both bills (H.R. 13163 and H.R. 14086) provide a total of \$75 million allocated over the next 3 years for the support of both alcoholism and drug addiction activities.

Since alcoholism would get only about \$35 million to \$40 million of this total sum, we would not be progressing much beyond the present authorization of \$15 million in fiscal 1970.

Furthermore, neither of these bills provides preferential matching for alcoholism except in designated poverty areas. The preferential matching proviso is crucial, and we understand that the Senate Subcommittee on Health last Thursday reported out a bill which emphasized preferential matching treatment for alcoholism in this country.

Commensurate with the enormous size of the problem of alcoholism in this country, we respectfully submit that much more money must be allocated to the field of alcoholism. We further propose that a minimum figure of \$30 million a year over the next 3 years, or a total of \$90 million be reserved for the construction and support of alcoholism units in community mental health centers.

We are very pleased that both the administration bill and the original Staggers bill (H.R. 13163) have sections devoted to the training of personnel in the field of alcoholism. I could give you reams of documentation to substantiate the point that we have done little or nothing to train workers in his badly neglected field.

Under both bills, the Secretary of Health, Education, and Welfare is given broad authority to make grants to any public or nonprofit agency to cover part of all of the costs of developing specific training programs or materials relating to the provision of public health services for the prevention and treatment of alcoholism, including inservice training, refresher courses, and the training of supervisory personnel to administer such services.

Both bills also contain important language authorizing similar grants for the conducting of surveys and field trials to evaluate the adequacy of programs for the prevention and treatment of alcoholism with a view to determining ways and means of improving, extending, and expanding such programs.

Since neither of these bills contain a specific dollar authorization, we propose that \$10 million a year over the next 3 years be allocated for these purposes.

One final point: To those of us in the alcoholism field, there is an obvious need for some initial planning money so that the many agencies and people in the community concerned with alcoholism can come together and draw up a satisfactory blueprint for treatment and educational services. Several of the bills before you contain this excellent planning provision, which provides up to \$50,000 to any single community for the planning of a general community mental health center.

However, it is essential that this planning provision be specifically spelled out in the alcoholism section of the bill you finally report. Planning grants for community mental health centers generally do not cover the specific problems of alcoholism.

For example, under the provisions of the Alcoholic Rehabilitation Amendments of 1968 (P.L. 90-574) alcoholism activities do not necessarily have to be part of a central community mental health center; they can be provided through an affiliate relationship with the center, or in those communities where no community mental health centers exist; alcoholism services can be established on their own. For these reasons, it is important that the planning grant mechanism be specifically extended to programs in the field of alcoholism which, in many cases, exceed the boundaries of present community mental health centers.

I think it is important for us to remember that alcoholism is a mass disorder of mankind, and we have never controlled a mass disorder by treating only the affected individual.

The need for comprehensive programs emphasizing research and education in the area of alcoholism will necessarily involve all the individuals in the patient's emotional and social ambit. Then an impact will be made on a serious public health problem in this country.

Thank you for allowing me to submit this material before the committee.

(Mr. Knott's prepared statement follows:)

STATEMENT OF DR. DAVID H. KNOTT, MEMPHIS, TENN., MEDICAL DIRECTOR, ALCOHOLIC REHABILITATION UNIT, TENNESSEE PSYCHIATRIC HOSPITAL; REPRESENTING NATIONAL COUNCIL ON ALCOHOLISM

I am deeply puzzled by our seeming inability to persuade the American public and our duly elected legislative representatives at the federal and state level that alcoholism has reached epidemic proportions in this country and requires a comprehensive federal, state and local effort in the area of research, training and treatment services.

You are no doubt familiar with recent statistics from the National Institute of Mental Health estimating that there are five million people in the United States who are alcoholics, affecting twenty million family members. An estimated 200,000 new cases of alcoholism are reported each year, and this seems to me a quite conservative figure.

In 1965, of the total reported arrests for all offenses in the United States, about one-third—more than 1,500,000 arrests—were for public drunkenness. In that same year, there were over 250,000 arrests for drunken driving. Various official agencies have estimated that alcohol is implicated in more than 50% of the 55,000 traffic deaths in this country each year.

For years, we have known about the enormous admission rate of alcoholics to state mental hospitals, general hospitals and other facilities. For example, alcoholics now comprise 15 to 20% of first admissions to our state and country mental hospitals. The situation is fairly comparable in our general and private hospitals; in 1965, 22% of male patients discharged from these facilities were diagnosed as alcoholic.

Losses to industry from absenteeism and other problems associated with alcoholism are estimated at about \$2 billion annually. An additional \$1¼ billion is spent each year to provide care, financial support and treatment for alcoholics and their families.

I have no illusions about the quality of care of the alcoholic in this country. My own personal visits to many institutions which care for alcoholics and my perusal of a number of recent surveys reinforce my conviction that care and treatment of the person afflicted with alcoholism is perfunctory, superficial and totally lacking in the requisite continuity of services designed to support the alcoholic during the various stages of his agonizing effort to return to the community as a productive citizen. For example, I am not impressed with the oft-quoted figure of 150 out-patient alcoholism clinics in the United States. Most of these operate on only a part-time basis; a great majority of them fail to provide any treatment in depth for a large proportion of the patients making an initial contact with the clinic, and many of them adopt a selective admissions policy which excludes lower class patients and members of minority groups.

Because it is important that you understand, and that you are able to separate rhetoric from reality in informing the public as to the paucity of our treatment services for the alcoholic, let me just give you a brief listing of some of our present abominable shortcomings as I have seen them, and as they have been perceived by the National Center for Prevention and Control of Alcoholism of the National Institute of Mental Health:

1. Medical care facilities, psychiatric agencies, social agencies, public welfare departments, etc., often are reluctant to provide care and treatment for problem drinkers; they tend to neglect and reject these patients.

2. Certain services, generally available to patients with other disorders, often are denied to problem drinkers by policy or practice. These include hospital insurance coverage, admission to general hospitals, assistance by public welfare agencies, voluntary admission to mental hospitals, and participation in most mental hospital after-care programs.

3. The understanding of the nature of problem drinking and of its management is often very limited in general helping agencies.

4. Where care and treatment is provided for problem drinkers, it may be narrow and segmented. That is, adequate assessment of the patient's total problems and potentialities is lacking. Only limited aspects of the patient's life situation and various problems are dealt with. Continuity of care, especially between in-patient and out-patient services and between medical services and behaviorally oriented ones, usually is absent.

5. Agencies serving problem drinkers generally prefer to work with the most motivated, the best educated and the socially most intact patients. Little care and treatment usually is provided to those who do not meet these criteria.

6. The specialized alcoholism services—mental hospital programs, alcoholism clinics, and half-way houses—often are isolated from the other community helping agencies.

Let us say we have reached a consensus: The problem of alcoholism is a massive one. We continue to turn out statistics, surveys and studies spelling out the dimensions of the problem and the shoddiness of treatment services, but what are we actually doing in the way of developing action programs to contain the disease now?

We are quite gratified with the current Administration's increasing interest in doing something about alcoholism. Testifying on July 25th of this year before a

Congressional Committee, Dr. Roger Egeberg, the Assistant Secretary for Health of the Department of Health, Education, and Welfare, said that a concerted attack on alcoholism was one of the four prime goals of his responsibility as the chief health officer of the Department. May I quote just a short excerpt from Dr. Egeberg's testimony:

"I suppose, like anyone else, my background predisposes me to a point of view about alcoholism, and that point of view is simply this: The worsening problem of chronic alcoholism in this country reflects the progressive failure of our health care system to meet the demands placed upon it.

"I firmly believe that one of our major priorities must be to create a national program that can bring the alcoholic patient into contact with the kind of help he needs—medical help, psychological help, social help, rehabilitation, in short all the arms of support than can check the progress of alcoholism in the individual and in our whole society.

"I believe it is my responsibility—I assure you it is my firm intention—to work for the establishment of such a national program. Not a Federal program, but a program involving Federal and State governments, local agencies public and private, the universities, industry—for indeed every institution in our society has a job to do in the battle against alcoholism.

"There are, within the Department of Health, Education, and Welfare, some serious shortcomings that must be corrected. As of now, for example, we are not making use of a very effective tool that could help build the national program that I believe is needed. The Community Mental Health Centers, of which there are now 375 in operation serving a population of 53,000,000 people, have already been identified as foci of a comprehensive Federal-State effort to help the victims of alcoholism. Budgetary restrictions have not permitted us to move as swiftly as we would like to implement our new authority in this area. But within the means available to us, we intend to make the best possible use of the authority Congress gave us in 1968 to emphasize alcoholism in the programs of these Centers."

On October 30th of this year, President Nixon forwarded to the Congress the Administration's proposals for renewal of the Community Mental Health Centers Act. Included in his message are significant provisions for alcoholism which signify a deep and gratifying commitment on the part of the Administration to expanded funding for alcoholism programs within the context of community mental health centers. We are indebted to Congressman Harley Staggers, Chairman of this full Committee, and Congressman William Springer, the ranking Republican member of the Committee, for the rapid introduction of the Administration proposals as H.R. 14617.

The Administration bill is quite progressive, going considerably beyond the inadequate provisions of the Alcoholic Rehabilitation Amendments of 1968 (Public Law 90-574). It incorporates a number of the provisions in S. 1997, introduced by Senator Javits and 44 colleagues on April 29th of this year, and H.R. 11361, introduced by Congressman Hagan of Georgia and several colleagues. However, in contrast to these earlier bills which provide an authorization of 206 million dollars over a five-year period for alcoholism activities, the Administration bill covers only three years in new authorizations and does not include any specific appropriation request. It asks for "such sums as may be necessary."

The main strength of the Administration bill is that it gives preferential federal construction and matching to community mental health centers which will initiate alcoholism units. Moving the federal matching percentage for construction of alcoholism units up to 90 percent and providing more realistic federal matching ratios for staffing, operation and maintenance of these units—from 90 percent matching during the first two years and then dropping by 10 percent a year until the final 10 percent matching in the tenth year of support—is a *considerable* improvement over the inadequate provisions contained in the present Alcoholic Rehabilitation Amendments of 1968 (Public Law 90-574).

However, it is our understanding that the Senate Subcommittee on Health on November 12th voted to provide 90 percent matching for the first two years, and 75 percent over the next eight years, for the support of specialized services for alcoholics. Since it takes a long and arduous effort to break down current stigmas and get an alcoholism program going, and since most alcoholics have little or no money to pay for treatment, we heartily endorse and support the higher percentages voted by the Senate Subcommittee.

In addition to the level of federal support, the duration of such support is equally important to avoid unreasonably precipitous demands upon local com-

munities struggling to sustain highly expensive and administratively difficult services for alcoholics.

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However, preferential matching is meaningless unless sufficient authorizing funds are provided. All of us in the field of alcoholism are deeply indebted to Congressman Staggers and to Congressman Rogers for the introduction of community mental health center renewal bills earlier this year which include specific funding for alcoholism activities. Both bills (H.R. 13163 and H.R. 14086) provide a total of 75 million dollars allocated over the next three years for the support of both alcoholism and drug addiction activities. Since alcoholism would get only about 35 to 40 million dollars of this total sum, we would not be progressing much beyond the present authorization of 15 million dollars in fiscal 1970. Furthermore, neither of these bills provides preferential matching for alcoholism except in designated poverty areas. The preferential matching proviso is crucial, and we understand that the Senate Subcommittee on Health last Thursday reported out a bill which emphasized preferential matching treatment for alcoholism services.

Commensurate with the enormous size of the problem of alcoholism in this country, we respectfully submit that much more money must be allocated to the field of alcoholism. We therefore propose that a minimum figure of 30 million dollars a year over the next three years, or a total of 90 million dollars, be reserved for the construction and support of alcoholism units in community mental health centers.

We are very pleased that both the Administration bill and the original Staggers bill (H.R. 13163) have sections devoted to the training of personnel in the field of alcoholism. I could give you reams of documentation to substantiate the point that we have done little or nothing to train workers in this badly neglected field.

Under both bills, the Secretary of Health, Education, and Welfare is given broad authority to make grants to any public or non-profit private agency to cover part or all of the costs of developing specific training programs or materials relating to the provision of public health services for the prevention and treatment of alcoholism, including in-service training, refresher courses, and the training of supervisory personnel to administer such services.

Both bills also contain important language authorizing similar grants for the conducting of surveys and field trials to evaluate the adequacy of programs for the prevention and treatment of alcoholism with a view to determining ways and means of improving, extending, and expanding such programs.

Since neither of these bills contain a specific dollar authorization, we propose that ten million dollars a year over the next three years be allocated for these purposes.

One final point: To those of us in the alcoholism field, there is an obvious need for some initial planning money so that the many agencies and people in the community concerned with alcoholism can come together and draw up a satisfactory blueprint for treatment and educational services. Several of the bills before you contain this excellent planning provision, which provides up to \$50,000 to any single community for the planning of a general community mental health center.

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Mr. JARMAN. Thank you, Dr. Knott. As you know, in these hearings, the committee has requested the administration to recommend specific appropriation requests rather than to leave it on the basis of the general terms "such sums as may be necessary."

We are hoping to get something specific on that before the committee acts on the bill.

Mr. GORMAN, would you care to present testimony to the committee at this time, or would prefer to wait?

Mr. GORMAN. I would prefer to wait. I am just here, Mr. Chairman, in an ancillary capacity, deeply interested in the problem of alcoholism, disturbed by the fact that most of our community health centers, and I visited 33 of them this past year, do not handle alcoholics, and we do need preferential treatment.

Mr. JARMAN. But you will be testifying?

Mr. GORMAN. Yes, on the children's aspects.

Mr. JARMAN. Mr. Rogers.

Mr. ROGERS. Doctor, wouldn't it perhaps solve your problem if we simply required that one of the services to be provided by community mental health centers would be for alcoholics?

Dr. KNOTT. Yes, I think that would be an important step. I am prejudiced in that regard, because this is my primary area of interest. I think the centers should involve themselves in alcoholism services.

Mr. ROGERS. Then you wouldn't have to have preferential treatment, but a requirement for those services, and it would be planned right at the beginning.

Dr. KNOTT. The advantage of preferential treatment will be to take the area of alcoholism out of the area of morality, where it still is, and place it under the medical aegis.

I think it might get swallowed up in administrative procedures in the mental health centers, and they would say they were doing it, but they would not be diagnosing and treating alcoholics.

Mr. ROGERS. I hope they would carry out the provisions of the law.

What does it take to cure someone? Do you have a cure for someone as an alcoholic?

Dr. KNOTT. Well, I think our basic approach to the alcoholism problem is one of control, rather than cure, which is the basic approach of medicine to most disease states. Recovery is different for different people.

Mr. ROGERS. This gets to be a very nebulous thing, too, how much good we are really doing, how much followup is required.

I think it would be helpful if you can supply for the record your experience and that of some of your colleagues on a set course of treatment so we can see what is the demand, how many days are usually required as an average, and I realize this varies greatly, on the need for hospitalization, half-way house treatment, social workers and so forth.

If you could, let us have some picture of that and its approximate cost.

Dr. KNOTT. I will submit that to you.

Mr. ROGERS. Thank you.

(The information requested was not available to the committee at the time of printing.)

Mr. GORMAN. Let me make a quick comment on it. I was in at the birth of the community health center legislation, which we started in 1976 and passed in 1963. I have a strong feeling about centers. I don't know if it would be workable to require some centers in rural areas to set up an alcoholism service.

It is nice, and I am all for it and it is great, but there must be a capability in the area to do it.

I would like to have it as an essential service. I have talked to an awful lot of people in the field of alcoholism in the past 2 years.

The general conclusion I have come to is that the alcoholic is expensive to treat. He is a repeater. We don't have a pill that is going to help him in the way we have methadone for the hard drug user.

We have to have an incentive for the treatment of the alcoholic. The alcoholic generally in terms of public health is a dirty and a neglected person. He is unattractive. He is a mess. He is the last person, outside the child, who is treated by the existing mental health center.

I say that in all seriousness.

So, when you get over the total stigma, I think you have to provide some kind of incentive to treat the people who in the past have been lying in the street or in the jail and not within the realm of medicine. That is the real battle.

Mr. ROGERS. I understand, though I am concerned that they are not treating these people, and maybe we ought to make it a part of the law so that if they get any funds at all they must provide this service. That would be dependent upon their getting any funding.

Mr. GORMAN. I am for you. I am just trying to be honest.

Mr. ROGERS. I understand.

Mr. JARMAN. What role does Alcoholics Anonymous play? Is that entirely privately financed?

Dr. KNOTT. Privately, yes.

Mr. JARMAN. But it is active in all the States.

Dr. KNOTT. Yes, and I think the difficulty in the past has been our whole idea about alcoholism and its treatment and recovery therefrom is based on the ideas of Alcoholics Anonymous, and I think there is room for new procedures to be introduced into the field.

Mr. JARMAN. Mr. Hastings?

Mr. HASTINGS. I am interested, Mr. Gorman, in your remarks as they pertain to alcoholics. I had been led to believe that most of the alcoholics had been not the downtrodden, but people in the middle and upper income brackets, people not in jail, but people who have a problem but don't admit it.

Is this correct?

Mr. GORMAN. Let me make one comment. There are two classes of alcoholics. There is the corporate type. They usually can get, though it is difficult in some cities, some kind of medical service. There is on the other hand the skid row drinker, who is the one we talk about as the revolving door type of drinker, who doesn't have the economic resources, who keeps being sentenced, as in the District of Columbia, 100 times over 2 years, to jail for drunkenness.

We are talking about both groups. We are talking about the denial of alcoholism in the middle and upper income classes, and I want Dr. Knott to talk about that, too.

There is a denial—

Mr. HASTINGS. There are a few here in Washington, too.

Dr. KNOTT. Your point is absolutely correct. NIMH says there are 5 million, but there are probably 20 million. Ten percent would be classified as the recidivist, skid row type.

The difficulty with the alcohol-related problem is that everybody identifies alcoholism with skid row. This is why a lot of people in the upper and middle socioeconomic brackets fail to come to treatment early, because they look at the skid row alcoholic, and they cannot identify with him.

Mr. HASTINGS. I cannot conceive of a situation where the wife of a bank president is going to come into the local mental health center for treatment.

Dr. KNOTT. It would be my hope that as more objectivity is given to the problem that people will come for treatment. We must not throw alcoholism into one therapeutic arena. Treating the middle-class person with an alcohol-related problem is much different than treating the skid row bum. Actually the skid row drinks less alcohol per capita per year than the middle-class social drinker.

They are more addicted to a way of life than to the drug alcohol.

Mr. HASTINGS. But the money we are talking about here relate to the 10 percent at the present time, do they not?

Dr. KNOTT. I hope not. I hope that the money will be used——

Mr. HASTINGS. As it stands today, the situation stands today, wouldn't it relate primarily to that percentage?

Mr. GORMAN. Probably, because of the stigma, Mr. Hastings, but that vice president that you talk about of that nice corporation is a guy that is trying to hide his disease, and unless he gets to AA and gets totally abstinent, what has he really got?

I am not speaking as a doctor, but he has very little and he denies the problem. We hope the day will come when he can walk into his own community health center and get treatment for his alcoholism, which is a problem affecting millions.

Mr. HASTINGS. That is why I talk about the money we are talking about, as they relate today, or to the problem as it may be some day.

No more questions.

Mr. JARMAN. Mr. Preyer?

Mr. PREYER. No questions.

Mr. JARMAN. Doctor, thank you for helping make our record in this.

Our next witness is Mr. Mike Gorman, executive director, National Committee Against Mental Illness, representing the Joint Commission on Mental Health of Children.

I say I am delighted to see Mr. Gorman here. This committee has known him since we first wrote the laws on mental health. He has had an important part to play in this whole field.

STATEMENT OF MIKE GORMAN, EXECUTIVE DIRECTOR, NATIONAL COMMITTEE AGAINST MENTAL ILLNESS

Mr. GORMAN. I am happy to be back. I rang bells for the chairman when he ran for office.

Mr. JARMAN. Mr. Gorman made a name for himself in the State of Oklahoma in his investigative and reporting work in the field of mental health years ago, and was a source of enlightened interest on the part of thousands of Oklahomans in a field in which they had previously had little information.

It is a pleasure to have you with us again.

Mr. GORMAN. Thank you for those kind words, Mr. Chairman.

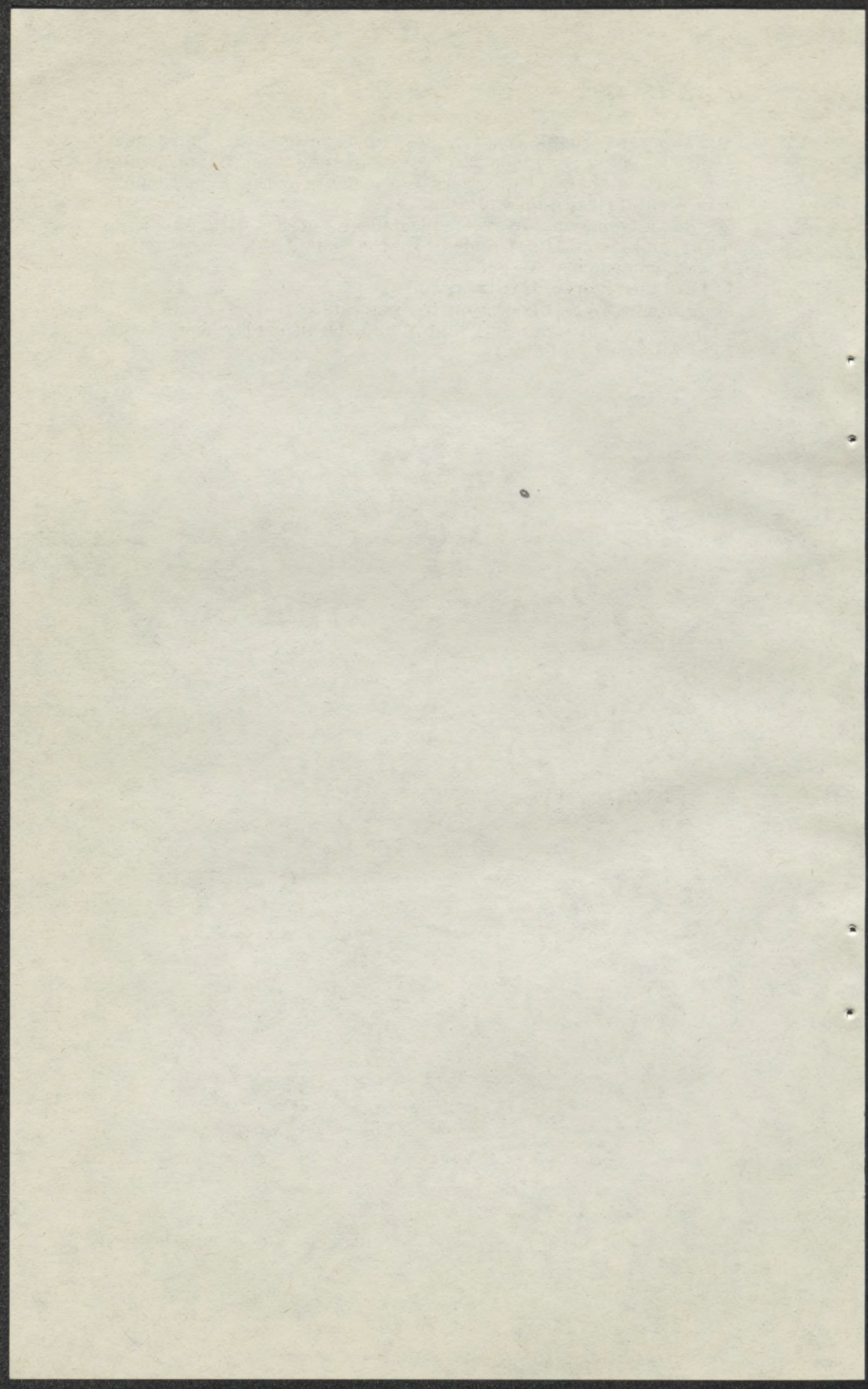
I am just going to summarize, because of limitations of time, and if I may start on page 5, I did serve as a member of the Joint Commission on Mental Health for Children.

We made some major recommendations on legislation which is pending, and I would like to submit for the committee's perusal a digest of our recommendations.

If I can turn it over, it will save time.

Mr. JARMAN. We will be happy to receive it.

(The "Digest of Crisis in Child Mental Health: Challenge for the 1970's," referred to follows.)



Digest of

CRISIS IN CHILD MENTAL HEALTH:

CHALLENGE FOR THE 1970'S

Final Report

of the

The Joint Commission on

Mental Health of

Children, Inc.

Fall, 1969

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NOTE TO THE READER

This Digest is a condensation of **CRISIS IN CHILD MENTAL HEALTH: CHALLENGE FOR THE 1970's**. **CRISIS IN CHILD MENTAL HEALTH** is based on a report made to Congress, the State Governors, the National Institute of Mental Health, and the Secretary of Health, Education, and Welfare in June, 1969,* and is soon to be published by Harper and Row. The Digest is provided as a convenience to interested individuals and agencies who desire a quick impression of the final findings and recommendations of the Joint Commission on Mental Health of Children, Inc. The Digest is by no means an appropriate substitute for the extensive analyses and recommendations found in **CRISIS IN CHILD MENTAL HEALTH**. For documentation of statements made in this Digest, the interested reader is referred to the final report, which will be available from the publisher or book dealers early in 1970. Further information on the publication of the final report may be obtained from Harper and Row, Order Department, 49 East 33rd Street, New York, New York, 10016.

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Preface

For the last fifty years, there has been a growing concern over the number of mentally ill and emotionally disturbed children in the United States and an increasing dissatisfaction with the unavailability of mental health services. When the previous Joint Commission on Mental Illness and Health, for unavoidable reasons, was unable to cover this important area, both professional and concerned citizen groups pressed for a study of the mental health needs of children. Members of Congress also responded to the need and, in 1965, Senator Abraham Ribicoff introduced an amendment to the Social Security Amendments of 1965 (P.L. 89-97) which provided the funds and framework for the Commission's work. Thirteen national professional associations joined the incorporators of the Commission to form a Board of Directors. The Board, with a grant from the National Institute of Mental Health, developed a staff and enlisted more than 500 of the country's leading authorities on early childhood, adolescence, and the young adult to work on Task Forces, substantive Committees, and the collection of specialized information. The collaboration and participation of both affiliate member organizations and specialists at every Governmental agency level provided the Commission with additional and invaluable contributions.

As a result of its three-year endeavor, the Commission produced a number of reports and papers, many of which will be published in 1970. These studies provided much of the documentation for the recommendations which appear in *CRISIS IN CHILD MENTAL HEALTH*. Throughout the Commission's work, it became increasingly apparent that health, mental health, and environmental influences are interwoven, particularly in the earliest years of life. Thus, *CRISIS IN CHILD MENTAL HEALTH* is more than a critique of clinical needs and problems related to mentally ill and emotionally disturbed children. It is also a portrayal of crises in our society which precipitate many kinds of childhood malfunctioning and give rise to the need for many kinds of intervention. Because it is a social as well as a clinical document, the Commission's report gives equal priority to recommendations of both a preventive and remedial nature. It is clear that if we are to dedicate ourselves to meeting the needs of our children and youth, the required services and programs in child-rearing, which is our largest "industry," should be one of the largest in optimal manpower utilization and therefore costs.

It is the Commission's opinion that this is as it should be. It will be far more costly in the long run in terms of mental illness, human malfunctioning, and therefore underproductivity, if we do not appropriately support this "industry." We have dedicated our report to the children and youth of our country in the hope that it will create an awareness of their needs and a prompt call to action.

The Commission's Board of Directors is deeply indebted to Mrs. Barbara J. Sowder for her editing of this Digest.

I

INTRODUCTION

We proclaim that we are a Nation devoted to its young. We believe that we have made great strides toward recognizing the needs of children and youth. We have enacted child labor laws, established a public education system, created treatment services for our disturbed and handicapped, and devised imaginative programs such as Head Start for our disadvantaged young. Yet, we find ourselves dismayed by the violence, frustration, and discontent among our youth and by the sheer number of emotionally, mentally, physically and socially handicapped youngsters in our midst. It is shocking to know that thousands of children are still excluded from our schools, that millions in need go untreated, and that many still suffer from hunger and malnutrition. We recognize in these ills some of the sources and symptoms of poverty and racism in which all of us, as a Nation, take part. Poverty, in this the richest of world powers, is still our heritage. Racism, in a country dedicated to its peoples' inalienable rights, speaks as clearly of "man's inhumanity to man" as did slavery.

In spite of our best intentions, our programs are insufficient; they are piecemeal, fragmented and do not serve all those in need. Unwittingly, we have failed to commit our vast resources to promote the healthy development of our young. We have yet to devise a strategy which will maximize the development of our human resources. Congress gave national recognition to this need in issuing a mandate to establish the Joint Commission on Mental Health of Children. In fulfillment of its task, the Commission declares:

—This Nation, the richest of all world powers, has no unified national commitment to its children and youth. The claim that we are a child-centered society, that we look to our young as tomorrow's leaders, is a myth. Our words are made meaningless by our actions—by our lack of national, community, and personal investment in maintaining the healthy development of our young, by the minuscule amount of economic resources spent in developing our young, by our tendency to rely on a proliferation of simple, one-factor, short-term and inexpensive remedies and services. As a tragic consequence, we have in our midst millions of ill-fed, ill-housed, ill-educated and discontented youngsters and almost ten million under age 25 who are in need of help from mental health workers. Some means must be devised to delegate clear responsibility and authority to insure the well-being of our young.

—This Nation, which looks to the family to nurture its young, gives no real help with child-rearing until a child is badly disturbed or disruptive to the community. The discontent, apathy, and violence today are a warning that society has not assumed its responsibility to insure an environment which will provide optimum care for its children. The family cannot be allowed to withstand alone the enormous pressures of an increasingly technological world. Within the community some mechanism must be created which will assume the responsibility for insuring the necessary supports for the child and family.

- This Nation, which prides itself on democratic values and equal opportunity, still imposes on its young the psychological repercussions of poverty and racism. No one is effectively empowered to intercede.
- This Nation, richly endowed with the knowledge to develop its youthful resources has yet to fill the gap between knowledge and action. We know, for example, that preventive measures are most essential and effective if taken in the earliest years of life; that during this period there are critical stages of development which, if neglected or mishandled, may result in irreversible damage. Yet, our services are nowhere more deficient than in the area of prenatal and infant care.
- This Nation, highly sophisticated and knowledgeable about mental health and child development, continues its planning and programming largely around the concept of treating, rather than preventing, mental illness. But no agency has the task and responsibility for assuring that treatment is, in fact, received by those who need it.
- This Nation, despite its emphasis on treatment, has yet to develop adequate mental health services and facilities for all children and youth, regardless of race and economic circumstances. Many receive no attention. The number of young, particularly adolescents, who are committed to mental institutions continues to rise markedly. Yet, we have not provided the resources and manpower to assist those who are devoted to caring for these children. As a result, any possible benefits of confinement are lost in the tragic waste of the back ward. Even less effort is made to develop coordinated community services so these children can be kept as closely as possible within their normal, routine setting.

The Commission strongly urges better treatment for the mentally ill, the handicapped, the retarded, the delinquent, and the emotionally disturbed. We join forces with those who propose a broader but more meaningful concept of mental health, one which is based on the developmental view with prevention and optimum mental health as the major goal. We contend that the mentally healthy life is one in which self-direction and satisfying interdependent relationships prevail, one in which there is meaning, purpose, and opportunity. We believe that lives which are uprooted, thwarted, and denied the growth of their inherent capacities are mentally unhealthy, as are those determined by rigidity, conformity, deprivation, impulsivity, and hostility. Unfulfilled lives cost us twice—once in the loss of human resources, in the apathetic, unhappy, frustrated, and violent souls in our midst, and again in the loss of productivity to our society, and the economic costs of dependency. We believe that, if we are to optimize the mental health of our young and if we are to develop our human resources, every infant must be granted:

—*the right to be wanted*

yet, millions of unwanted children continue to be born—often with tragic consequences—largely because their parents have not had access to or knowledge of the benefits of birth control information and devices.

—*the right to be born healthy*

yet, approximately one million children will be born this year to women who get no medical aid during their pregnancy or no adequate obstetrical care for delivery; thus many will be born with brain damage from disorders of pregnancy. For some, protein and vitamin supplements might have prevented such tragedy.

—*the right to live in a healthy environment*

yet, thousands of children and youth become physically handicapped or acquire chronic damage to their health from preventable accidents and diseases, largely because of impoverished environments. Even greater numbers living in poverty will become psychologically handicapped and damaged, unable to compete in school or on a job or to fulfill their inherent capabilities—they will become dependents of, rather than contributors to, our society.

—*the right to satisfaction of basic needs*

yet, approximately one-fourth of our children face the probability of malnutrition, inadequate housing, untreated physical and mental disorders, educational handicaps, and indoctrination into a life of marginal work and opportunity.

—*the right to continuous loving care*

yet, millions of our young never acquire the necessary motivation or intellectual and emotional skills required to cope effectively in our society because they do not receive consistent emotionally satisfying care. Society does little to help parents. There are few programs which provide good day care, which aid in developing more adequate child-rearing techniques, or which assist in times of temporary family crisis or where children are neglected or abused.

—*the right to acquire the intellectual and emotional skills necessary to achieve individual aspirations and to cope effectively in our society*

yet, each year almost a million of our youth drop out of school and enter the adult world with inadequate skills and with diminished chances of becoming productive citizens; countless others are denied the opportunities to develop to their fullest potential through effective vocational training, meaningful work experience, or higher education. For all of our children and youth the transition to adulthood is made difficult. We fail to provide avenues for learning adult roles, for acquiring skills, or some approved means by which youths' voice can influence a world in which they too must live.

We know that when these rights are granted, development will proceed favorably for most infants. Few children, however, encounter continuously those ideal circumstances that maximize their hereditary potential for health, competence, and humanity. At conception, at birth, and throughout development, there are vast variations and inequalities in the life chances of our young. Undoubtedly, many will continue to be psychologically damaged. If our more unfortunate are to become functioning and productive citizens, we believe they must be granted:

—*the right to receive care and treatment through facilities which are appropriate to their needs and which keep them as closely as possible within their normal social setting*

yet, several millions of our children and youth—the emotionally disturbed, the mentally ill, the mentally retarded, the handicapped, and the delinquent—are not receiving such care. The reasons are innumerable. Many go untreated because the services are fragmented, or nonexistent, or because they discriminate by cost, class or color. Others are diagnosed and labeled without regard to their level of functioning. They are removed from their homes, schools, and communi-

ties and confined to hospital wards with psychotic adults or to depersonalized institutions which deliver little more than custodial care.

Going back as far as the first White House Conference on Children in 1909 we have repeatedly, and with considerable eloquence, announced our intentions to develop a strong, imaginative program to care for emotionally disturbed children. For example, the 1930 White House Conference on Child Health and Protection, composed of several thousand citizens and government officials, proclaimed that:

"The emotionally disturbed child has a right to grow up in a world which does not set him apart, which looks at him not with scorn or pity or ridicule—but which welcomes him exactly as it welcomes every child, which offers him identical privileges and identical responsibilities."

The 1930 White House Conference estimated that there were, at that time, at least two and one-half million children with well-marked behavioral difficulties, including the more serious mental and nervous disorders.

In the four decades since the issuance of that report, the care of the emotionally disturbed child in this country has not improved—it has worsened considerably. During the three years of its deliberations and fact-finding efforts the Commission has gathered together an impressive body of descriptive material on the plight of the emotionally disturbed child in America today.

Using the most conservative estimate from various school surveys, the National Institute of Mental Health estimates that 1,400,000 children under 18 needed psychiatric care in 1966.

Are they getting this treatment? Surveys of various psychiatric facilities, undertaken by the National Institute of Mental Health, show that nearly a million of those children needing psychiatric care in 1966 did not receive treatment. These estimates indicate that we are providing care to only one-third of our children who are in serious need of attention. An additional seven to ten percent or more are estimated, by school surveys, to need some help for emotional problems.

What happens to these emotionally sick children for whom there are no services in the community? Each year, increasing numbers of them are expelled from the community and confined in large state hospitals so understaffed that they have few, if any, professionals trained in child psychiatry and related disciplines. It is not unusual in this year 1969 to tour one of these massive warehouses for the mentally ill and come upon a child, aged nine or ten, confined on a ward with 80 or 90 sick adults. Our present data indicate that slightly over 27,000 children under 18 were under care in state and county mental institutions in 1966. On the basis of a trend which has been developing over the past few years, the National Institute of Mental Health estimates that by 1970 the number of children aged 10-14 hospitalized in these institutions will have doubled.

The National Institute of Mental Health also reports that thousands upon thousands of elderly patients now confined on the back wards of these state institutions were first admitted as children 30, 40, and even 50 years ago. A recent report from one state estimates that one in every four children admitted to its mental hospitals "can anticipate being permanently hospitalized for the next 50 years of their lives."

What happens if the disturbed child is fortunate enough to escape the state institution treadmill? There are a few private, residential treatment centers which

care for about 8,000 children a year. Since the average cost to the parents of such hospitalization ranges from \$30 to \$50 a day, it is obvious that only those of our citizens who are in the higher income brackets can take advantage of such services. Even among those rarified income brackets the situation is far from satisfactory; for every child admitted to one of these private facilities, 10 or more are turned away because of lack of space. In 8 of our states, there are no such facilities, either public or private. In many of our states, there are no public units to care for children from low and middle income groups.

What happens to all our children who receive no help for emotional problems? Here the statistics become much less precise, since a vast majority of these children are literally lost. They are bounced around from training schools to reformatories to jails and whipped through all kinds of understaffed welfare agencies. No one is their keeper. No agency in the community is equipped to evaluate either the correctness of their placement or the outcome of such placement.

If they are sent to a training school, as recent testimony before a Senate Committee revealed, they generally receive poorer treatment than caged animals or adult convicts. Appearing in 1969 before a Senate Committee, Joseph R. Rowan, an expert on delinquency who is now director of the John Howard Association of Illinois, characterized these institutions for juveniles as "crime hatcheries where children are tutored in crime if they are not assaulted by other inmates or the guards first." Another witness, Arlen Specter, the District Attorney of Philadelphia, told the same committee that these so-called correctional institutions for juveniles take a 13 year old and in 12 years, turn out "a finely honed weapon against society."

Commenting on the failure of juvenile courts and juvenile correctional facilities to even begin to meet the manifest needs of emotionally disturbed and sociopathic children, Judge David Bazelon, a member of the Commission, noted in a recent talk that although this nation is aware of the problem, it does not support funds to treat and care for these children *because it has really given up on them.*

We must ask ourselves whether we can continue to deny our children their inalienable rights. Can we continue to gamble with our Nation's future by allowing children to grow up in environments which we know are psychologically damaging— and compound this by lack of adequate care and treatment?

We have the knowledge and the riches to remedy many of the conditions which affect our young, yet we lack a genuine commitment to do so. We blind ourselves to the fact that we create most of the social problems of our young which we so deplore—infants who fail to thrive, seriously disturbed children in mental institutions, adolescent drug addiction, acts of violence and destruction by youth.

Our lack of commitment is a national tragedy. We know already that it is more fruitful to prevent damage to our young than to attempt to patch and heal the wounds. We know that much of the damage could be avoided in the first three years of life. We know that the basis for mental development and competence is largely established by the age of six. Yet we do not act on this knowledge. Studies indicate that most children, regardless of class or race, whether in the ghetto or in suburbia, do not receive the needed support and assistance from our society. But, it is the damaged, the vulnerable, and the poor who are given the least from our health, welfare, and educational services. Those who are the most helpless are the most neglected.

This Commission proposes a shift in strategy for human development in this nation—one which will deploy our resources in the service of optimizing human development. We emphasize the critical need to concentrate our resources on the new generation and eliminate problems which later exact so high and tragic a price.

In the allocation of these resources, it is the consensus of most of the Commission's task force and committees that equal priority should be given to the following:

- Comprehensive services which will insure the maintenance of health and mental health of children and youth.
- A broad range of remedial mental health services for the seriously disturbed, juvenile delinquents, mentally retarded, and otherwise handicapped children and their families.
- The development of an advocacy system at every level of government to insure the effective implementation of these desired goals.

The services we propose should cover the entire range of childhood, from systematic maternal and infant care to the transition of the adolescent and college age youth into effective young adulthood.

It should be emphasized that fostering the development of human beings in this country is a means to an end—a means to stem the increasing numbers of people who have no meaningful role in society. Their services in health, education, welfare, and other human and community services are desperately needed and currently unused.

Commitment, genuine commitment, to our children and youth is, necessarily, the beginning. We must look honestly at the scope of the problem and begin *now* to follow our words by action. We must develop advocacy functions at all levels of government and society, functions which will insure that the needs of children and their families are being met. This commitment to advocacy means commitment to change. It means that we—as parents, educators, professionals and legislators—must participate and collaborate in change in national, state and local levels. We must reorder our priorities so that the developmental needs of children rank first in importance. The commitment requires finding effective ways to link our fiscal resources, services and manpower so that every infant will be guaranteed the continuous care and the opportunities required for his optimal development. The creation of an advocacy system means that we, at last, will act to insure the rights of our living and unborn young. For in our children lie our future and our hope for the fulfillment of our national goals. We must not—cannot afford to do less.

**RECOMMENDATIONS OF THE JOINT COMMISSION ON
MENTAL HEALTH OF CHILDREN**

- I. Proposals for a Child Advocacy System**
- II. Community Services and Programs of a Supportive, Preventive, and Remedial Nature**
 - A. Physical and Mental Health Services**
 - B. Assistance, Employment, and Environmental Programs**
 - C. Social Services**
 - D. Education**
 - E. Work, Leisure, and Preparatory Activities**
- III. Research**
- IV. Manpower and Training**

RECOMMENDATIONS

I. A Child Advocacy System to Guarantee Mental Health

The Commission recommends that Federal funding be provided for the establishment of an advocacy system at every level of society.

At the *National level*, the Commission urges that Congress provide for the President to appoint an Advisory Council on Children similar to the Council of Economic Advisors. Advocacy for children and youth would then derive its strength from the highest office in our Nation. This President's Advisory Council on Children would advise the President, the Cabinet, the Congress, and the Bureau of the Budget. It would be charged with the responsibility of studying and gathering information on the problems of children and youth in the United States and with doing long-range planning, policy making, and programming, both for services and for manpower. This advisory body would be concerned about how well Federal agencies are working together, competing, or overlapping in providing services. It would advise the President and Congress on the effectiveness of programs and would make recommendations for legislative and program changes and on the allocation of monies spent for children and families.

The Commission further recommends that the Secretary of HEW should have a strong unit, headed by a high official in his office, to give leadership to all programs for children and youth. Included in this function would be policy clearance and development, coordination of efforts, evaluation of results, and recommending allocation of resources to the Secretary. Coordination of Federal interprogram relationships to State Comprehensive Plans would rest in this unit.

The advocacy concept at the *state level* would be carried out by a State Child Development Agency. This Agency would be charged with developing a comprehensive state plan for children and youth on an on-going basis and be governed by law and regulations not unlike the Federal Comprehensive Health Planning requirements. Its crucial task would be to develop a state plan—in conjunction with broad Federal guidelines—and to lay out program goals and operating guides for all the services and programs required to meet the needs of children and youth in the state. The Commission recommends that Congress provide that the State Comprehensive Plan include consideration of all child and youth programs, not just those that are Federally funded. The State Agency would also advise the Governor on programs and allocations for children. It would plan the creation of local Child Development Authorities and Councils and assist in their development. It would review applications from local Authorities for the establishment of Councils and would periodically evaluate the Councils. Local Authorities and Councils would develop local plans for the State Agency. The Federal agency would act on the State Comprehensive Plans, and on approval, would fund the State Agency and the local Authorities and Councils. As an incentive for states with comprehensive plans, higher percentages of Federal matching funds could be granted for all Federally funded children's programs.

At the *local governmental jurisdiction* (city, county, or combination of these), a local Child Development Authority would be created. It would serve as a coordinating, planning, and policy-setting body for all human services in its political jurisdiction as assigned by state law within Federal guidelines. It would develop a local comprehensive plan for the State Agency and would initiate and organize the Child Development Councils in neighborhoods within its jurisdiction.

At the *neighborhood level*, the Commission recommends that Federal funding be provided for the establishment of a network of Child Development Councils throughout the Nation. The location and operation of these Councils would vary, according to community needs. These Councils would act as the direct advocates for children and youth. They would have the responsibility and prerogative of insuring that complete diagnostic, treatment, and preventive services are made available to all children and youth in the neighborhoods which they serve. The spectrum of services to be obtained and insured for children and youth by the Child Development Councils are summarized below in recommendation II.

At all levels—neighborhood, local, state and national—participation and representation in the various advocacy bodies would include professionals, laymen and citizens. At the neighborhood level, consumers of services would be involved in the planning and operating of the Councils. It should be emphasized that these advocacy bodies are concerned with planning, facilitating and coordinating services and with insuring these services to children, youth and their families. *In no instance are these bodies responsible for providing services directly.* This function would be incompatible with their advocate roles. However, where necessary, Councils may set up services directly, but would operate these only until they could be run effectively by another agency.

Funds will come mainly from Federal and state sources. Local funds would be supplied according to state decision. In general, Federal grants would be provided in accordance with a state plan developed by the State Child Development Agency.

States which do not develop comprehensive plans and hence do not develop State Authorities and Councils would not receive Federal funds. Federal law should provide that direct local grants for local planning could be made in such instances.

Ultimately, it is hoped that Child Development Councils will be established to serve every child and youth in America. However, the Commission recognizes that these cannot be funded and established overnight. We recommend that the following steps be taken within the immediate future:

- A. The creation of the President's Advisory Council on Children.
- B. The establishment of a State Child Development Agency in each state to develop the state comprehensive plan for services (with option to consolidate under present regional planning areas). Federal funds would be provided to develop the state plan based on Federal guidelines.
- C. The establishment of at least one local Child Development Authority in each state.
- D. The establishment of approximately 100 Child Development Councils throughout the Nation, with at least one in each state.
- E. The creation, by full Federal funding, of approximately 10 Evaluation Centers, with each being placed in a different type of community. These Evaluation Centers, whether independent of or related to the Child Development Councils, would study, test and evaluate the goals proposed for the Councils and would provide data for the establishment of future Councils and for improvement of already existing Councils.

II. Community Services and Programs of a Supportive, Preventive, and Remedial Nature

The Commission recommends the creation of a network of comprehensive, systematic services, programs and policies which will guarantee to every American,

from conception through age 24, the opportunity to develop to his maximum potential. These should be linked to the Child Development Councils recommended above.

Among the components of highest priority are:

A. *Systematic and comprehensive health and mental health and supportive services:*

- (1) Family planning and birth control services, including genetic counseling.
- (2) Systematic prenatal care.
- (3) Comprehensive pediatric and supportive services for children under the age of three.
- (4) Physical and mental health services for children beyond age three, to be coordinated with the educational system.
- (5) Remedial mental health services which are dispensed according to the child's level of functioning rather than on the basis of diagnostic labels.
- (6) Increased development of community based facilities which will keep children as closely as possible within their normal, routine settings.
- (7) For those who must be institutionalized, highly personalized and individualized treatment, habilitation and rehabilitation services should be made available.

A broad range of remedial services are needed: information-referral services; comprehensive developmental and psycho-educational assessment; treatment for the child and his family when indicated; special education programs (including pre-school home training programs, regular and therapeutic nursery schools, regular and special classes within public schools, and special schools); rehabilitation programs and facilities; residential care; transitional services; relief services for families of severely ill children; intensive-care units in general hospitals; acute and intensive diagnostic treatment services on an inpatient basis; special therapeutic recreational or work programs; special foster homes and small group living arrangements; and Re-ED type schools to work with disturbed children.

To insure the foregoing, the Commission recommends that the Federal Government:

- *** Enact a system of national health insurance, national health service, or some other system to guarantee equal access to services; and
- *** Establish the facilities and services required to meet the physical and mental health needs of American children and their families.

B. *Employment, Assistance and Environmental Programs:*

Because of the many adverse effects which poverty has on child mental health and development, the Commission recommends:

- (1) *Guaranteed employment for all who are able and willing to work.* (The Commission is opposed, however, to any mandate which would require mothers of young children to go to work.) Special attention should be given to providing training and employment for persons with physical, mental, and social handicaps, especially youth. Legislation should be enacted which will provide all employed persons a *minimum wage level* and humane working conditions. We urge co-ordination of manpower and training programs; expansion of programs in the human service field; and creation of industry in underdeveloped and disadvantaged areas.

- (2) The Commission recommends revision of all present income maintenance programs to insure a *guaranteed minimum income* for all Americans.
 - (a) *Public assistance* should be granted as a right, based on the sole criterion of need, and national minimum standards should be established for such assistance.
 - (b) *Unemployment compensation* should be made uniform in coverage and duration among the states by Federal law; benefits should be more realistic in terms of the worker's earnings and include provisions for dependents.
 - (c) *Social Security* should be increased and made consistent with current living costs. Congress should give attention to ultimately administering the AFDC program together with the OASDI.
 - (d) *Children's Allowances* should be established in law to provide an adequate universal system of providing greater assistance to our Nation's children.
- (3) Because hunger and malnutrition have so many adverse effects on physical and psychological growth, the Commission believes it is imperative to eradicate such unnecessary hazards to the development of our Nation's children. Providing families with an adequate income is obviously the best solution; however, under present arrangements, we have addressed ourselves to *Federal Food Programs*. We recommend:
 - (a) That *Federal expenditures for food programs* be increased, that the distribution of food not be dependent upon local or state option, that the system be free of stigma, and based only on the criterion of need.
 - (b) That *food and nutrition programs for school children* be universally available, and that *nutritional supplements* be administered through Federal medical programs, especially for pregnant women and infants.
 - (c) That *consumer education* be made more effective through expansion of services, greater use of indigenous personnel, more effective techniques of nutrition education in schools, and increased expenditures for research in nutrition education programs.
- (4) Because the physical and mental health of millions of our children are threatened by poor and/or segregated *housing*, the Commission recommends:
 - (a) Universal open housing laws.
 - (b) Elimination of the ghetto and the creation of wholesome communities which do not segregate by any criteria, through sound housing, urban and community development programs.
 - (c) Converting the millions now spent in public monies for housing welfare recipients in slum dwellings into positive programs of home ownership and rehabilitation of dwellings.
 - (d) Giving priority to human needs in planning housing programs.
 - (e) Greater Federal expenditures to communities for self-help and community development programs.

C. *Social Services:*

Because of the deficiencies in our service system, the Commission recommends that Congress, or the President's Advisory Council on Children, establish a body which would undertake, directly or indirectly, the assess-

ment of problems such as manpower; availability of services; new approaches to services and alternative strategies for attaining service goals; formulation of experimental approaches to delivering high quality child-centered services; as well as systems of data gathering.

We believe these functions would best be carried out by a permanent study group which is relatively small but substantially funded, combined with a series of temporary programs which the group would bring into being to focus on particular problems.

Turning to more immediate solutions to the deficiencies in our child services, we stress the need for coordination of welfare services and policies at all levels of government and between public programs and voluntary agencies. In addition, these services should be integrated with other components of the suggested comprehensive network of services and programs. We recommend that the services listed below be available to all American children and families as a social utility through coordinated service systems.

- (1) *Programs for the pre-school child* including day care and pre-school programs.
- (2) *Adoption and Foster Care*, (including institutional care) should be improved through:
 - (a) Strengthening existing service agencies and providing financial assistance for underdeveloped parts of the child welfare system.
 - (b) Expanding foster care and adoption services. Professionals should make every effort to identify early those children who cannot return to their families and be prepared to provide long-term familial or peer-group care. Substitute family programs should take kinship and friendship patterns into account and all payments to foster parents should be increased.
 - (c) Services for children born out of wedlock should be extended to a larger proportion of low-income mothers; be comprehensive in nature; provide long-term supports to encourage natural mothers to care for their children if they desire; and include early identification of children to be placed and assistance to mothers seeking placement.
 - (d) Mental health services need to be increased for all populations served by Child Welfare Agencies.
 - (e) Major needs in institutional care provided by social agencies are for small group residences and half-way houses. Because of the shortage of foster homes, the Commission recommends that there be further experimentation in the group care of infants and young children.
- (3) Other social services which need to be extended to all communities are:
 - (a) Vocational rehabilitation services;
 - (b) Probation services which insure for the court care and treatment services where indicated;
 - (c) Legal services;
 - (d) Family, marital and pre-marital counseling;
 - (e) Homemaker services; and
 - (f) Protective services for children who are neglected or abused.

D. *Education:*

Because our society has delegated to its schools and colleges a major responsibility in preparing its young people to participate in society, we must be

continually aware of the problems facing educators. As education becomes more and more a necessity in our technological society, we must view with alarm any deficiencies which prevent our young from acquiring the skills to become productive citizens. We recommend:

- (1) The creation of high quality, universally available pre-school educational and day care programs which are continuous, year-round, and based on sound knowledge of child development. These programs should be integrated with comprehensive health, mental health, social, and recreational services. Such programs should reach the child in his home as well as outside his own habitat.

Parent and Child Centers as well as Project Head Start should be expanded in accordance with their original objectives. As noted above, these pre-school programs should include special schools and programs for the emotionally disturbed and mentally ill children.

- (2) *Mental Health and the School Environment.* The school has a much greater responsibility for the mental health of children in the middle years of childhood than can be met by special services. To be effective, there must be continuity between the underlying principles of the total educational milieu and the focus of specialized services. In short, there should be a consistent mental health base for everything the child experiences in his school life. Achievement of this goal would lead to less proliferation of specialized services and be a step forward on the preventive level. For the school to be a mentally healthy environment, there must be a change in the concept of how this institution shall serve society through the children it educates. We recommend:

- (a) Federal grants for programs undertaking responsibility for mental health goals as an integral part of the educative process and selection of schools for involvement in grants, or designation as models under the Education Professions Development Act, on the basis of such guidelines and criteria as the following:

- educational goals focused on developmental processes of childhood;
- instructional methods and technology which advance intellectual power and positive emotional growth;
- learning activities which allow active and independent pursuit by the child, encompass and integrate thinking and feeling, and allow for direct expression of feelings;
- organization of learning tasks to make maximum use of the peer group;
- flexible and rational authority structure;
- policies which allow the teacher to hold the pivotal position in the educative process,

- (b) The Commission further recommends that the U.S. Office of Education establish contracts with diversified school systems in cooperation with university centers to develop pilot programs specializing in such areas as:

- development of diversified curricula in the elementary school that are both responsive to the needs of impoverished children and oriented toward developmental sex differences;
- construction of a plan for continuous evaluation of teaching innovations, including the effects and implications for the role of teacher and teacher-child relationships;

- development of a strategy for recruiting men teachers;
 - development of patterns of flexible and differentiated use of instructional personnel;
 - planning administratively for an “open school” design;
 - development of the school as a broad gauge community center involving parents in the formulation of the school’s long-range plans; and
 - the development of in-service training programs for teachers with focus on child development knowledge, use of mental health consultation, and preparation for understanding and tolerating a wide range of behavior in the classroom.
- (3) *Expanding Opportunities for Higher Education.* The educational system must prepare all youth more effectively for their occupational and citizenship roles. A comprehensive program needs to be established from the elementary to the post-secondary school levels to provide financial assistance, information, and counseling programs and enrichment courses to prepare children for work, participation in a democracy, further training, and the flexibility to assimilate new ideas. We recommend:
- (a) that free public education be provided at least two years beyond high school;
 - (b) that public-supported junior colleges be expanded to train youth in both technological and human services employment fields; and
 - (c) that the Higher Education Act of 1965 be amended to provide funds to assist colleges and universities to develop programs in student development.
- (4) *Special Education.* Although all states have recognized the right of each child to an education, this right has not been extended to all the severely retarded, seriously disturbed, and those with severe neurological impairments. In addition to the special classes and schools recommended above, the Commission urges expansion in teacher training for the handicapped and disturbed. We also recommend that the U.S. Office of Education, Bureau of the Handicapped:
- (a) undertake a national survey to assess the quality and outcome of current programs and determine needed changes;
 - (b) establish demonstration districts to develop models of service; and
 - (c) collect and disseminate information related to a broad spectrum of educational services designed for the handicapped.
- (5) *Crisis Conditions.* The disruption, disorder and violence in schools across the Nation calls for the development of new and appropriate strategies by the community and the school. To help meet these crises conditions, the Commission recommends:
- (a) that the U.S. Office of Education establish three regional centers to provide assistance to schools upon request. These centers would have the responsibility to:
 - train personnel and consultants for crises situations;
 - develop institutes, conferences, and training programs for educational administrators to develop understanding which will prevent and manage disruption; and

—disseminate instructional materials to schools and communities so they can develop techniques to deal effectively with these crises.

- (6) *School-Community Relations.* Federal funding should be provided for model programs to demonstrate the effect of school-initiated projects in bringing about closer school-community relations.
- (7) *The Education of Minority Group Children.* Special attention should be given to the development of a curriculum relevant to the group's culture, language and projected employment opportunities in minority communities. All school systems should include more about cultural diversity with the goal of promoting understanding and eradicating prejudice. The Commission also recommends:
 - That schools for minority group children should be reviewed and revitalized. Consideration should be given to the physical setting, age of entry into school, length of the school day, study space for children after school, etc.
 - Boarding schools for Indian children should be eliminated and quality education in local schools substituted as soon as possible. Existing boarding schools should be upgraded to meet the psychological requirements of students.
 - Ways should be found to increase motivation for achievement, such as career-mobiles, travel grants, domestic cultural exchange programs, experimentation with material rewards, etc.
 - Incentives, such as increased pay, Civil Service and tenure systems, and flexible administrative practices, should be instituted to attract well-qualified teachers to teach in schools serving oppressed minority groups.

E. *Work, Leisure, and Preparation for Adult Roles.*

With the changing times, we have provided our children and youth less opportunities to interact with adults, younger children, and those from different social and cultural backgrounds. Similarly, they have fewer opportunities to learn adult roles or to be meaningfully involved in institutions which affect their lives. Many new programs need to be created to provide citizenship training as well as opportunities for personal development, vocational readiness, job training, and academic improvement. We recommend increased Federal support for:

- (1) *Leisure activities*, such as year-round camping programs, teen centers, well-equipped and supervised playgrounds, and community and neighborhood recreational programs. Youth should be involved in the planning and operating of these activities. Older youth should be utilized to work with younger children.
- (2) *Participatory Activities* should involve young people in helping others, reaching into their communities, reforming their schools, and serving in a variety of ways. We recommend:
 - (a) involving children, from very young ages, in learning about and participating in adult roles, such as decision making according to democratic principles.
 - (b) involving adolescents and youth in social problems such as projects to eradicate slums, programs for disadvantaged and handicapped youngsters, projects to achieve racial harmony, etc.

- (c) involving youth in specific teaching projects, such as tutoring young children, emotionally disturbed children, youngsters with learning problems, etc.
- (3) *Vocational Readiness Programs* should begin in the elementary school to familiarize the child with the concept of work and help him develop rational habits of thought. At the high school level, occupational preparation should be realistic. Those outside college preparatory course work should acquire a saleable skill suited to their individual needs and interests. We recommend:
 - (a) increasing the scope and variety of combined work-school programs;
 - (b) increased vocational counseling from junior high on;
 - (c) staggering high school graduation over the year to facilitate the absorption of youth into the labor force;
 - (d) publically supported post-secondary education courses for youth interested in vocational education; and
 - (e) increased training programs which teach youth how to look for a job, pass tests, etc.
- (4) *Vocational Education* should be based on the ability to succeed in a field of work rather than on academic grades, as stated in the 1963 Vocational Education Act. In addition, we recommend:
 - (a) that the "general" curriculum should be eliminated and vocational courses integrated with basic skills and academic courses. Attention should be given to devising ways to raise the prestige of the vocational education curriculum;
 - (b) that regulations be revised so students would not have to choose vocational curriculum in the 9th grade and be unable to change curriculum thereafter;
 - (c) that Federal action should be taken to end the segregation in vocational educational facilities; and
 - (d) that exchange programs should be initiated which would bring adult workers into the schools and youth to their places of work. Emphasis should be on the need to devise summer work programs for youth.
- (5) *Youth Work-Training Programs* should be expanded and include built-in opportunities for advancement. The Federal Government should aid communities to develop their own manpower system; provide incentives to industry to establish work-training programs and incentives to unions to expand apprenticeship programs and drop present exclusionary policies which bar youth from obtaining bonding. Further, police records should be based on convictions, not arrests, and potential employers should be barred from viewing juvenile arrest records.
- (6) *Vocational Readiness for the Handicapped, Retarded, Delinquent, and Severely Disturbed* is provided for in legislation (Vocational Education Act of 1963) supporting programs in residential schools. We urge that Congress appropriate funds for such programs, which it has failed to do, to date. We also recommend that the Federal Government provide incentives for developing programs that will involve community employers in all facilities which serve the various types of handicapped youth. We urge professionals involved in the care and rehabilitation of these children to become more employment oriented and include

this in their treatment programs. After-care services should be part of the spectrum of services and include supportive counseling after job-placement.

- (7) *Youth Employment* shows a definite relationship to feelings of competence and self worth; conversely, the lack of employment is associated with feelings of rejection, inadequacy, hopelessness, and dependency. Areas of widespread youth unemployment are usually areas of high delinquency rates and poverty. We recommend:
 - (a) Federal funding for expanded training and employment opportunities for youth, particularly in the human services; and
 - (b) Amendment of the Fair Labor Standards Act to establish a minimum wage rate for teenagers and covered employment at 75 percent of the standard minimum wage for adult workers.

III. Research

The Commission recommends increased support for research.

The broad scope of the Commission's recommendations reflects the complex state of being which we call mental health and illness. Although we know a great deal about mental health, emotional disorders, and mental illness, much remains elusive and ill-defined. If we are to continue to make strides in helping our children and youth, we must continue to add to our knowledge of human development.

- A. The Commission strongly believes that the following principles should guide research programs:
 - (1) A high priority must be given to the establishment and preservation of a national research climate which optimizes the productivity and opportunities of the individual researcher.
 - (2) Behavioral research is essential to a technological society if we are to narrow the gap between the well-being of the individual and of the society. Both basic and applied research are necessary.
 - (3) Short-range, applied research projects should be planned on the basis of their potential for productivity at a given time in the Nation's history.
 - (4) Carefully designed applied research projects need to be increased to evaluate and assess action programs.
 - (5) The role of the universities in carrying out basic research must be preserved. Universities may wish to contribute to applied research; however, funding and other restrictions should not undermine the independence of research workers.
 - (6) Multi-disciplinary collaboration between researchers in both basic and applied fields should be supported.
 - (7) There is a drastic need for longitudinal studies of human development that cover the entire life span and include the study of both biological and social variables; for multi-variate research; and for more epidemiological studies.
 - (8) We recommend that NIMH sponsor, in connection with its Clearing-house activities, studies which would develop techniques for evaluating material which should be quickly retrieved and more rapidly disseminated to the relevant professions.

- (9) Further efforts are needed to increase the training of research manpower.
 - (10) There is a need for an emphasis upon the area of methodology in research on child development and mental health.
- B. The Commission makes a number of recommendations for research into specific areas of child development and mental health. *We further recommend that 10 child mental health research centers be established under the auspices of NIMH or NICHD to study issues related to childhood mental health.* These centers should be concerned with such problems as:
- (1) The development of a more adequate system of classification of emotionally disturbed children.
 - (2) The longitudinal study of the natural history of emotional disturbance in children from the point of earliest identification through the adult years.
 - (3) The study of early childhood autism, childhood schizophrenia, and similar severe disturbances from both a biological and behavioral point of view.
 - (4) The study of the effects of various forms of therapeutic intervention on the course and life of the child, including the effects of institutionalization and prolonged drug use.
 - (5) The comparative study of the effectiveness of various kinds of intervention procedures.
 - (6) The development of assessment procedures to facilitate the types of studies noted in (4) and (5) above.
- C. The Commission also recommends support for research into the several topics included in our recommendations, such as education, work, manpower, assessment of Child Development Councils, and so on.

IV. Manpower and Training

The Commission recommends that high priority be given to devising new approaches to constructively and realistically meet the present problems in the mental health manpower field.

Currently, there is an acute shortage in manpower in the core professions concerned with child mental health and related services. The increased demand for services in recent years has not been matched by the increases in manpower. Further, available personnel is poorly distributed and tends to serve only a small and usually more affluent segment of urban populations.

Clearly, we must seek new solutions to meet the need for both preventive and therapeutic services. However, we cannot expect mental health professionals to assume total responsibility for the mental health of our children and youth. All of us—as parents, legislators, teachers, urban planners, professionals, etc.—are ultimately involved in the development of our young. Those who are expert in the mental health and related fields must extend their areas of influence. They must reach out to all of us and advise us as to the ways in which each of us may enhance the development and mental health of our children. They must provide mental health training throughout the community so that all those who come into contact with children, or are sought to advise on their behavior, can establish a

series of "helping relationships" in which one person can aid others in developing their talents and capabilities.

But those in the mental health professions must do more than advise and train. They must also listen. They must be sensitive to the times and determine the needs and expectations of the various communities they serve. They must look at the shortcomings within their own professions and devise ways of evoking in their members a genuine sense of the responsibility which underlies their public trust. And they must support new solutions to the problems of manpower.

A. *Federal Programs:*

To help meet the need, the Commission recommends that the Federal Government:

- (1) Develop an effective Federal manpower policy which will grapple with the priority problems of the various professions.
- (2) Expand training facilities and personnel.
- (3) Subsidize students for both professional and paraprofessional training. Special efforts should be made to recruit persons from lower-socio-economic strata and ethnic minorities.
- (4) Allot a minimum of 50 percent of training funds of the NIMH to the education of psychiatrists, psychologists, social workers, psychiatric nurses, teachers, counselors, and other mental health specialists for work with children and youth.
- (5) Provide tax-incentives to facilitate a more equitable geographic distribution of scarce manpower.
- (6) Establish some form of National Service which would allow young people of 18 and over to participate in service programs. We recommend that a number of National Service pilot programs be established in different regions of the country to determine the amount and type of participation desired by youth and young adults.

B. *Specific Professions:*

The Commission hopes that the Federal Government will provide technical and financial assistance in providing manpower and training in such specific areas as: medical personnel for services to the mother and young child; personnel for services to adolescents; family specialists; foster care; child care workers for institutionalized children (at various levels of professional training); clinical personnel; various types of personnel for Re-ED type schools; and paraprofessionals to serve in health, education, and welfare services.

C. *Paraprofessionals:*

The Commission has made a number of recommendations which are specific to all of the above professions; however, the most important area, for the purpose of increasing our manpower supply, is that of paraprofessional training and utilization. Concerning paraprofessionals, the Commission recommends:

- (1) The development of a hierarchy of new careers and the restructuring of old ones. These careers should range from trainee positions to fully-trained ones. The concept of progressive development of the individual must be a central component of any such plan. A "career ladder" concept must allow the individual to move both vertically and horizontally within public programs; that is, an employee should be able to move

upward to increasingly responsible work levels and increasingly high rates of pay, and also must be able to move from one field of work to another. Wages must be adequate to attract interested personnel.

- (2) Generic education and training in the field of health, education and welfare should be available to provide a base for occupational movement in the various sectors of human services.
- (3) Recruitment and employment should be based on the interests of the potential employee and the work to be done.
- (4) It is essential that there be well supervised but flexible in-service training and that the educational and job programs be coordinated. Trainees must be paid for the time spent in in-service education and training.

D. *Manpower for Child Development Councils:*

As Councils move from the initial pilot stage to full-scale operation across the Nation, the proposed goals will require an immense increase in manpower. In fact, this problem is so important that it constitutes a major argument for a Federal advocate agency which would be given the specific challenge to recruit workers for staffing both the Councils and the service institutions with which the Councils collaborate. Expert sources indicate that several categories of personnel are needed:

- (1) People from existing professional groups and especially from the newer technician levels being developed in pediatrics, psychology, etc.
- (2) A new professional group trained in child development at a number of levels (B.A., M.A., Ph.D., Ed.D., etc.), to serve as administrators of the Councils; educationally oriented child-care specialists to supervise day-care and pre-school facilities; and child-parent counselors to visit homes and train and supervise paraprofessional workers in home visiting.
- (3) A new paraprofessional group of child-care workers, aides, "up-bringers," etc., approximately at the level of the high school graduate who could, if they desire, move into professional roles.
- (4) Adolescents for both service and training to work with children in various programs.
- (5) Volunteers, paid and otherwise, who are employed full or part time. These could be drawn from several groups; e.g., parents, "foster grandparents," college men and women, retired teachers, "indigenous workers," church groups, and rehabilitated persons who are purposefully seeking a centering point for their lives.

II

CONTEMPORARY AMERICAN SOCIETY: ITS IMPACT ON THE MENTAL HEALTH OF CHILDREN AND YOUTH

Our society has seen its men walk on the moon. It has yet to see its children walk with equal pride upon its land. In spite of our great wealth, millions of our children are deprived of adequate nutrition, physical care, and wholesome homes and environments. Many fail to receive the intellectual stimulation, emotional guidance, and opportunities for creative and safe play which they need for healthy development. For some, the consequent damage is irreversible.

All of our children face the many pressures of our changing, impersonal and highly technological society. Massive institutions threaten the individual's sense of unique significance. The divisive factors of racism and social class create a growing sense of polarization and separatism. Despair, apathy, and violence are becoming characteristic of the American scene. These problems are felt most acutely in the idealistic stage of adolescence. Today's adolescents face increasing achievement pressures for educational accomplishments; the imperatives and difficulties of "getting into college" and getting a job; the shifts in sex behavior and values; and the stresses of the draft.

Today's mental health crisis is reflected in the high rates of delinquency, non-learning, and mental illness. Our inadequate statistics show that 10 to 12 percent of our children and youth have psychological problems. Unknown numbers are falling far short of their developmental potential. In addition, there are the all too common problems of teen-age illegitimacy, venereal disease, drug use, youth unemployment, and widespread alienation from society.

Predictions indicate that this tragic state of affairs is likely to grow worse, given the expected increase in our youth population and in the complexities and pressures of our expanding technological society. At our present pace, we cannot hope to provide for future needs. The existing services for children and youth are inadequate even for today's needs. Mental health services exist for only about seven percent of the identified population in need, and these are dispensed mostly to the more affluent. One fourth of our children and youth receive few, if any services. Prevention—the key to developing mentally healthy and productive citizens through attention to the needs of the very young—is not yet even in sight.

Most definitions of mental health include the following elements: the capacity for control over one's own human impulses, coupled with the ability to assess realities with considerable accuracy and to act appropriately on this assessment; the ability to form satisfying human relationships; and the ability to learn, and to use what one has learned in useful work and self-renewing play.

These abilities and capacities are largely acquired. Development proceeds throughout life, but its foundations are laid in the child's first few years. Many of our children's life-time chances for development are seriously undermined in the earliest days and years of life. To insure the development of maximum positive

mental health for each child, we must provide a wide range of coordinated services: medical, economic, educational, and social.

Given a sufficiently strong commitment, we can meet these needs. Many industrialized nations much less wealthy than our own have moved far ahead of the United States in providing a network of developmental and protective services for their young people. We have fallen seriously behind in creating the coordinated, preventive, public programs in health, education, and welfare found in many other countries.

Our programs in education, health, manpower training, and employment show promise. However, they have been poorly coordinated one with another, meager in kind, and sometimes short-lived. Often, they have failed to reach those most in need. Too frequently they have been directed to special and separate problems rather than to the whole child and his family.

To promote the mental health of children and youth, we must also promote the overall well-being of their families and communities. Thus, action for the mental health of children and youth must incorporate many programs which start at National levels and move out to states, communities, and neighborhoods. These needs led to the Commission's recommendation for an advocacy system. We have the technological and financial resources to make this goal a reality. The basic human resource of our land—our children—must have our highest national priority.

III

CONTEMPORARY AMERICAN SOCIETY: ITS IMPACT ON FAMILY LIFE

Stable, well-organized families are of crucial importance to the mental health of children and youth. Ideally, the family provides much-needed warm acceptance and long-lasting personal supports to both parents and children. This is vastly important in an age when the family's major function lies in the emotional and psychological realm. The supports are needed so that family members can cope effectively with the harsh requirements of our technological, complex society.

Family life in this country shows signs of strain. Thirteen percent of our children are being reared in one-parent families. A large number are being raised in families where step-parents are present, largely because of earlier divorces and remarriages. One fourth of our young people marry before the age of 20—a fact that greatly increases the risk of later breakdown.

All our families face the stresses of our modern automated and depersonalized society. One-fourth of all families still live in, or near, poverty, with incomes of less than \$5,000 a year. About one-fifth of the Nation's families move each year. Mobility is particularly high among very young, non-white and low-income families. There are few services to aid our highly mobile, isolated and fragmented families in times of crises.

Matters threaten to become more acute with the "population explosion" that seems sure to occur as our large youth population reaches marriage age. Birth rates, at present, are high for poorly educated, low-income families, despite the fact that such families, like others, aspire to having no more than two or three children. Shifts in family structure and in the functions of mothers, along with high costs of living, are factors which contribute to the increasing number of women who enter the labor force. Although maternal employment apparently does not adversely affect the child's physical and mental health if good substitute care is available, there is presently a severe and critical shortage of high quality day care available for children of working mothers.

The specialized services that have been developed in many communities are a potential aid to families. However, these services have become so overly specialized, frequently so expensive, so poorly coordinated, and so centered on individuals rather than families, that very few parents have the resources needed to mobilize these services for the well-being of each family member or for the family as a unit. There are enormous gaps, especially in day care, relevant education, and physical and mental health facilities.

These service gaps must be filled. It is far wiser and more economical to protect and promote the well-being of families in general than to focus only on families in which a member or members have serious emotional problems. Specialized, but splintered, services must be coordinated. The physical, social, and economic structures of communities must be better adapted to the mental health of individuals and families. The planning and administration of these services and programs should be directed toward the strengthening of the family so that it can adapt

to today's society, and carry out its important functions. Since the family is a dynamic system, interacting with agencies and individuals, programs and services should be family-focused and should include parents as partners in administering and carrying out programs. The Child Advocate system, the Child Development Authorities, and the local Child Councils recommended by the Commission should afford the needed mechanisms for the development and coordination of these needed family-focused programs and services.

IV

POVERTY AND MENTAL HEALTH

There are many indications that poverty adversely affects physical and mental health. The following are facts that threaten nearly one fourth of our Nation's children and youth:

- Studies suggest a close correlation between prematurity and low socioeconomic status and between low birth weight and high rates of infant mortality, and such serious handicaps as brain damage, mental retardation, blindness and other disabilities. Data show that a large proportion of poor mothers, particularly non-white mothers, receive no prenatal care and inadequate obstetrical care at delivery.
- Of the estimated 3 percent of children who are mentally retarded, 75 percent show no obvious brain damage and have few physical handicaps. Typically, these seemingly non-organic cases come from census tracts where the median income is \$3,000 a year or less.
- Analysis of Head Start children showed that at least 10 percent were judged to be crippled in their emotional development by the age of four years. In some cities, this figure is estimated at 20 to 25 percent.
- One study found that 70 percent of several thousand first graders in a typical Negro district in Chicago were mildly to severely maladapted to the psychological requirements of the first grade. Compared to a well-adjusted white group, these youngsters ran a 9 to 1 risk of developing psychiatric symptoms by the end of the school year. In the same district, some 10 percent of the youngsters between 7 and 17 years of age came to the attention of authorities each year because of delinquent behavior.
- The early results of a current study of mental and emotional disorders among children in Manhattan show that rates are much higher for poor children and for children who are members of oppressed minority groups.
- Disadvantaged children show high rates of cumulative educational retardation; e.g., it is estimated that 85 percent of the eighth grade students in Harlem are "functional illiterates." Typically, these youngsters know only dilapidated, understaffed and ill-equipped schools.
- There is a consistent correlation between poverty and the number of school dropouts. Of the million youths who will drop out this year, about 65 percent will come from families with incomes of less than \$5,000 a year; about 85 percent from families with incomes of less than \$7,500. Dropout rates for certain minority groups run as high as 60 to 70 percent.
- Unemployment is a serious problem for youths between the ages of 16 and 19. In 1967, the rate for white youths was double the overall National average; the rate for non-white youths was seven times higher.

Data indicate that the very poor from disorganized communities tend to lack opportunities for a smooth and relatively progressive development. Such environ-

ments seem to produce in children attitudes of mistrust rather than trust, doubt and a sense of powerlessness rather than autonomy, indecisiveness instead of initiative, a sense of failure rather than mastery, isolation instead of intimacy, and despair rather than ego integrity.

Studies show that it is important to distinguish between the poor who have retained the social and psychological characteristics of well functioning societies and the poor whose family and group structure has been highly unstable for generations. While it is difficult to work with disorganized groups, data indicate that these people may be motivated to respond to programs on the basis of at least two commonly felt needs. One such need is health care; the other is programs that promise help for their children. Research findings indicate that the disorganized poor are in need of both such programs far more than any other group.

Data further show that eight major factors are associated with poverty: little education, the poverty environment, chronic unemployment, low income, poor physical and mental health, large families, broken families, and life styles which are a product of impoverishment. These factors interact in ways that keep poor families entrapped in an intergenerational cycle of poverty.

Clearly, poverty cannot be reduced or prevented unless there is a coordinated, simultaneous attack on removing or reducing these factors and their effects. To effectively solve the problems of poverty, we must systematically reorder our impersonal and inadequate social and economic systems so that they will meet human needs. Citizens and professionals must work together so we can use the available knowledge to develop new approaches to solving the problems of poverty which threaten the physical and mental well-being of every community member. We must act now on these data.

V

CHILDREN OF MINORITY GROUPS: A SPECIAL MENTAL HEALTH RISK

The mental health problems of minority group children are so severe that they warrant immediate and drastic attention. Poverty and racism combine to threaten the nutritional, physical, and psychological health of large proportions of oppressed minority group children. Indeed, poverty and racism have created a divisiveness which threatens our future and weakens our society and its citizens. Racism is believed by some to be our Nation's "number one public health problem."

There is, however, a new hope because there is a new spirit among the peoples of oppressed minorities. Each group is seeking—and sometimes even demanding—a recognition and acceptance of its unique cultural identity and the right to equal opportunities. This direction is one conducive to positive mental health and should be fostered and valued by the majority culture, rather than viewed as a threat.

The response to date by the mainstream culture has not been amelioration of grievances but punitive action. There have been few basic social or economic changes directed toward altering the value system of our society.

One of the realities of present-day America is that increasingly large segments of the minority population will be obliged to live in segregated communities, at least over the next couple of decades. In general, without massive intervention, this fact means that the majority of minority children born between now and the end of the century will be growing up in mentally unhealthy atmospheres rampant with substandard housing, inferior education, and poor health care. They will continue to suffer the damaging effects of discrimination.

This country must outgrow its legacy of racism. There must be massive outpourings of resources, both financial and human, if the problems are to be resolved. A minority child must grow up seeing himself and his life as having positive value. The white child must grow up learning to judge a fellow human being by what he is, rather than by the color of his skin, and be equipped to live as a member of a multi-racial world. These achievements will allow them both to grow up less handicapped by the effects of guilt, fear, anger, and anxiety.

The mutual distrust so prevalent in this country is leading to the polarization of Americans. The growth and viability of our society are dependent on everyone achieving a full measure of growth and development. This is true no less of the majority whites than the minority group member. While the financial cost of eradicating racism in all walks of National life will obviously be immense, the result of making it possible for millions of wasted human beings to contribute to our National productivity and creativity, the development of millions of new consumers for our National product, the improvement of our commercial relations with other nations, the cut in the present enormous costs of inadequate welfare programs, would seem to make it a relatively sound investment. The society can truly find new strength and integrity by an acceptance of all diversity.

VI

EMOTIONALLY DISTURBED AND MENTALLY ILL CHILDREN AND YOUTH

At least 10 million of our young people under 25 are thought to suffer from mental and emotional disorders. It is estimated that .6 percent are psychotic and that another two to three percent are severely disturbed. An additional eight to ten percent are in need of some kind of help from knowledgeable persons.

These children and young people are crippled in their ability to learn, to relate to others, to see the real world as it is, or to adequately handle their impulses of anger, fear, and sex interest. They do not feel that they are a vital and effectual part of society. The future seems to promise only more such human tragedies.

At present, there is no community in the United States which has all the facilities for the care, education, guidance, and treatment of mentally ill and emotionally disturbed children. The few services which are available are poorly coordinated and do not serve all those in need. Many ill and disturbed children are poorly diagnosed and are institutionalized as being retarded or delinquent. Thousands are losing all possibility for partial or full recovery. They are forgotten and left to deteriorate slowly on the back wards of mental hospitals.

Research indicates that most children and adolescents with minor emotional and learning disturbances recover fully if they are given competent understanding guidance and help. Most of the more seriously handicapped are found to improve with appropriate treatment. Only a few show no improvement, despite the best professional efforts; these, however, need sheltered living environments based on the concepts of health rather than illness.

Appropriate care for these children and young people requires the creation of a network of coordinated diagnostic, treatment, and care facilities and services, which is based on sound child development knowledge, rather than oriented toward adult needs as are present services. Services must be continuous and fitted to the child's individual needs.

We must begin to apply the knowledge we have toward active and vigorous programs of prevention. Services must be designed to reach parents at a very early stage—before conception if possible. Genetic assessment and counseling and high quality prenatal and obstetrical care are approaches which promise to reduce the number of biologically impaired children whose handicaps are so often coupled with emotional and learning problems. Continuous and comprehensive services to the child and his family would lead to a reduction in almost every known form of childhood disorder.

Specialized services for children with emotional and mental disorders need to be planned and administered as part of a larger community program which is directed toward meeting the health, educational, recreational, housing, employment, social and economic needs of all its citizens. Continual improvement of such a program should be assured through careful evaluation and research.

VII

SOCIAL-PSYCHOLOGICAL ASPECTS OF NORMAL GROWTH AND DEVELOPMENT: INFANTS AND YOUNG CHILDREN

Healthy human development is related to many interwoven factors—biological, social, emotional and intellectual—and is largely shaped by the events that occur from the time of conception until the age of two. It is in these early years that the foundation is laid—often irreversibly—for the individual's total well-being. This is also the time during which the child is most flexible and responds most quickly and easily to any needed remedial services.

Research shows that a child's development is greatly affected by the physical and mental health of his parents—especially his mother's nutritional and emotional state in the nine months or so preceding his birth. The child's development is also influenced by the spacing and number of children in the family into which he is born, by his family's social and economic condition, and by the care—or lack of care—he receives.

High quality prenatal, natal, and postnatal care are imperative to healthy development. This care includes proper attention to the child's needs for love and affection, first-rate physical care, good food and housing, and a wealth of learning experiences. The quality of parental, or substitute parental care, is of fundamental importance. Ideally, it is the mother upon whom the infant can depend and trust to be sensitive and responsive to his needs.

Every society has a responsibility and vested interest in the development of its infants. Studies show that our Nation has not sufficiently met its obligation nor been sufficiently concerned with its human resources. Our infant mortality rate is among the highest of all western industrialized nations and thousands of our infants are born each year with serious birth defects. The majority of these tragedies occur among low income mothers who come to childbearing with a long history of poor nutrition and health and often fail to receive adequate prenatal care or obstetrical care at delivery. Poverty prevents them from providing their surviving infants with adequate nutrition, housing, and care. As a consequence, many impoverished children die between the first month and first year of life or else suffer developmental damage.

However, our services for infants and young children and their families are insufficient for the needs of our total population. Among the most deficient are mental health services. Emotional, mental, and behavioral disorders among infants and young children usually go unchecked until the child enters formal schooling. By this late age, effective remediation is often difficult, if not impossible.

Day care and regular and special pre-school educational services are also highly inadequate. These lacks are reaching acute proportions as more and more mothers at all socioeconomic levels enter the labor force. Many of these mothers must work and cannot find adequate substitute care for their children. Consequently their

youngsters do not receive the continuous affectionate care and the intellectual stimulation which they need for healthy development.

The normal healthy growth of children is dependent upon healthy families and a healthy society. Their capacity for growth from helpless dependence towards ever-increasing skill, competence, self-direction, and ability to relate to others requires constant attention and help from parents and trained persons as well as a concerned society and its agencies.

VIII

SOCIAL-PSYCHOLOGICAL ASPECTS OF NORMAL GROWTH AND DEVELOPMENT: ADOLESCENTS AND YOUTH

Adolescence is not only a time of rapid physical maturation, but also a social and psychological opportunity for significant growth into mature individuality. Research indicates that a comparatively smooth adolescence is tied to early and continuous friendly relations and open communication with parents, a sense of positive self-esteem that has developed over the years, and the use of democratic, rather than authoritarian, child-rearing practices.

A relatively calm adolescence is more frequently found among middle to upper class youngsters. On the other hand, many youngsters from poverty backgrounds have quite a different adolescent experience because they are handicapped by a complex of past and present adverse conditions and by their meager hope for a markedly better future.

Each adolescent brings to this stage his entire life history and his own unique biological traits. He does not become a different individual simply because he becomes an adolescent, although he may express himself in somewhat different ways at this period as he progresses toward full adulthood.

Adolescence is also a different process for boys than for girls. For boys, there are great pressures for achievement in sports and the larger world of occupations and advanced education. For girls, emphasis is placed on becoming a lovable and marriageable young woman.

Adolescence in our culture seems to be divided into two merging stages. In early adolescence, the primary concern is with winning independence from deep family involvements. At a later stage, the average adolescent is more concerned with two major issues. One revolves around finding one's place in the wider world and the other around developing a capacity for intimacy, including psycho-physical intimacy with the opposite sex. Thus, occupational and marital choice are both crucial issues to the older adolescent. The choices, however, are related not only to individual development but to what is actually available to the young person in the society in which he lives. For the advantaged youth, the central problem will be the difficult, but luxurious, question of choosing between many available opportunities. For the disadvantaged young person, there may be only two choices: to accept social rejection and educational or occupational failure in a pattern of fatalism and passivity or to lash out violently against the society which condemns him to inferiority, deprivation, and humiliation.

Adolescence is made more difficult in our society because the adolescent is physically mature long before society is ready to give him adult roles. He is intellectually adept long before he has had enough education and training to prepare himself for adult roles. He is idealistically motivated before he is able, through growth and experience, to evolve the principles on which he can realistically and flexibly build his adult life. He is ready for significant participation in society

while adults are still demanding that he be a passive, dependent onlooker of a scene which affects him deeply and which is changing too profoundly and rapidly for his adult mentors to understand and manage. These sets of conflicts within and between the generations frequently create an explosive situation.

While it is extremely important that adults support the growth of adolescents and youth and provide them the services essential to their development, it is just as crucial that adults share power and position with young people. Unless adolescents and youth are allowed to actively participate in the building of a better society, we will witness, in all likelihood, an increase in the current trends of youthful protest and violence and/or, conversely, a "tuning out" or turning away from a society which has become too rigid, too selfish, and too sterile to meet the young person's needs.

IX

**EDUCATION AND THE MENTAL HEALTH OF
CHILDREN AND YOUTH**

The schools possess an enormous potential for affecting the mental health of our children and youth. They can be an effective agent in the prevention of emotional and mental disorders and the promotion of healthy growth and development through effective education and meaningful curriculum and through remedial services provided in cooperation with other community agencies.

The school, like all our social institutions, is showing alarming signs of strain. Everyone, or almost everyone, criticizes the schools at the same time they expect them to accomplish almost miraculous feats. Upheavals in the schools are fundamentally related to social stresses in our society.

These stresses include such factors as: the enormous growth in our child and youth population; the rising demands that schools successfully educate all youngsters at higher and higher levels of competence; the problems of the inner city engendered by poverty, racism, massive population shifts, the loss of an adequate tax base; the shortage of highly qualified teachers; the critical link between educational achievement and occupational success; current shifts and confusion about values; the disorganization and separatism of many parts of our larger society; and deficits in needed human services of all kinds.

In general, schools need to open up their doors to the community—just as the community should open its doors to the schools. Children and youth stand to gain from such a process. Their education should be deeply and immediately related to life and include opportunities to learn about the realities of living in today's society. School is meant to prepare youngsters to fulfill their potentials so they can become effective adults. Such preparation is bound to be distorted and inadequate if it is conducted in a closed social system. Opening up the school to the larger society also means opening up the curriculum to the issues of living in today's world. It requires changes in the expectancies and attitudes we have towards teachers and other school personnel to accord them the rights and freedom we give other professional adults. It calls for greater flexibility and experimentation in school practices and for expanding work opportunities for men in the field of education.

Democratic procedures are closely associated with the mental health of the schools and of those persons associated with them. The total environment of the school deeply affects the child's mental health in all its aspects: physical, social, emotional, and intellectual.

Our school system must devote specific attention to children with particular problems, including those related to emotional and mental disorders. To the maximum extent possible, these children should be kept in the mainstream of the school life, not shunted off to special schools or classes. To help meet the problem, greater support should be given to providing teachers and parents consultation from mental health specialists.

X

EMPLOYMENT: PROBLEMS AND ISSUES RELATED TO THE MENTAL HEALTH OF CHILDREN AND YOUTH

Work satisfaction, security and success play important roles in the mental health of our children and youth. Work continues to be a central part in a man's—and increasingly a woman's—sense of personal identity, significance, and status. To most Americans, it is the major source of individual and family income, a particularly critical matter in our consumer-oriented society, and thus a critical factor to the individual's mental health.

Careful planning is needed if we are to solve the problems of work satisfaction in a technological society and of employment for each individual to earn a living for himself and his family. Our youth employment rate is the highest of any industrialized nation even though our young people stay in school longer than youth in these other countries. A large proportion of our young people are underemployed in low paying, non-rewarding jobs that offer little future. Working class youth find little personal satisfaction in their generally routine jobs in large organizations: work is merely a means to an end—economic security. Many of our youth, however, do not view economic security as a primary goal. Almost half of our college-trained youth are dissatisfied with the junior executive jobs in business and industry which they find open to them. They are seeking employment that is personally satisfying, and directed toward social goals.

Work, like play and education, should be an integral part of the child's life, increasing in range and complexity as he grows older. Work experience should be tied to the child's developmental level and special interests and abilities. We need to experiment with new, flexible ways to find a means of involving children and youth in the work of the schools, neighborhoods, and ever-widening communities, and, at the same time, protect them from exploitation. This approach would be a radical one in this country, but has much to recommend it from a mental health viewpoint. One mechanism for such an approach can be found through the Child Development Councils and child advocate systems recommended in this report.

Many of our attitudes toward work are outmoded. We must come to accept the fact that some people, through no fault of their own, cannot earn a "living wage" through employment and that they have a right nevertheless to dignity, respect, and adequate public assistance. However, many unemployed and underemployed persons possess the capacities to become productive members of society. We need only to capitalize on their potential. In all fields of human service—medical, social, educational, recreational—we are woefully short of services and personnel. Greatly expanded services are needed, and there are many people who need the jobs that such expanded services would offer.

XI

RESEARCH

We urgently need to establish and preserve a national research climate which optimizes the productivity and opportunities of individual researchers. Both basic and applied research are needed in the social, behavioral, and biological sciences if we are to effectively promote the healthy development of children and adolescents, prevent problems of emotional and mental dysfunction, and adequately treat those who are suffering from related disorders.

There must be a constant interweaving between action programs and research so that observations and clues from the action field can be referred to research fields for theory building and testing and findings from research can be fed back into action and training programs.

In these research programs we need a multi-disciplinary team approach directed towards specific problems. It is also recommended that multi-variate research be developed and addressed to the multiple criteria of positive mental health; that longitudinal research projects be undertaken with sufficiently large samples to permit adequate study of children from various kinds of backgrounds; and that applied research programs be designed to study the effectiveness, impact, and possible side effects of various forms of program strategies.

Among the various areas that particularly require further study are the following:

1. The prevalence in the population of moderate to severe emotional and mental disorders and the factors within the individual and the community which are associated with varying levels of behavioral dysfunction.

2. The origins and development of schizophrenia (including autism), learning disorders, and "failure to thrive."

3. The development of various levels of behavioral functioning over time. In these studies, particular emphasis might well be given to the neglected age periods of one to three years of age and 21 through age 55.

4. Basic research in such fields as genetics, neurophysiology, neuropsychology, processes of child development, and similarities and differences between cultural groups is essential if applied research is to flourish. Program research should include many more carefully designed studies, especially on the relative impact and effect of various forms of therapeutic endeavors on the individual and his family, and on the various approaches to most of the services and programs recommended in this report. Such research should include long-term evaluation components and should encourage a number of planned experimental projects accompanied by sophisticated evaluation components.

5. The results of research findings should be analyzed and made available for the development of policies and legislation as well as for the improvement of programs and training.

6. Research manpower in these fields is extremely scarce and we need a far

larger investment in manpower training for research and for the support of researchers in basic and applied fields related to mental health.

7. Large-scale research and development centers are needed to test out a variety of approaches to the prevention and treatment of behavioral dysfunctions and emotional and mental disorders in children and youth. These centers should be linked to each other so that experimental approaches can be tested and replicated in different parts of the country under a variety of conditions with a variety of staff personnel and treatment populations. Such an approach is essential so that we can arrive at more generalized knowledge in these important fields.

XII

HUMAN RESOURCES FOR HUMAN SERVICES

For a decade or more, experts in the mental health manpower field have recognized that, under the traditional system, we have not, do not, and probably never will have enough properly trained professional personnel to meet the mental health needs of our Nation. The traditional answer has been to train more professionals. Although we have increased our supply of the core professionals—physicians, nurses, social workers and psychologists—in the past few years, the increases have not been sufficient to meet rising demands for services. The problem is further compounded by the uneven geographic distribution of highly trained personnel, which leaves many communities with few, if any, services.

Limitations inherent in our traditional answer to manpower problems make it imperative that we look more systematically and creatively at the existing situation and the accompanying problems. We do need to train more professionals; however, we also need to develop means for making better use of our highly trained personnel. It is equally important that we develop new supporting manpower roles to provide for the mental health needs of our children, such as the training and employment of paraprofessionals as well as specialists trained at the B.A. and M.A. levels. We will need to continually expand existing educational and training facilities in ways that will maintain high standards and quality, and we will have to face the inherent resistance of the professions themselves to intervention and change. But, change itself can be creative; and it is possible that, in the long run, we may develop a much better system of services. Certainly the needs of our children can not be met under the existing mental health care network.

CONCLUSION*

It is difficult to determine precisely the actual cost in dollar amounts of the Commission's recommendations. Obviously the costs will be considerable. One of the Commission's Board members noted, in a speech before the San Francisco Mental Health Association: "As a rough guess, we estimate that eventual implementation of all our far-reaching recommendations will cost somewhere between six and ten billion dollars a year. A considerable portion of this financing will consist of re-allocating monies now devoted to ineffective programs; but a major portion will be devoted to new appropriations for new kinds of services.

"We do not flinch at the size of this financial recommendation. If we really intend to replace all of the nauseating rhetoric about our children with a massive program designed to optimize their physical and mental potential we must, as a Nation, drastically re-alter our priorities . . .

"If we can spend 80 million dollars a year for the defense of our country, we can surely afford 10 percent of this for strengthening that generation which will inherit a host of agonizing problems on both the domestic and world scene.

"... the prognosis for significant legislation carrying out the major recommendations of the Joint Commission during the next year or two is quite good . . .

"However, in the final analysis, the Administration and the Congress will not move until they hear from the citizens all across this land. We of the Commission have done our job; it is now up to you in mental health associations and allied organizations to take up the torch.

"The entire fate of the report of the Joint Commission on Mental Health of Children now rests upon the shoulders of all of us. As Thomas Jefferson once said: 'There is no substitute for the enlightened action of an aroused citizenry.'

"Let us move into the action phase."

*This portion of the summary is not included in *CRISIS IN CHILD MENTAL HEALTH*. Quotes from a speech by Mike Gorman: "An Action Program for the Mental Health of our Children," June, 1969.

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EXECUTIVE DIRECTOR
(1965-1969)

Joseph M. Bobbitt, Ph.D.

Mr. GORMAN. However, in the interim, we must deal with the thousands upon thousands of disturbed children who are being turned away right now because of lack of personnel and facilities. As one who was deeply involved in the drafting of the original community mental health center legislation, I state categorically that children have been largely neglected in the community mental health center program.

There are many reasons for this—the typical mental health center with limited financing finds it almost impossible to take on children who are very expensive to treat, since any effective program with them also includes therapeutic sessions with the family.

Furthermore, the adult patients are able to exert pressures upon the centers, and the children, who have little or no voice, are shunted aside.

We are therefore grateful, Mr. Chairman, that services for children are included in the original Staggers bill (H.R. 13163). This is the first time since the inception of community mental health center legislation in 1963 that they have been deemed worthy of attention.

The Staggers bill provides \$31 million over a period of 3 years for the inclusion of children's services in community mental health centers. I respectfully submit, and this is also the view of my colleagues on the Joint Commission on Mental Health of Children, that such an allocation is much too small to have any real impact in terms of the demonstrable needs which the Commission report outlined in great detail.

However, it is my understanding that the Senate Subcommittee on Health on November 12 marked up a bill which provides approximately \$228 million for children's services over a 5-year period. We naturally support the higher Senate figure as much closer to the recommendations of the Joint Commission.

Even more important than the amount of money to be appropriated is the key issue of preferential matching for children's services and I agree on the preferential matching provisions.

No matter how much money the Congress appropriates, we will not establish these units in mental health centers until we give them an additional inducement to take on these very expensive services. I have visited 33 of these centers in the past year, and I know that practically all of them want to provide treatment for children, but they do not have the financial resources to do so.

I think this was brought out tangentially in yesterday's testimony, but there was a resolution by 65 community health center directors meeting in Denver in the latter part of October pleading for preferential treatment for children's services. These are the guys running the centers, so I think they know what they need, better than any national organization, certainly better than I do.

The National Advisory Mental Health Council, on which I have the privilege of serving, is deeply aware of this problem. At its last meeting early in September of this year, after a 4-hour discussion of the lack of children's units in community mental health centers, we unanimously voted for a resolution supporting preferential matching for operation of all children's services at the level of 90 percent for the first 2 years and 75 percent for each of the next 8 years.

It is my understanding that the Senate Health Subcommittee on November 12 adopted the matching provisions which the National Advisory Mental Health Council had recommended for children's

services in the network of the community mental health centers renewal bill.

We are grateful for the provision in H.R. 13163 for the training of child care workers to staff and operate these units for children. The Joint Commission devoted a tremendous amount of time to the study of child health manpower and we concluded that a major effort must be made during the next decade to train both professional and non-professional personnel with specialized skills in the care and treatment of children.

H.R. 13163 provides a total of only \$10 million over the next 3 years for this enormous training task. We submit that this is not going to solve the problem.

We therefore propose a minimum of \$10 million a year over the next 3 years to begin a major national training effort in the field of child care.

If I could just make one parenthetical observation in conclusion, Mr. Chairman, and members of this distinguished committee: I have walked the wards of many State hospitals in this country. I have been accused of visiting more State hospitals than anyone in the country, and I plead guilty to that charge. I am, I suppose, insulated, maybe almost indifferent, if I may say so, to the plight, maybe, of hundreds—indifferent is too strong a word, but maybe anesthetized to the adults—but I still to this day get a pain in my heart and a sick feeling in my stomach, and I speak seriously, when I walk on the wards of a mental State hospital and I find on a ward for 90 adult patients a boy of 12, and that little boy, because there are no facilities in his community for early treatment and detection, is going to wind up, according to the reports of our Joint Commission—they didn't have to tell me this, but I served on the Commission—he is going to wind up probably a lifetime custodial patient of a State hospital institution at a lifetime cost of about \$100,000 to \$120,000.

So, I think that when we talk—I do not talk apologetically when I pleaded for preferential treatment for children. I am so sick of the rhetoric about children and what we are going to do about the children of this Nation that I have a total case of nausea.

We are going to have a White House conference in 1970 on youth. We have had one every 10 years. I can write the resolutions for them now, because they will be the same ones as passed in 1909.

Bill Carr, who was the former executive director of the National Education Association, did a wonderful trick. He proposed a set of resolutions to the 1960 conference, and most of these resolutions were severely disputed and attacked, and he got up and said, "These are the resolutions we passed in 1930 at the White House conference."

You can roll eggs on the White House lawn and it will have the same effect on legislation.

We have 27,000 children in our State hospitals today, still today, when we have a doubling of children under the age of 14 in these State hospitals, a doubling in the last 10 years—why?

Because on the one hand we recognize the problem now of childhood mental illnesses. I don't have to tell the distinguished member of the committee from Kentucky. We recognize the problem, but we have no place for them to go.

So, I plead with you for preferential treatment for children, and it is based upon heavy documentation.

Thank you, Mr. Chairman.

(Mr. Gorman's prepared statement follows:)

STATEMENT OF MIKE GORMAN, WASHINGTON, D.C., EXECUTIVE DIRECTOR, NATIONAL COMMITTEE AGAINST MENTAL ILLNESS; REPRESENTING JOINT COMMISSION ON MENTAL HEALTH OF CHILDREN

Our major national, professional organizations estimate that there are now approximately four million children under the age of 18 who are in need of some kind of therapeutic intervention because of emotional difficulties. Of this number, anywhere from one-half million to a million children are so seriously disturbed that they require immediate treatment.

Are they getting this treatment? A survey undertaken by the National Institute of Mental Health in 1966 concluded that, of the 70 million children under 18 in the United States, 1,400,000 were in need of psychiatric care. Only 473,000 of these children received care, indicating that our service facilities failed to serve two-thirds of these in need. Other estimates of those in need of care, based on surveys conducted through various school systems, all confirm the need for psychiatric care for two to three percent of the children. However, these studies identified an additional seven to nine percent who need help for emotional problems.

What happens to these emotionally sick children for whom there are no services in the community? Each year, increasing numbers of them are expelled from the community and confined in large state hospitals so understaffed that they have few, if any, professionals trained in child psychiatry and related disciplines. It is not unusual in this year 1969 to tour one of these massive warehouses for the mentally ill and come upon a child, aged nine or ten, confined on a ward with 80 or 90 sick adults. Data for 1966 indicate that over 27,000 of these children were confined in state and county mental institutions. On the basis of a trend which has been developing over the past few years, the National Institute of Mental Health estimates that by 1970 the number of children aged 10-14 hospitalized in these institutions will have doubled.

The National Institute of Mental Health also reports that thousands upon thousands of elderly patients now confined on the backwards of these state institutions were first admitted as children 30, 40, and even 50 years ago. A recent report from one state estimates that one in every four children admitted to its mental hospitals "can anticipate being permanently hospitalized for the next 50 years of their lives."

After two years of studying the situation, the Clinical Committee of our Commission had this to say of the hospitalization of these disturbed children:

The admission of teen-agers to the state hospitals has risen something like 150% in the last decade. . . . Instead of being helped, the vast majority are the worse for the experience. The usual picture is one of untrained people working with outmoded facilities within the framework of long abandoned theory (where there is any consistent theory), attempting to deal with a wide variety of complex and seriously sick youngsters and producing results that are more easily measured by a recidivism rate that is often 30 to 50%, and occasionally higher.

What we have, in effect, is a state of quiet emergency, unheralded and unsung, silently building up its rate of failure and disability and seemingly allowed to go its way with an absolute minimum of attention from the public, the legislators, or the clinical professionals. Nor is it difficult to understand why this state of affairs obtains—no one likes a delinquent youth, a bad actor, and when he is sent away the chief wish is just that, that he "go away." Out of sight. Out of mind.

What happens if the disturbed child is fortunate enough to escape the state institution treadmill? In a few of the major cities in this country, there are private, residential treatment centers which care for about 8,000 children a year. Since the average cost to the parents of such hospitalization ranges from \$50 to \$75 a day, it is obvious that only those of our citizens who are in the higher income brackets can take advantage of such services. Even among these rarified income brackets the situation is far from satisfactory; for every child admitted to one of these private facilities, 10 or more are turned away because of lack of space. In 15 of our states, there are no such facilities for children, either public or private; in 24 of our states, there are no public units to care for children from low and middle income groups.

What about all the rest of our four million children who, as indicated above, need some kind of help for an emotional disturbance? Here the statistics become much less precise, since a vast majority of these children are literally lost. Many are bounced around from training schools to reformatories to jails and whipped through all kinds of understaffed welfare agencies. No one is their keeper. No agency in the community is equipped to evaluate either the correctness of their placement, or the outcome of such placement.

If they are sent to a training school, as recent testimony before a Senate Committee revealed, they may receive poorer treatment than caged animals or adult convicts. Appearing in 1969 before a Senate Committee, Joseph R. Rowan, an expert on delinquency who is now director of the John Howard Association of Illinois, characterized these institutions for juveniles as "crime hatcheries where children are tutored in crime if they are not assaulted by other inmates or the guards first." Another witness, Arlen Specter, the District Attorney of Philadelphia, told the same committee that these so-called correctional institutions for juveniles take a 13-year old and, in 11 years, turn out "a finely honed weapon against society."

Commenting on the failure of juvenile courts and juvenile correctional facilities even to begin to meet the manifest needs of emotionally disturbed and sociopathic children, Judge David Bazelon, a member of the Joint Commission, noted in a recent talk that, although this nation is aware of the problem, it does not support funds to treat and care for these children *because it has really given up on them*.

A review of numerous case histories, plus independent research, led the Clinical Committee of the Joint Commission to the following inescapable conclusion:

As of today, the treatment of the mentally ill child in America is uncertain, variable and inadequate. This is true on all levels, rich and poor, rural and urban. The problems are most widespread among the poor, as are all health problems, but the fact is that only a fraction of our young people get the help they need at the time they need it.

From all of its studies, the Joint Commission concludes that it is an undeniable fact that there is not a single community in this country which provides an acceptable standard of services for its mentally ill children.

As a nation, what do we do about this heavily documented neglect of children? The Joint Commission proposes a network of child development councils supported by federal, state and local matching grants. Because of the massive nature of this proposal, we are going very slowly and very carefully in the development of legislation. We do not expect any legislation before 1970, and we realize that this comprehensive national network will take years to bring into being.

In the interim, we must deal with the thousands upon thousands of disturbed children who are being turned away right now because of lack of personnel and facilities. As one who was deeply involved in the drafting of the original community mental health center legislation, I state categorically that children have been largely neglected in the community mental health center program. There are many reasons for this—the typical mental health center with limited financing finds it almost impossible to take on children who are very expensive to treat, since any effective program with them also includes therapeutic sessions with the family. Furthermore, the adult patients are able to exert pressures upon the centers, and the children, who have little or no voice, are shunted aside.

We are therefore grateful, Mr. Chairman, that services for children are included in the original Staggers bill (H.R. 13163). This is the first time since the inception of community mental health center legislation in 1963 that they have been deemed worthy of attention. The Staggers bill provides 31 million dollars over a period of three years for the inclusion of childrens services in community mental health centers. I respectfully submit, and this is also the view of my colleagues on the Joint Commission on Mental Health of Children, that such an allocation is much too small to have any real impact in terms of the demonstrable needs which the Commission report outlined in great detail. However, it is my understanding that the Senate Subcommittee on Health on November 12th marked up a bill which provides approximately 228 million dollars for childrens services over a five-year period. We naturally support the higher Senate figure as much closer to the recommendations of the Joint Commission.

Even more important than the amount of money to be appropriated is the key issue of preferential matching for childrens services. No matter how much money the Congress appropriates, we will not establish these units in mental

health centers until we give them an additional inducement to take on these very expensive services. I have visited 33 of these centers in the past year, and I know that practically all of them want to provide treatment for children, but they do not have the financial resources to do so.

The National Advisory Mental Health Council, on which I have the privilege of serving, is deeply aware of this problem. At its last meeting early in September of this year, after a four-hour discussion of the lack of children's units in community mental health centers, we unanimously voted for a resolution supporting preferential matching for operations of all children's services at the level of 90 percent of the first two years and 75 percent for each of the next eight years. It is my understanding that the Senate Health Subcommittee on November 12th adopted the matching provisions which the National Advisory Mental Health Council had recommended for children's services in the network of the community mental health centers renewal bill.

We are grateful for a provision in H.R. 13163 for the training of child care workers to staff and operate these units for children. The Joint Commission devoted a tremendous amount of time to the study of child health manpower, and we concluded that a major effort must be made during the next decade to train both professional and non-professional personnel with specialized skills in the care and treatment of children. H.R. 13163 provides a total of only 10 million dollars over the next three years for this enormous training task. We submit that this is not going to solve the problem.

We therefore propose a minimum of 10 million dollars a year over the next three years to begin a major national training effort in the field of child care.

Mr. JARMAN. Thank you, Mr. Gorman.

Mr. Rogers?

Mr. ROGERS. I think all of us are concerned about the children. I think one of the directors said 40 percent of their patient load was composed of age 21 and under.

I wonder, rather than starting to pinpoint in an inadequate way, and you say the money that they are talking about is inadequate, why wouldn't it be really better to require—I am wondering if we shouldn't get to the business of requiring certain services in the law if a community mental health center is going to be funded at all, to require children's mental health services, treatment of alcoholism, treatment of narcotics and drug abuse, along with the other treatments, and specify them, increase the funding and perhaps make it on an operational basis of so much.

I wonder if this isn't a more advisable approach than just picking out one at a time and really you don't get adequate funding and you are not requiring that all of them do it.

You are just saying, "Well, if they put in for an application and get it, they will do it."

But if we require it as a prerequisite to any funding at all, I think this is the way to get at it.

Mr. GORMAN. Mr. Rogers, as usual, you have gotten right to the heart of the matter. I don't like to come up behind somebody who wants preferential matching and say we want it, too, for everything from the common cold to the 7-year itch.

All right, I would be delighted if this committee in its wisdom would require children's services. I do submit, without being sticky or technical, sir, that our experience—and I have talked to many center directors—is that these services are more costly. One has to deal with family therapy, with the school, with a whole constellation of people providing services, and not just the child alone.

When I ask some center directors why they don't have the children's services, they say, "We are in the red by \$20,000," or something like

that, and they don't have the money. The children's services are running 40 and 50 percent higher than for the single adult who can get himself to the center and do things kids can't do.

May I make myself clear? If this committee in its wisdom decides to make it a regulation, we will live with it, and we hope that the centers will find enough money to do it.

Mr. ROGERS. I would agree that we would have to make some change in the formula, but require it as a service in every one.

Mr. GORMAN. I think the baseline ought to be the requirement, and if you can in your deliberations give preferential treatment that is very fine.

I know a little better than to try to kid this distinguished committee. This is my conviction, that these centers—I know directors of centers that would go into children's services, but they feel they would go deeply, deeply into the red if they do so.

Mr. ROGERS. Thank you, Mr. Chairman.

Mr. JARMAN. Dr. Carter?

Mr. CARTER. I regret that I was detained and wasn't able to be here to check over all your testimony, but from what I can see, I feel that it is quite a good account, and it shows keen insight into the problems of our young people.

It was brought out yesterday that children who are victims of mental diseases particularly, and teenagers, are very difficult to treat, and that we haven't surmounted this problem. We haven't been able to—well, at best, treatment is difficult, and I feel that we should concentrate on this.

I am in agreement with the doctor here, and certainly I do want to earmark funds for the children.

I have seen this happen personally, and I know of it, and it is the saddest thing in the world to see a youngster of 15, or 14, lose contact with reality and be in such a difficult state that it takes all the effort in the world, even with good luck, to bring him back to normalcy.

Isn't it realized generally and understood generally by psychiatrists that schizophrenia, particularly of the young people, is more intractable than that of other ages? Is that not true?

Mr. GORMAN. Let me say this. From serving on this Joint Commission, knowing of your interest in this, we came to this conclusion, sir, that for most of the adolescents difficult to treat, that we had no facilities to treat them, so they went to the State hospital where they became a lifetime burden, and 25 percent of the backward patients in our State hospitals today were first admitted 30, 40, and 50 years ago as teenagers. That, alone, is an agonizing figure.

In other words, we haven't brought to bear what we know.

Mr. CARTER. I know you say 1,400,000 would suffer, and we treat only a third of them.

Mr. GORMAN. Approximately a third.

Mr. CARTER. This is a serious indictment of the present program, and I agree with you, and I shall do everything in my power to be of help, and I urge the members of the committee to do it.

If they could just once see these youngsters, I feel like that we would all be in agreement that we should do more.

Mr. GORMAN. I could take them to St. Elizabeths here in Washington and show them children scattered throughout adult wards.

Mr. CARTER. I thank the gentleman for his statement. I am in complete agreement with what he said.

Mr. JARMAN. Mr. Preyer?

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

I think you have already shown what to me are startling statistics. Thank you.

Mr. JARMAN. Mr. Hastings?

Mr. HASTINGS. Thank you, Mr. Chairman.

I appreciate your testimony, Mr. Gorman. I am impressed by your knowledge, experience, and sincerity. You mentioned the schools in relation to the problem of children with mental problems. And I would think it is an absolute necessity that schools be deeply involved in this problem. I don't have a great background in it, but I would think that in order to point out these youngsters who need help you would have to go to the schools first.

I know in our State, the State of New York, we have psychiatric services within the school system on a combined board of education program. I don't know how prevalent it is throughout the country, but exactly how would you get into the schools with your psychiatrist from the community mental health programs?

Mr. GORMAN. Let me say this, Mr. Hastings. No. 1, as a former resident of New York City for many years, you have technically certain services for children in schools, not psychiatric services. You have psychological services, and you test them.

Mr. HASTINGS. I must take exception. We have psychiatrists in our school system today.

Mr. GORMAN. You mean upstate New York. It is better upstate.

Let's say there are services, but they cannot take care of all children in trouble. New York City alone has a million kids, and 10 percent of them become problems.

We think the mental health center can be the place where parents can go. The school authorities cannot handle several hundred disturbed kids. I checked on the public school system in Washington, D.C., and if a junior high school has one or two guidance counselors and one or two psychologists, that is remarkable, and no school entity in Washington, D.C., has a full-time psychiatrist who is treating the children.

I am talking to the point of where a child needs 3 hours a week treatment.

Today, you test the child and you tell him to come back in 6 months.

When we talk about a center, Mr. Hastings, we are talking about real service. We are talking about live psychiatrists in there, who will start with the child and plan a treatment program.

Mr. HASTINGS. All right. But to get back to my point, don't you think it would be advisable if we had psychiatrists within the school who would make referrals of young people for treatment. I don't suggest that the psychiatrist in the school would be able to treat them. The numbers would be too great. But somebody has to be able to identify the youngsters who need the help, and if we could have a working relationship between the schools and the psychiatrist in the schools to identify the youngsters, they could be referred to your agency.

Mr. GORMAN. I agree. The most referrals now come from the schools. There is a close tie-in between the two.

Mr. HASTINGS. I don't have the great confidence that parents will bring them to you voluntarily. A lot of parents just don't care, and a lot of parents can't recognize or admit that their youngsters have a mental problem.

Thank you, Mr. Chairman.

Mr. JARMAN. Mr. Carter.

Mr. CARTER. Along the same line, certainly I feel that with the limited number of psychiatrists that it is almost impossible at the present time to even scan the children in our schools, but I should hope that some day this would be possible.

Not too long ago I had a rather interesting experience with a dyslectic child, a fine youngster, a fine appearance. His I.Q. was 120, I believe, but still, for some reason, he couldn't read, and one day, since the youngster was left-handed, I got the idea that perhaps he was dyslectic, and in his presence I took up a book and held it upside down and started reading, and he laughed, just laughed like everything when I did that. I said, "Can you read this this way?"

He took the book and read it upside down, showing that he had an unrecognized disability. It shows the necessity of closer examination of these children.

Thank you, Mr. Chairman. Thank you for yielding.

Mr. JARMAN. Mr. Gorman, of course the committee is familiar with and has copies of the voluminous and complete report of the Joint Commission on Mental Health of Children, and it will be a source of real information to the committee on its work.

We appreciate the very effective statement you gave.

Mr. GORMAN. Thank you, Mr. Chairman, and members of the committee, very much.

Mr. JARMAN. Our next witness this morning is Dr. J. Wilbert Edgerton, professor of psychology, University of North Carolina, representing the American Psychological Association.

STATEMENT OF J. WILBERT EDGERTON, PH. D., ASSOCIATE PROFESSOR OF PSYCHOLOGY, UNIVERSITY OF NORTH CAROLINA, REPRESENTING THE AMERICAN PSYCHOLOGICAL ASSOCIATION; ACCOMPANIED BY DR. JOHN J. McMILLAN

Mr. EDGERTON. Mr. Chairman, I have also brought with me Dr. John McMillan from the American Psychological Association.

I should like to register my pleasure at seeing Congressman Rogers again, busily at work on health matters. The last time I saw him he was making a speech on health in Miami at the meeting of the American Public Health Association.

It is a pleasure to see my fellow tarheel, Congressman Preyer, here, too.

Mr. PREYER. I admire Dr. Edgerton very much, and Dr. McMillan, and we are delighted to welcome you here today. We are proud that we have one of the strong and growing health service complexes in North Carolina, composed of the university, Duke University, and the research triangle, and I think that that area is going to make a real contribution to medical services in this country. It is good to have you here.

Mr. CARTER. Would the gentleman yield?

Mr. JARMAN. Dr. Carter?

Mr. CARTER. Certainly I want to extend my welcome to the distinguished physician and also to Dr. David H. Knott, from Memphis, who happens to be a professor in the university of which I am an alumnus.

I regret that I didn't hear his statement, but I shall read it carefully.

Thank you, Mr. Chairman.

Mr. JARMAN. Dr. Edgerton?

Mr. EDGERTON. I might add for Congressman Preyer that Dr. McMillan is also a tarheel.

I am J. Wilbert Edgerton, a psychologist who has spent nearly 18 years of professional life directly involved with the community mental health enterprise of this country. The range of my activities includes clinical services in a local health facility, direction of a State mental health association, and program consultation to some 13 State mental health programs. Currently I am engaged in the training of mental health personnel for work in community mental health centers, and in community mental health program development and research. My base of operations in the department of psychiatry, the department of mental health, and the department of psychology, all at the University of North Carolina in Chapel Hill. I also have a close affiliation with the North Carolina State Department of Mental Health in Raleigh, and several local mental health centers.

I am speaking on behalf of the American Psychological Association, the primary national organization of 29,000 psychologists, all of whom, as citizens, have a stake in the matters before this committee today. A high proportion of American psychologists are linked with mental health center functioning through rendering direct service to troubled people, through administration, through consultation, through research and program evaluation, or through training psychologists and others for work in community mental health centers.

I am delighted to testify in support of legislation continuing the mental health centers program for this Nation. The conceptual ideal underlying this program, providing appropriate mental health services to every citizen in easy accessibility, deserves the support of this committee, and future committees, until it has become a viable program reality. Hopefully the imperfections in program design and implementation will be remedied year by year to the point that no citizen will be forced to deal with his problems of emotional growth or rehabilitation with only the resources he can muster out of the loneliness of the dark recesses of his soul. The essence of being human and humanitarian requires that we provide the help he needs.

I should like to speak in brief support of a number of the features of the proposed legislation and then to concentrate particularly on the program features of consultation and education, and research and evaluation.

In my view, both the construction and staffing authority should be extended the maximum feasible number of years for the basic program, as well as for alcoholism and narcotic addiction. Budget authorization and subsequent allocations should truly be commensurate with the size of the problem.

This would mean sums considerably above any which have so far been proposed. Hopefully, "such sums as may be necessary" anticipates a level of support that does match the size of the problem. Not to be presumptuous, would not congressional and Federal program efficiency and community confidence be served by an extension of no less than 5 years? **Community long-range program planning** would certainly be enhanced with the knowledge that both time and money are as certain as can be. Five years would probably be early enough to decide whether the program deserves further extension.

There seems to be now ample evidence that the 51 months of staffing support is not adequate. Developing third-party payment plans, plus additional State and local operating moneys has not proved to be equal to the deficits incurred as Federal staffing money decreases and disappears. In fact, why not plan some level of support indefinitely? The problems in the mental health field constitute a national problem, so if the Federal Government is not to underwrite the total program, could it not at least support mental health center construction and staffing at the same level it supports interstate highways (90 percent) and vocational rehabilitation (80 percent)?

I commend the preferential status of poverty areas in the proposed legislation. My contacts with the essentially rural areas of my State convince me of the necessity for this. It is well known that those areas of highest priority in need have not the leadership and other resources with which to take advantage of Federal moneys. Not only are they unable to do the necessary planning in the first place, but they have not the means for continued financing of programs. How can they do so, with more than 40 percent of the families with incomes below the established poverty level? In this area I know best, the median family income is less than \$4,000 a year, and more than 70 percent of the families exist on less than \$6,000 annually. Study after study shows that serious mental disorder is more prevalent among the people with low or marginal income. So I would endorse the proposed initiation and development grants, especially for poverty areas. It also seems to me imperative that continuing support levels for these areas be maintained at a reasonably high level, and indefinitely.

Further, in planning, there should be assurances that representatives of all elements of the population to be served participate in the program development. So far the services have been mainly a charity for the poor, and not rights for services built on a contract between equals. This system fosters dependency, mediating against change. There must be active participation by the patient, possible only in treatment directed at autonomy, in which there is free choice. Full participation in the planning should help to assure an active voice in the program design.

Mr. Chairman, the provisions in the legislative proposals which support all program personnel are most commendable. In practice, every person who contributes to the total operations facilitates the program and should be eligible for reimbursement.

Psychologists have been wary of establishing a system of care which might become resistant to experiment and innovation, and too reluctant to respond to the needs of a changing society. Dr. Nicholas Hobbs voiced this concern in his testimony in support of S. 755 and

S. 756 in 1963, as did Dr. Arthur Brayfield on H.R. 6431 before this committee in 1967.

We applaud the provision in H.R. 14617 which supports construction and staffing of mental health centers which "demonstrate new or particularly effective or efficient methods of delivery of mental health services." This would permit, for example, the construction and staffing of a range of transitional facilities (quarterway, halfway, and fullway houses) which would allow many more patients to live in the community. It would also be possible to develop "inpatient" programs outside of hospital settings. Without opportunities such as these we may continue to see far too much "innovation without change," which only gives new organization to old professional practices and program structures. Innovation practices of all kinds must have the encouragement and sanction of Federal support, at least until proven. Otherwise there may be no margin for experimentation.

Too much have the services been based on the primacy of the inpatient hospital unit. All other things being equal, the priority goes to the center that is related to a general hospital. This is the most expensive service, and the least effective use of personnel, but most deplorably it perpetuates the omnipotence of the professional, frequently depriving the patient of participating in decisions about his treatment. All too often the treatment is not relevant to the patient's life in the community.

Much more emphasis must be given to the program elements of consultation and education. This federally mandated preventive program exists too much in name only. The press for direct services to patients preempts professional manpower. People in pain or misery get first call, and the gratification to the clinician at being able to ease the pain is understandable. It is also easier to treat people because professional training has been geared to this end. Consultation and education require complex knowledge and skills and the payoff is in what other helping people have been helped to accomplish. But it enables the multiplication of the scarce manpower by many factors through the strategy of helping the other helping professions deal with the many vulnerable subpopulations in the community. Prevention resides in just this activity of strengthening individuals to withstand stress, or shielding them from stressful environmental forces or agents. It resides in enhancing the individual's coping techniques—his social or behavioral skills, skills that are real to the individual in his own terms.

Prevention is less dramatic and commands less resources in manpower and money. Just so does consultation and education in the mental health center. Centers which rely on fees to operate are the first to abandon this part of the program. Much of consultation is to other public agencies, and though some contracts may be negotiated, the program is rarely, if ever, self-supporting.

In education the targets are so diverse and the program is frequently so general, especially in its early phases, there is no way to collect fees. Therefore, special subsidy should be provided for consultation and education. It is strongly recommended that the Federal participation rate for this element of service be of the magnitude for break-even financing, say 90 percent, throughout the life of the grant.

Psychologists would like to know that appropriate clinical services are provided to all, but this is not enough. Over the long haul, preventive social intervention is an imperative. Even with the infectious diseases, reduction of new cases was more a result of intervention in physical, biological, or social systems than of treatment. In the realm of behavior disorders or developmental deficits, the mental health center can very properly be one of the instruments of change which focus on the enrichment of the quality of life. It can surely foster a social environment which permits the maximum in the development of skills of competent interaction and confident autonomy. As the center collaborates with the political, economic, and other helping systems of the larger community, it must have the opportunity to experiment with other than the traditional medical model with which to produce changes in behavior of individuals. This view would underline the importance of concentrating major resources in the mental health of children, either directly through mental health centers legislation, or through other legislation that integrates children's programs with those of mental health centers. Children have a developmental task to accomplish and require an environment which may planfully emerge.

I should like to give attention now to another facet of mental health center functioning of special concern to psychologists by reason of their interests and their training in investigative methods—research and evaluation. In my view psychologists have an obligation to engage in these activities defined by this committee in 1965 as “research in mental illness, epidemiological studies of incidence and distribution of mental illness in the community and evaluation of the treatment procedures and programing of the center.”

If the center becomes an agent of social intervention, there must be constant monitoring of the effects in order to correct for any untoward consequences. Ideally, the psychologist and his collaborators should strive for change processes that are self-correcting. Part of this requires clear communication with the community for there is where the control ultimately resides. Knowledge about change, about effectiveness of programing will accrue as these research and evaluation efforts go forward. There should also be an opportunity to take advantage of community events as they occur. Most centers are not able to do this at the present time, but there are what you might call capricious events that come along, and you need to be able to get data about these events at the time when they arise.

Appropriate, economical, center programs will not be built without research and evaluation. But service needs are so great that State and local communities are extremely hard put to finance research and evaluation. Although it should result in economy of effort and resources in the long run, those communities most in need cannot afford this seeming luxury. It is strongly recommended that research and evaluation be federally supported at not less than 90 percent of the costs for the life of the grant. If only 25 percent of centers could mount effective community research and evaluation programs, so much could be learned having application in other communities.

I must add a word on training in behalf of the basic centers program. (I do support the provisions for training in alcoholism and narcotic addiction.) It has become commonplace that there are roles

for the nonprofessionally trained or for aides or technicians in the various professional disciplines. In various places persons with ability and warm human qualities who live in the world of reality have been recruited and trained to provide a much needed service. This innovativeness is heartening, and should be rewarded. Once again, communities with the scarcest resources have the greatest need to utilize all the potential indigenous manpower. I recommend that special incentive in the form of Federal subsidy at not less than 90 percent be provided for support of training in the mental health centers. Centers not only have an obligation for training for increasing manpower supplies, but it is the only place that can provide relevant community experience for the traditional mental health disciplines. It is a rare mental health center that can provide stipends for training, not to mention sufficient training staff time for appropriate modeling and supervision.

Mr. Chairman, we have made a start on providing mental health services in the communities throughout this land. We have learned some additional things about delivery of services through experiences to date. This committee is to be commended for moving to correct the deficits in a system which, with modification, could truly meet the needs. Let me opt again for maximum financing for a maximum period of time. Let us really do this job, bearing in mind that, of construction and staffing, staffing is far more important.

Thank you for the opportunity to appear here today.

Mr. JARMAN. Thank you very much, Dr. Edgerton and Dr. McMillan. We appreciate your coming. Do you have any comment, Dr. McMillan?

Dr. McMILLAN. I don't believe so. I am pleased to be here.

Mr. ROGERS (presiding). We are delighted to have you both, and your testimony is helpful to the committee.

If you have any examples of where you think you have seen improvement in delivery of services, if you could supply that to the committee, I would be interested in seeing that, and I am sure the committee members would be.

(The following information was received for the record:)

SUPPLEMENTAL MATERIAL ON THE ROLE OF PSYCHOLOGISTS IN IMPROVING DELIVERY OF MENTAL HEALTH SERVICES IN COMMUNITY MENTAL HEALTH CENTERS

Psychologists have been directly involved in Community Mental Health Centers since their inception in 1963. Along with the other professional disciplines who are working in centers, they have constantly evaluated their own work in hopes of improving services rendered to the public. The goal of these improvements is making the services more effective, more efficient, and available to a wider range of people in need. The examples below are illustrative of improvements currently in operation in selected community mental health centers around the country.

A center in Chicago, directed by a psychologist, is particularly responsive to the needs of the poor black population of the catchment area. The training and employment of indigenous mental health workers has helped to provide an effective means of delivering mental health services to this area.

A center in Minnesota, directed by a psychologist, is oriented toward helping the community caretakers to serve as the primary preventive agents. Approximately 80 percent of the staff time is devoted to consultation and education services.

A center in Montana, directed by a psychologist, serving the largest geographic area of any of the operating community mental health centers receiving Federal support, has decentralized its program with a strong community consultation orientation in order to meet its special geographical situation.

At a center in New York City, a psychologist who is the community coordinator is involved in working with approximately 80 community organizations comprising a council to the community mental health center. He is also involved in developing the center's programs to help alcoholics and drug addicts.

At a center in Alabama, directed by a psychologist, ministers are hired as part of the mental health center staff and coordinate their mental health activities with the other mental health professionals.

In a California center, a clinical psychologist produced a film on "Behavior Modification in the Class Room" used in training teachers and parents in the use of behavior modification procedures to help their children. He also conducts a program of home visits to instruct parents and children to modify learning behavior in the natural setting in which their behavior difficulties arise.

A Florida center, directed by a psychologist, has an effective satellite center program serving its rural areas.

A psychologist in a Kansas center is involved in coordinating the center's community program. It contains, among other things, an outreach program which incorporates "worry clinics" to deal with the every day problems of living. These clinics are held on a regular basis in homes, churches, and community centers in each of the 20 counties of the catchment area.

Mr. ROGERS. Do you have questions, Mr. Preyer?

Mr. PREYER. Along that line, I understand the universities are conducting experimental programs on the delivery of health care throughout the State.

I hope that within a few years we may learn something from that.

Mr. EDGERTON. Yes, sir. We have a special project in which we are trying to help a rural community in which there is, of course, scarcity of resources, to develop the mental health programs which are tailored to its needs and resources. Primarily this means making better use of the scarce resources that are there already, because unless we do get some kind of plentiful Federal subsidy, it is going to be necessary for places like this to operate in this way.

So, we are doing a feasibility study aimed in that direction.

Mr. PREYER. I think we would be interested in the results of that.

Along that line, on page 3, the statistics you give about the areas you worked in, do they apply to the entire State of North Carolina?

Mr. EDGERTON. Those are straight out of the two rural counties where we are now working in this project, yes.

Mr. PREYER. Could you tell me what those counties are?

Mr. EDGERTON. Yes, sir. Franklin County and Vance County, and we have Mecklenburg County in Virginia which is also part of our study.

These figures came directly from the 1960 census, and from a sample survey we did.

Mr. PREYER. I would just ask one more question. I think a number of your suggestions are very good ones and will provoke some discussion. On page 6 you have a sentence that says, "If the center becomes an agent of social intervention, there must be constant monitoring of the effects in order to correct for any untoward consequences."

I was curious as to just what you meant by that, "as an agent of social intervention."

Mr. EDGERTON. Yes, sir. It is my feeling that in order to provide maximum effects for mental health we are going to have to change some environments, particularly for the poor and underprivileged, for example—not only those, but particularly for those. That means we have to learn more about intervention at community levels, and when we begin to practice this sort of thing, there may be consequences which

we can't foresee. Therefore we need to be alert and to be sure that any kind of change at a community level can be immediately seen and corrected if need be. Hopefully you can have a self-correcting system for change.

I don't know if that helps.

Mr. PREYER. That will be the moment when some people will say that you stop preaching and go to meddling, I think.

Mr. EDGERTON. Well, I think we are meddling all the time. When somebody comes to us for help, we are trying to provide an intervention. I wouldn't call it a meddling, but certainly we are trying to help, even at a community level.

Mr. PREYER. I agree. Thank you.

Mr. ROGERS. Dr. Carter?

Mr. CARTER. I want to compliment the distinguished gentleman on his presentation, and certainly I am for full funding of the present bill.

I believe that for construction this year, \$29 million is to be appropriated. Is that right, Mr. Chairman?

Mr. ROGERS. I think that is approximately right.

Mr. CARTER. And for staffing, \$51,300,000 and for treatment of narcotics addiction, \$8 million, and alcoholism \$4 million.

Taken altogether, of course, we are dealing in millions, but in relation to what we are spending on so many other things it seems pitifully small.

For instance, in just a few days in Vietnam, we blow this much money away, never to be recovered again, and with the number of children that are affected in our country it seems a pitifully small sum.

I am in hopes that more can be done in this area, and I should like to see the time come when, after adequate planning, mental health centers can be established in pleasant locations throughout our country, and where our children can be treated separately, as they should be, by well trained people.

This is something, this is a goal we must set, and we must all work for, and certainly I think it is, as has been stated many times, "a consummation greatly to be desired," if we can provide help for our mentally sick people.

Thank you, Mr. Chairman.

Mr. ROGERS. Thank you, Doctors. We appreciate your help.

Our next witness is Clinton Fair, legislative department, AFL-CIO.

**STATEMENT OF CLINTON FAIR, LEGISLATIVE REPRESENTATIVE,
DEPARTMENT OF LEGISLATION, AMERICAN FEDERATION OF
LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS; ACCOMPANIED BY LAWRENCE SMEDLEY, ASSISTANT DIRECTOR, SOCIAL
SECURITY DEPARTMENT**

Mr. ROGERS. Your statement will be made part of the record. Could you highlight the points you think most important for us?

Mr. FAIR. Thank you, Mr. Chairman.

I would like to put this resolution in the record.

Mr. ROGERS. Without objection, it will be made part of the record following your prepared statement.

Mr. FAIR. Mr. Lawrence Smedley, assistant director, AFL-CIO social security department, is with us.

Mr. ROGERS. We are delighted to have you, Mr. Smedley.

Mr. FAIR. We do bargain in this area. The retail clerks in the city of Los Angeles have a service for the members and their families. But their contract is exceptional, however.

It is difficult to negotiate in this area. I would say to you that our statement is extremely accurate when we say we have a direct interest in community health centers, because outpatient service and care are not generally covered in our collective bargaining agreements.

Our second point is this: We feel identified with this program because our members need it. They are part of the population, but because of changing jobs, and moving, they feel the pressures of our society as well as anyone feels them.

Three, I would like to make a point that we feel the period of the present limit of 51 months for staffing aid should be increased substantially. It gives the community a better chance for phasing out, a better opportunity to sell the community on the program itself. It takes time to bring these things about.

The next point that I would like to emphasize is that—as do the bills—more attention should be given to areas of both urban and rural poverty, because poverty problems in themselves bring on tensions that create emotional and mental problems, and we feel they are least able to participate in a joint program between the Congress, the State, and the local community.

You will note we support the authorization for facilities for alcoholics and narcotics addicts, and we would support the statement that in many areas they should be combined with the mental health centers.

If you make this a legal obligation, however, you should provide certain flexibility. I come from a rural area personally, and I don't remember any addict in my life except one of our local doctors who got mixed up with narcotics. Peddlers do not go where there is no money to be made. If you are talking about rural mental health centers, we surely need them, but you may want to make your statute more flexible. All centers need not provide identical services.

Above all, if you follow the recommendation of the administration pertaining to an open-end authorization, I would certainly hope that this committee in its report would emphasize the important need of the program, so that the Appropriations Committee would recognize that you have a very sincere feeling that there needs to be good and adequate funding of the program.

Lastly, I would say to you that if you expand these programs, it is obvious none of the proposed legislation authorizes adequate funds. If you expand the programs and put them into one package, more funds than now authorized will be necessary.

We thank you for the opportunity to appear before you.

Mr. ROGERS. Thank you, Mr. Fair and Mr. Smedley. This is most helpful, and you have done a good job in summarizing quickly, and the committee appreciates the points you have made.

I notice also in your statement you feel we should not yet give a veto power over community mental health centers to the State planning agency.

Mr. FAIR. Right. We concur with the comments made earlier in the hearings with regard to waiting for a while before we give a veto power to the agencies.

In a short time, we may change our position, because we support the idea of planning.

(Mr. Fair's prepared statement and mental health resolution follow:)

STATEMENT OF CLINTON FAIR, LEGISLATIVE REPRESENTATIVE, DEPARTMENT OF LEGISLATION, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

Mr. Chairman, Gentlemen of the Committee. My name is Clinton Fair. I am a Legislative Representative of the AFL-CIO Department of Legislation. With me is Lawrence Smedley, Assistant Director of the AFL-CIO Social Security Department. We appreciate the opportunity to appear today to present our views on proposed legislation to amend, extend and improve the Community Mental Health Center Act.

Mr. Chairman, the magnitude of mental illness with the difficulties it creates for the individual in society is a major national problem. Millions of those affected, directly or indirectly, are union members and their families. Mental health relates to the individual workers' ability to hold a job, to enjoy leisure and to raise properly a family. In broader terms, it relates to discrimination, slums, unemployment and poverty. Mental health concerns labor because our members are inextricably involved.

The rapid growth of automation, which depersonalizes work, is having a profound impact on the attitudes and emotional state of workers. Improved technology is bringing material abundance, and its by-products—frequent changes in jobs, skills and home communities—create widespread tension and anxiety. Even more drastic is the resulting financial and emotional impact that a period of mental illness brings to the home and to the work environment.

Because of these problems, organized labor has in recent years intensified its efforts to provide more economical and effective mental health care. Organized labor, like the rest of the nation was slow to realize the magnitude of mental illness. The economic cost to society and, even more important, the emotional cost in terms of the agony, despair and tragedies to millions of individuals and their families are well known to the members of this Committee.

The AFL-CIO supports the Community Mental Health Center Program because of the benefits all citizens derive from the program, including our members. We also have a direct interest because outpatient services and early care are not generally covered in collectively bargained health and welfare plans. This program has enabled our affiliates to bargain with their employers to pay for the services furnished through a community mental health center.

The Community Mental Health Center Program has in the short period of its existence demonstrated its effectiveness in bringing mental health services to a broad spectrum of our population. Next June, almost 500 centers will have been established in 50 states, Puerto Rico and the District of Columbia.

Mental Health Centers have developed innovative models of prevention and outpatient mental health care. They have significantly reduced the need for more expensive long-term hospitalization and custodial care. The number of resident mental patients has declined from an all time high of 559,000 in 1955 to less than 401,000 by the end of 1968. It is estimated the number of hospital patients will decline to 189,000 by 1973. Community mental health centers have played a major role in this heartening decline in the number of hospitalized patients.

The program has also redistributed mental health manpower into communities which have lacked such resources. Local citizens, including trade union members, participate in the identification of a community's mental health needs and the design and planning of service programs. Local participation plays an important role in the operation of the Center's programs. Clearly, this program is having

a beneficial influence on the quality of life in our nation and represents a major thrust toward a more rational organization of health services for all Americans.

However, experience demonstrates that the original estimates of the extent and duration of federal financial participation for the initial implementation period have proven to be too low and changes are needed to meet problems which have emerged. Expectations were overly optimistic of the development of non-federal resources to augment and replace the federal matching support.

The task and the time that is involved in organizing a community to assess its needs were underestimated. Educating the public and marshalling both public and private resources to undertake the program with its fiscal responsibilities have not come without costly guidance. The time required to create a high quality, stable and effective program is after many experiences only now fully appreciated.

The Community Mental Health Center movement is therefore at the crossroads. Faced with the end of federal support, many centers are desperately searching for State, local and private funding in order to avoid cutting back on services. We are advised that in some instances, they may have to close the centers entirely. Future programs will be in jeopardy and will experience a similar fate unless Federal support is increased in amounts, duration and scope. H.R. 13163, H. R. 14086 and H.R. 14617 would all make a contribution to the resolution of these problems, but frankly, Mr. Chairman, the \$210 million authorized for construction and the \$120 million authorized for staffing over the three year extension period 1971-73, are unusually modest when measured against the magnitude of the problem. The Administration bill, H.R. 14617, does not authorize any specific amount. It states "such sums as may be necessary, We would urge the Committee to include in its Report, if an open end authorization is recommended to the House, that adequate funds be appropriated on the basis of shown need.

We are pleased, however, that the bills, to some degree, extend the present limit of 51 months for staffing aid. Many centers already face difficulties in meeting operating costs at the expiration of present federal aid. In view of the difficulties faced, 51 months is an unusually short period to secure alternative sources of funds. A 10 year program would allow a center to adjust smoothly to the phase out of federal funds. Disruptions which will now occur as federal funds cease will be avoided. It is now clear that a shorter period than 10 years will not resolve the problem to anyone's satisfaction.

In addition, it is essential to remove the restriction which limits staffing grants to "professional and technical" personnel under present law.

Similar restrictions do not exist in other grant programs and there is no reason in this program to differentiate among various kinds of personnel in a center. All are essential to its operation. The National Institutes of Mental Health must make time consuming and burdensome checks to administer this provision. It is often difficult to determine whether a position is professional or nonprofessional and whether or not the individual filling it is primarily involved in the treatment and care of a patient. The removal of this restriction would make it possible to provide federal assistance for all staff employees including those concerned primarily with administrative and housekeeping responsibilities in the mental health center. It would help give encouragement to a growing trend to employ sub-professionals in a variety of useful ways.

A major problem, perhaps the biggest problem, is to provide mental health services for the socially deprived victims who endure the stresses of chronic poverty. This is the high risk segment of the population which has the highest rate of admission to state mental hospitals. Although the experts are not sure in what manner the burdens of poverty affect mental illness, they do know with certainty that most mentally ill persons from a poverty environment have to go to state mental hospitals because they have nowhere else to go. This costly solution must be changed.

Fortunately, the bills under consideration by this Committee include several provisions which can make a vital contribution to resolving this problem. Foremost, they authorize a higher federal percentage for construction and, with the exception of H.R. 14086, staffing costs up to 90 percent of total costs within poverty areas.

Effective mental health services in urban and rural poverty areas are essential, if the community mental health center program is to be successful. The inadequate resources of poverty areas will prevent the establishment of centers on a scale commensurate with the need without increased federal funding. Only 7 percent of existing Community Mental Health Centers are located in areas with

a high concentration of low income families. A higher federal percentage for costs of construction and staffing would do much to assure that a greater proportion of the total resources of the program will be utilized for development of services in areas of greatest need.

All bills would allow a small portion of staffing grants to meet the costs for initiation and development of programs in poverty areas. These grants could go as high as 100 percent of costs for a one-year period, not to exceed \$50,000 per grant.

Relatively few groups or institutions in poor communities, who are potential applicants for community mental health center funds, have professional resources or funds to undertake the initiation, planning and development of a mental health center program. For this reason, there is a critical need to provide financial help to assess mental health needs properly and to identify potential staff, financial resources and existing services.

We also urge that any bill reported by the Committee contain a feature important to mental health progress in poverty areas. Experience has shown that broad and active community participation is vital to obtain the widespread community support so crucial to the funding and support of services. In addition, community participation contributes greatly to pinpointing service priorities where the needs are greatest. We urge that any bill reported out by the Committee give assurance to all social groups in a poverty area that they will have an opportunity to participate in developing programs of mental health services in their communities.

H.R. 13163, H.R. 14086 and H.R. 14617 would all extend the authorization for facilities for alcoholics and narcotic addicts for 3 fiscal years. They authorize up to 100 percent federal payment to train personnel, develop materials, and evaluate alcoholic programs. Alcoholism, the abuse of narcotics and other dangerous drugs have become major public health problems of national concern. If the excessive use of alcohol is to be lessened and the abuse of drugs is to be controlled, Federal, State and local communities must marshal their resources in a comprehensive and coordinated program of research, education, treatment and rehabilitation. The objectives of such programs should be aimed toward prevention rather than punishment.

Fortunately, in recent years, the nation as a whole, as well as a growing number of communities, has made a beginning by establishing rehabilitation programs for alcoholism and drug abuse. Federal support of community mental health services has played and is playing an important role in these community efforts and most particularly toward continued rehabilitation in his home community as a means of helping the individual following treatment.

There is a need to intensify these community services for treatment of alcoholism and drug abuse. Alcoholism is already a national problem. Drug abuse among the young is growing at such a pace that a crippled younger generation may be the nation's legacy. The time has come to tool up for the job that must be done. We urge larger authorizations than that contemplated by any of the bills under consideration by this Committee. The program must be made commensurate with pressing needs.

H.R. 13163 would authorize a new program for the construction of facilities for mental health services to children. In addition the bill provides for the staffing, training of personnel and evaluating the program. The amounts authorized for the three year period 1971-73 are small—a total of \$31 million for construction and staff and \$10 million for training and evaluation. This is too modest a beginning. All efforts in the important area of better health services to children are to be welcomed.

In most States, comprehensive health planning is embryonic, still largely in the fact gathering stage. Therefore, we recommend that the State health planning agencies have the power only to review and comment on proposed community mental health center construction. An interim period is essential to evaluate the competence of the newly created planning agencies.

We urge, therefore, that State comprehensive health planning agencies created in accordance with section 314(a) of the Public Health Services Act shall not be given veto power over the construction of community mental health centers.

Mr. Chairman, the Community Mental Health Center Program has been a success. It holds even greater promise for the future. Twenty percent of the total population will be served in large and small communities throughout the nation when currently funded centers are in full operation. Community mental health centers will serve close to 5 million of the 20 million people living in designated

metropolitan poverty areas. There will be 122 centers serving the 486 counties designated as our poorest rural counties.

We urge your Committee to report favorably a bill which will accelerate the access of mental health services to all—rich and poor alike.

MENTAL HEALTH

RESOLUTION NO. 262

The Community Mental Health Center Program has in less than five years demonstrated its effectiveness in bringing mental health services to people who previously had no access to such services. This new program to combat and prevent mental illness represents a significant and important step forward especially in regard to the Federal role and participation in the financing of mental health care. By June 1970, about 500 centers will have been funded to provide services for more than 75 million persons in communities ranging from the poorest counties of Appalachia to urban areas and the suburban fringes of the country's major cities.

The Community Mental Health Center Program is therefore having a forceful impact on the quality of life in our country and represents a major development toward a rational comprehensive network of health services for all Americans. It can be a vital force in the AFL-CIO's campaign to alter and improve the traditional patterns of the organization, delivery and financing of health care.

It is now evident that if these mental health centers are to continue to develop viable programs of high quality mental health services, reflecting and responsive to community needs, some changes are needed to meet problems which have emerged.

Existing centers faced with termination of Federal support are desperately seeking State and local fiscal resources as well as private sources to enable them to continue services without curtailment and, in some cases, to keep from closing their doors completely.

Future programs are in jeopardy and they will encounter similar difficulties unless Federal support is extended in amount, scope of costs supported and duration of support. Beyond this, State and local governments must develop continuing fiscal mechanisms through which they can contribute to and fulfill their fiscal responsibilities for these programs.

The disparities in resources and services in urban and rural poor areas are particularly acute. It is therefore desirable that special consideration be given to such communities to strengthen their capacities to plan for mental health services and to compete for Federal grant support. Moreover, in recognition that the urban and rural poor are in greatest need of community-based mental health services, preferential Federal funding should be provided for mental health center programs to serve them.

In negotiating for mental health benefits, all affiliates should give special attention to the potentialities of contracting for mental health services directly from community mental health centers. Where insurance benefits are negotiated, attention should be given to assuring full and comprehensive coverage on a prepayment basis with no financial deterrents to utilization for services provided by the mental health centers. Similarly, special attention should also be given to the potentialities of mental health programs which are components of or integrated with comprehensive health care plans, including those of union health centers.

Of particular concern are the alcohol and drug abuse programs as part of community mental health services. The Trade Union movement has long been concerned with the inadequacy of treatment and rehabilitation programs for alcoholics. In recent years the abuse of narcotics and other dangerous drugs has also become a major public health problem of national concern.

There is increasing recognition of the fact that the problem of alcohol and drug abuse represents the end product of many social, psychological and cultural forces rather than a purely criminal phenomenon. In this situation, legal deterrents have proved to be ineffective in preventing the significant growth in the abuse of their misuse.

Because of the complexity of the health, social, economic and legal problems surrounding the misuse of dangerous drugs such as marijuana, amphetamines, and others, as well as narcotics, the AFL-CIO supports efforts to evolve a national drug control program based on the actual facts, utilization of research findings

and funding of additional research, rather than on myths and emotional judgments. Therefore, be it

Resolved: The AFL-CIO will vigorously support federal, state and local legislation to provide adequate additional funds for the continuing operations of community mental health centers and other programs that show promise of making comprehensive mental health services more widely available and accessible for all people.

That all affiliates be urged to work toward the provision of mental health care on a direct service basis through an organized setting such as the community mental health centers and through comprehensive health plans.

That central labor bodies are urged to lend their support to or to take leadership in developing citizen organizations to plan and promote better mental health programs and to encourage fuller use by trade unionists of community mental health facilities of all kinds and to encourage and to prepare labor representatives to serve effectively in community mental health efforts.

That affiliates are urged to work toward the expansion and adequate funding of Federal support of alcohol and drug abuse programs relying on community-based treatment and rehabilitation and to support the establishment of the degree of risk in the use of dangerous drugs by medical and scientific evidence as the basic criterion on which legal prescription of drug use is to be defined and enforced.

Mr. ROGERS. Thank you.

Mr. Preyer?

Mr. PREYER. No questions.

Mr. ROGERS. Dr. Carter?

Mr. CARTER. I agree that our funding, our authorization, should be increased. There is no question about it. The communities don't have the funds. The Federal Government has preempted the taxation, and this is a great problem.

I am further in agreement with what you said about narcotics in villages and in smaller towns. There isn't as much addiction there. There is very little of it, in fact, and perhaps treatment in these cases should be, or could be, in different centers, more widely spaced centers.

However, in the case of alcoholism, to which we have not given sufficient attention, and for which we have an appropriation this year for the first time of \$4 million, I think that that is inadequate, and I certainly think that our community centers should take care of this, because this is a grave problem and something that is neglected for some reason.

People who attempt to help the alcoholics often consider this degrading, which it isn't. Some of our finest people do become alcoholics. It is a disease, and we should work strongly in this area, as I see it.

Thank you, Mr. Chairman.

Mr. FAIR. I would concur, and I would add from my personal experience that alcoholism is not necessarily an urban problem.

Mr. ROGERS. Thank you so much.

Our next witness will be Dr. Herbert Fill, Commissioner, Mental Health Services, New York.

STATEMENT OF DR. J. HERBERT FILL, COMMISSIONER, NEW YORK CITY MENTAL HEALTH AND MENTAL RETARDATION SERVICES

Mr. ROGERS. We will put your statement in the record and please highlight the sections you think important.

Dr. FILL. Mr. Chairman, I should have with me the administrator of the Maimonides Community Health Center in Brooklyn, Dr. Mark Tarail, but he is giving a speech in Washington and apparently has been delayed. He would wish me to apologize for not being able to be here.

All three bills now before the committee, H.R. 13163, H.R. 14086 and H.R. 14617, contain significant improvements and solutions to a number of problems large cities such as New York have had with the current Community Mental Health Centers Act.

None of the bills, however, correct one of the most troublesome deficiencies of the act, as it pertains to the development of mental health services in poverty areas, or unserved areas, where there is no ability to initiate the required five mandatory service categories simultaneously. These required services are: Inpatient, outpatient, around-the-clock emergency, partial hospitalization, and consultation and education.

Experience in large metropolitan areas of low income clearly shows that neighborhoods most deprived of services would not be affected by the proposed legislation because of the inability of those communities, lay or professional, to initiate a complete comprehensive mental health center at once. Even if initial planning funds are provided as in the proposed bills, there are in most poverty areas of New York City no available local facilities capable of developing and implementing these five mandatory services simultaneously.

Legislation providing for Federal financing, permitting a phasing in of a facility with some but not all of the five crucial mental health service categories would stimulate the initiation of neighborhood mental health services where they are needed most. The same applies to large urban areas which are not definitively poverty areas, but are and always have been unserved or underserved. Many of these large, often overpopulated areas do not have within their neighborhoods—which here could be defined as a catchment area—any mental health facility, or for that matter any kind of medical facility to serve this population on a local level. The original act and its amendments require that all five mandated services be implemented simultaneously. At least this requirement is reflected in the regulations of HEW.

Many communities, however, have been consistently unable to develop such complex facilities on their own or to induce distant facilities to develop the five mandated services for their own community. Large established facilities, able to provide the five mandatory services in their own area, have shown a willingness to provide some mental health services in underserved areas outside of their boundaries of services, if properly funded. They also have at times been willing to provide inpatient services as a backup facility for such unserved areas. In no case, however, have we been able to elicit their interest, or action, in the provision of all five mandated services in underserved areas outside their boundaries. Such a program would at the present time be considered an overreaching of a community mental health center's mandate, going beyond its administrative, service, and plant capacities.

Accordingly, we recommend that the committee adopt an amendment to the Community Mental Health Centers Act similar to the one now included in the Senate Labor and Public Welfare Committee print of S. 2523.¹

¹ "Notwithstanding the provisions of paragraph (2) of the preceding sentence the requirement therein with respect to essential elements of comprehensive mental health services shall not apply in the case of an application for a grant to any community mental health center which undertakes to initiate and develop a program for delivery of community mental health services in an area designated by the Secretary as an urban or rural poverty area for the 2-year period commencing on the date such application is filed if the Secretary is satisfied that such center will meet such requirement prior to the end of such period."

That amendment would provide Federal funding for mental health services where less than the five mandatory services—such as outpatient, emergency, day care and crisis intervention—could be implemented immediately.

We would regard the creation of such smaller neighborhood services as a crucial first step for anchoring services in a locality. Thereby a focus would be created which would later permit coordination with larger existing facilities in other areas and would facilitate the construction of functionally comprehensive arrangements in the near future. We consider the concept of comprehensiveness to be vital in the overall context of planning for mental health services.

However, realistically, service elements must be created, and time allowed for these elements to be brought into a functional correlation. We estimate that, from the time of the implementation of a neighborhood service, it should take no longer than 3 years to develop a complete comprehensive care delivery system combining the originally initiated neighborhood services with inpatient services in a sometimes distant hospital, and with other mental health facilities, which may thereafter be functionally tied in with the neighborhood services.

In New York City, to be specific, there are a large number of areas which have not benefited from the original bill and which would not benefit even if the bills now pending before the committee were passed. These are all areas with nonexistent or extremely limited services and resources of their own. Among them are South Shore—Far Rockaway, East New York, Bushwick, North Brooklyn (Williamsburg), Greenpoint, Red Hook, Sunset Park, and Hunts Point. These areas will not be able to develop any federally fundable mental health programs in the foreseeable future unless services can be phased in over a 3-year period.

We feel an amendment along these lines would be consonant with the essential purpose of the Community Mental Health Centers Act. Specifically, we would suggest that the language now in the committee print of the Senate bill, which we have set out in full, be adopted by the House as well.

Thank you, Mr. Chairman and members of the committee.

I will be prepared to answer any questions you have.

MR. ROGERS. Thank you so much. We appreciate the testimony, and I think you have made a very good point here that the committee certainly will consider in its deliberations, and I am sure, based upon the experience you have had in your city, it is a very valid point.

Mr. Preyer?

MR. PREYER. No questions.

MR. ROGERS. Dr. Carter.

MR. CARTER. No questions.

MR. ROGERS. Thank you so much.

I believe Mrs. Ruth Brock was here, but has submitted a statement for the record, and it will be made a part of the record at this point.

(The prepared statement of Mrs. Ruth Brock follows:)

STATEMENT OF MRS. RUTH BROCK, ADMINISTRATIVE ASSISTANT, NORTH AMERICAN ASSOCIATION OF ALCOHOLISM PROGRAMS

Mr. Chairman and Members of the House Commerce Committee, I am Ruth Brock, administrative assistant of the North American Association of Alcoholism Programs. NAAAP is composed of alcoholism program directors of the various

states and Canadian provinces, along with other groups and individuals concerned with the disease of alcoholism and alcohol problems and drug abuse in our society.

On behalf of the membership of NAAAP, I wish to express support for H.R. 14617 to amend the Community Mental Health Centers Act. Passage of this legislation, with provision for 90 percent federal funding participation for construction of alcoholism care facilities and preferential treatment of alcoholism in the staffing, operation and maintenance of these facilities, would represent a significant step forward in our national commitment to combat this nation's third-ranking disease.

The leadership and members of this Committee have been in the forefront of this effort in recent years. Specifically, the enactment of the Alcoholic Rehabilitation Amendments of 1968 represented this country's first comprehensive national attack on the disease of alcoholism.

Now, the provisions of H.R. 14617 would extend the beachhead established in that pioneer legislation enacted by the 90th Congress.

To be sure, the threat posed by alcoholism to the nation's health and economy knows no politics or partisanship. It is, therefore, appropriate that the development and implementation of this legislation has the bipartisan support of the leaders and members of your Committee, as well as strong bipartisan support throughout the Congress.

Alcoholism has been the long-neglected stepchild among our country's major diseases. The efforts of recent years have given hope to millions of its victims and their families that expanded community facilities and services can provide such treatment and rehabilitation programs as are needed to curb this disease.

Much yet needs to be done to fulfill that hope. As a significant step in that direction, H.R. 14617 deserves the support of the American people and their representatives in the Congress.

Mr. ROGERS. Our last witness is Dr. Wiseman. Is Dr. Wiseman here?
He is not here.

That will conclude our hearing. We appreciate the contribution of all those who came to give the committee their help.

The committee stands adjourned.

(The following letters were received for the record:)

BREVARD COUNTY ASSOCIATION FOR RETARDED CHILDREN, INC.,
Rockledge, Fla., October 31, 1969.

HON. HARLEY STAGGERS,
House of Representatives,
Washington, D.C.

DEAR MR. STAGGERS: A bill, HR 14327, was introduced on Wednesday, October 8, 1969, by Congressman Rogers of Florida. This bill extends and enlarges upon the Mental Retardation Facilities Construction Act of 1963 which will expire in June of 1970.

The passage of this bill before the 1963 Act expires is vital to the cause of Mental Retardation nationwide. It will provide funds for facilities, staffing, reach, etc. These facilities and services will provide an opportunity for many of the retarded citizens of our great nation to learn to function in such a way that they may become tax payers and not tax liabilities.

As Chairman of the Interstate and Foreign Commerce Committee, I feel that you are in a position to secure an early hearing on the bill.

Retarded citizens, their parents and all who work in the field will be eternally grateful to you for any effort you may put forth to secure the passage of this vital bill.

Sincerely,

HUBERT BURGHARDT, *President.*

CENTRAL MINNESOTA MENTAL HEALTH CENTER,
St. Cloud, Minn., November 12, 1969.

HARLEY O. STAGGERS, *Representative,*
Rayburn House Office Building,
Washington, D.C.

DEAR REPRESENTATIVE STAGGERS: The Central Minnesota Mental Health Board at its meeting on Tuesday, October 28, 1969 reviewed in detail the bills now pending in the Senate and House which would further amend Public Law 88-64. The Board also discussed in detail a resolution which was adopted by board members and directors of comprehensive mental health programs. We are attaching a copy of this resolution, as it was also adopted by our Board, and request that you give it your full support.

We call attention to item #10 which provides that "all personnel" working in comprehensive mental health programs be covered where these programs have been approved for funding under Public Law 88-64 as amended. States such as ours have been penalized under existing law as it provides federal funds for "new" positions and "new" programs, but not those that are pre-existing. This serves to penalize areas and people who have supported forward-looking mental health programs. We did feel that so long as our program qualifies as a comprehensive program for federal funding purposes, that all of our positions should be included. In our particular situation that would mean a difference of funding for 8 positions rather than the present 2.

While there is good rationale for federal funds to aid in program development, we feel the present approach could ultimately have an adverse and opposite effect in the development of local initiation. State legislators and others waiting for federal "developing funds" so they would receive "their full share". In essence, then, we are suggesting unless there is some change in philosophy in these types of programs that federal funds will ultimately retard local development and initiation as people will wait for you to act rather than develop services as the need for them becomes apparent.

We would be most happy to provide you with whatever informations might be useful to your making a decision on this matter.

Sincerely,

REV. HAROLD J. KOST,
President, Board of Directors.

RESOLUTION

Whereas, the National Community Mental Health Center Program has initiated the provision of comprehensive mental health services and,

Whereas, a substantial portion of these services are preventive and educational and,

Whereas, state and local governments do not have the tax base, together with fees, service contracts and local philanthropy to wholly support the programs, and

Whereas, the survival of some centers is now threatened for lack of adequate funding,

Now, therefore, the National Conference of Federally Funded Comprehensive Community Mental Health Centers does hereby resolve that

1. the community mental health legislation (Public Law 88-164 as amended) should be extended five (5) years.
2. increased levels of fiscal authorization be supported.
3. the centers' programs receive full funding; i. e., the appropriation matching the authorization.
4. the period of support for all centers (old and new) be extended from fifty-one (51) months to ten (10) years.
5. Support levels in poverty areas be increased to ninety (90) percent during the first two years and seventy-five (75) percent for years three through ten.
6. the support levels in non-poverty areas be no less than seventy-five (75) percent during the years one and two, sixty (60) percent for year three, forty-five (45) percent for year four, and thirty (30) percent for the years five through ten.

7. full cost grants of one year duration be made available for initiating and developing mental health center programs.

8. special programs in alcoholism and drug addiction be supported at no less than ninety (90) percent for the first two years and seventy-five (75) percent thereafter.

9. training and evaluation grants for alcoholism programs be supported at levels indicated above.

10. all personnel working in community mental health centers be eligible for federal support.

11. children's programs be encouraged with federal support and integrated into community mental health centers as appropriate.

12. indirect services of consultation and education be funded at a higher federal participation percentage than direct services in any given support year.

13. research and evaluation be funded at the ninety (90) percent level for the duration of the grant period.

14. the acquisition of land for community mental health centers and architects fees be included in eligible construction costs.

15. the level of the states' allotment for administering community mental health center construction plans be increased from two (2) to five (5) percent.

Unanimously adopted, October 25, 1969, Denver, Colo.

THE RANGE MENTAL HEALTH CENTER, INC.

Virginia, Minn., November 18, 1969.

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

DEAR REPRESENTATIVE STAGGERS: I am writing to you to request your support of House Files 13163, 14086, and 14617 that have to do with continued fiscal support for comprehensive community mental health centers. I am president of the Minnesota Association of Mental Health Programs and also responsible for Public Health Service, Region VI, which encompasses the states of Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota and South Dakota.

It is imperative that the Federal government continue to support these comprehensive community mental health centers since mental illness is one of the biggest problems currently facing this nation. We have found through experience that a 51-month grant period is not sufficient in order to allow a center to obtain local financial support.

Recently a group of directors of Federally supported comprehensive community mental health centers met in Denver to discuss mutual problems. Enclosed is a resolution that was unanimously passed by these directors. We feel that it is important that all 15 provisions outlined in this resolution be included in the Federal legislation that you currently passed.

I think you would be doing your constituents a great service if you will support the continuation of the community mental health center program.

Sincerely,

WILLIAM F. HUNTER, PH. D.

RESOLUTION

Whereas, The National Community Mental Health Center Program has initiated the provision of comprehensive mental health services and,

Whereas, a substantial portion of these services are preventive and educational, and

Whereas, state and local governments do not have the tax base, together with fees, service contracts and local philanthropy to wholly support the programs, and

Whereas, the survival of some centers is now threatened for lack of adequate funding,

Now, therefore, the National Conference of Federally Funded Comprehensive Community Mental Health Centers does hereby resolve that—

1. the Community Mental Health Center legislation (Public Law 88-164 as amended) should be extended five (5) years.

2. increased levels of fiscal authorization be supported.

3. the Centers' programs receive full funding; i.e., the appropriation matching the authorization.

4. the period of support for all centers (old and new) be extended from fifty-one (51) months to ten (10) years.

5. support levels in poverty areas be increased to ninety (90) percent during the first two years and seventy-five (75) percent for years three through ten.

6. the support levels in non-poverty areas be no less than seventy-five (75) percent during years one and two, sixty (60) percent for year three, forty-five (45) percent for year four, and thirty (30) percent for the years five through ten.

7. full cost grants of one year duration be made available for initiating and developing mental health center programs.

8. special programs in alcoholism and drug addiction be supported at no less than ninety (90) percent for the first two years and seventy-five (75) percent thereafter.

9. training and evaluation grants for alcoholism programs be supported at levels indicated above.

10. all personnel working in community mental health centers be eligible for federal support.

11. childrens' programs be encouraged with federal support and integrated into community mental health centers as appropriate.

12. indirect services of consultation and education be funded at a higher federal participation percentage than direct services in any given support year.

13. research and evaluation be funded at the ninety (90) percent level for the duration of the grant period.

14. the acquisition of land for community mental health centers and architects' fees be included in eligible construction costs.

15. the level of the states' allotment for administering community mental health center construction plans be increased from two (2) to five (5) percent.

Unanimously adopted, October 25, 1969, Denver, Colo.

LIBERTY, IND., November 19, 1969.

GENTLEMEN: I am a volunteer worker in Mental Health in Union County, the third smallest county in Indiana. I know that you usually hear from the larger city areas and from professional people, but the needs for facilities for patient treatment are more often wholly lacking in areas such as mine.

There are no facilities for treatment of mental illness nor clinics for treatment of these patients from our country other than total commitment to a state institution, for both adults and children.

Our school system estimates that there are an average of 20 children alone in this small county who annually need treatment which can become available only through continuation and expansion of the Community Mental Health Centers through H.R. 13163 and S. 2523.

Union County is included in the catchment area of Wayne, Randolph, Fayette and Union counties in east-central Indiana. We are now making plans for the direction we will move with our community mental health services. We need the program of construction and staffing being considered before your distinguished committee for the five years if it is to be of the greatest service.

I cannot over emphasize how vital a community mental health center is for both our children and adult patients who deserve the opportunity to recover through treatment other than total commitment to an institution.

Other people in small counties like ours throughout the United States will appreciate your thoughtful consideration and action to help us.

Respectfully,

MRS. FLOYD HOWARD,
Union County Mental Health Volunteer.

U.S. CONFERENCE OF CITY HEALTH OFFICERS,
Washington, D.C., November 26, 1969.

HON. JOHN JARMAN,
Chairman, Subcommittee on Public Health and Welfare, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: The United States Conference of City Health Officers has studied with much interest the bill, H.R. 14617, presently before your subcommittee, which would extend and improve the provisions of the mental retardation facilities and community mental health centers construction act of 1963.

We would like at this time to express for your subcommittee's record our support for those provisions of H.R. 14617 that enable federal grants of up to 90 percent of the construction and initial operating costs for community mental health centers in poverty areas, urban or rural, as well as those demonstrating "new or particularly effective or efficient" delivery of mental health services. These provisions are an appropriate recognition of that poignant combination of higher costs and lower revenues that afflicts the poverty areas of our country, urban and rural.

Similarly we are pleased to see the expansion of operating costs eligible for federal contribution to include "operation, staffing and maintenance" rather than simply professional and technical personnel salaries, and the allocation of sums under the bill for mental health needs assessment, program design, and community involvement in poverty areas.

As local health officers, we also endorse the bill's liberalizing provisions with respect to federal share and includable costs of efforts better to deal with our spreading problems of alcoholism and narcotics addiction. Sec. 4(e) of the bill, adding to the Act a new Sec. 246, appears particularly promising for local public health agencies, which so badly need the specialized training programs and materials, trained personnel, and evaluation of alcoholism programs that this section would support.

I thank you for making our views, here expressed, part of the Subcommittee's record.

Very truly yours,

JOHN J. GUNTHER, *Executive Director.*

(Whereupon, at 12:20 p.m., the committee adjourned.)

