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COMMUNITY MENTAL HEALTH CENTERS
AMENDMENTS OF 1969

GOVERNMENT

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HEARINGS
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON
LABOR AND PUBLIC WELFARE
UNITED STATES SENATE
NINETY-FIRST CONGRESS

FIRST SESSION

ON

S. 2523

TO AMEND, EXTEND, AND IMPROVE CERTAIN PUBLIC
HEALTH LAWS RELATING TO MENTAL HEALTH, AND
FOR OTHER PURPOSES

JULY 28 AND 30, 1969

Printed for the use of the Committee on Labor and Public Welfare



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COMMUNITY MENTAL HEALTH CENTERS AMENDMENTS OF 1969

MONDAY, JULY 28, 1969

U.S. SENATE,
SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C.

The subcommittee met at 10:15 a.m., pursuant to call, in room 4232, Senate Office Building, Senator Ralph Yarborough (chairman of the subcommittee) presiding.

Present: Senators Yarborough (presiding), Hughes, Dominick, and Javits.

Committee staff members present: John S. Forsythe, general counsel; James Babin, professional staff member; and Jay Cutler, minority counsel.

The CHAIRMAN. The Subcommittee on Health of the Committee on Labor and Public Welfare of the U.S. Senate will come to order.

We will begin hearings on S. 2523, the Community Mental Health Centers Amendments of 1969.

(The bill referred to follows:)

(1)

91ST CONGRESS
1ST SESSION

S. 2523

IN THE SENATE OF THE UNITED STATES

JULY 1, 1969

Mr. YARBOROUGH (for himself, Mr. CHURCH, Mr. CRANSTON, Mr. EAGLETON, Mr. HUGHES, Mr. JAVITS, Mr. KENNEDY, Mr. MONDALE, Mr. NELSON, Mr. PELL, Mr. RANDOLPH, Mr. WILLIAMS of New Jersey, Mr. BURDICK, and Mr. YOUNG of North Dakota) introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

A BILL

To amend, extend, and improve certain public health laws relating to mental health, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 SHORT TITLE

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

1 TITLE I—GRANTS FOR CONSTRUCTION OF COM-
2 MUNITY MENTAL HEALTH CENTERS

3 EXTENSION OF DURATION

4 SEC. 101. (a) Section 201 of the Community Mental
5 Health Centers Act (42 U.S.C. 2681) is amended (1) by
6 striking the word "and" which appears immediately before
7 "\$70,000,000", and (2) by inserting immediately before
8 the period at the end thereof the following: ", \$95,000,000
9 for the fiscal year ending June 30, 1971, \$115,000,000 for
10 the fiscal year ending June 30, 1972, \$115,000,000 for the
11 fiscal year ending June 30, 1973, \$135,000,000 for the fiscal
12 year ending June 30, 1974, and \$135,000,000 for the fiscal
13 year ending June 30, 1975".

14 (b) Section 207 of such Act (42 U.S.C. 2687) is
15 amended by striking out "1970" and inserting in lieu thereof
16 "1975".

17 PERCENTAGE OF ALLOTMENTS AVAILABLE FOR STATE

18 PLAN ADMINISTRATION

19 SEC. 102. (a) Section 403 (c) (1) of the Mental Re-
20 tardation Facilities and Community Mental Health Centers
21 Act (42 U.S.C. 2693) is amended by striking out "such
22 part" and inserting in lieu thereof "this Act"; section
23 403 (c) (2) of such Act (42 U.S.C. 2693) is amended by
24 striking out "such part A" and inserting in lieu thereof
25 "this Act".

1 (b) Effective with respect to expenditures referred to
2 in paragraph (1) of subsection (c) of section 403 of the
3 Mental Retardation Facilities and Community Mental Health
4 Centers Construction Act of 1963 made after June 30,
5 1970, such paragraph (42 U.S.C. 2693) is amended by
6 striking out "2 per centum" and inserting in lieu thereof
7 "5 per centum."

8 TITLE II—GRANTS FOR STAFFING OF COMMU-
9 NITY MENTAL HEALTH CENTERS

10 FEDERAL SHARE

11 SEC. 201. Effective with respect to costs of development
12 and operation of any center for any period after June 30,
13 1970, for which a grant has been or is made under subsec-
14 tion (a) of section 220 of the Community Mental Health
15 Centers Act (42 U.S.C. 2688), subsection (b) of such
16 section is amended to read as follows:

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

19 "(1) except as provided in paragraphs (2) and
20 (3), 75 per centum of the costs for each of the first two
21 years after the first day of the first month for which
22 such grant is made with respect to such center, 60 per
23 centum of such costs for the third year after such first
24 day, 45 per centum of such costs for the fourth year

1 after such first day, and 30 per centum of such costs for
2 each of the next six years after such first day;

3 “(2) in the case of grants to any center which pro-
4 vides services for persons in an area designated by the
5 Secretary as an urban or rural poverty area, 90 per cen-
6 tum of such costs for each of the first two years after the
7 first day of the first month for which such grant is made
8 with respect to such center, and 75 per centum of such
9 costs for each of the next 8 years after such first day;
10 and

11 “(3) in the case of a grant which undertakes to
12 initiate and develop a program for delivery of com-
13 munity mental health center services for persons in
14 an area designated by the Secretary as an urban or
15 rural poverty area, 100 per centum of the costs (or
16 \$50,000, whichever is less) attributable to the initia-
17 tion and development of such program for the one-year
18 period beginning with the first day of the first month for
19 which such grant is made for such purpose.

20 No grant shall be made under this section, in the case of any
21 center referred to in paragraph (1), for any period of time
22 which is later than the last year referred to in paragraph (1),
23 or, in the case of any center referred to in paragraph (2),
24 for any period of time which is later than the last year re-
25 ferred to in paragraph (2).”

1 APPLICATIONS AND CONDITIONS FOR APPROVAL

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

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

17 EXTENSION OF DURATION

18 SEC. 203. Section 221 (b) of such Act (42 U.S.C.
19 2688a) is amended by striking out "1970" each place it
20 appears therein and inserting in lieu thereof "1975".

21 AUTHORIZATION OF APPROPRIATIONS

22 SEC. 204. (a) The first sentence of section 224 of such
23 Act (42 U.S.C. 2688d) is amended (1) by striking out
24 the word "and" which appears immediately after "1969",

1 and (2) by inserting immediately after "1970," the follow-
2 ing: "\$60,000,000 for the fiscal year ending June 30, 1971,
3 \$60,000,000 for the fiscal year ending June 30, 1972,
4 \$80,000,000 for the fiscal year ending June 30, 1973,
5 \$80,000,000 for the fiscal year ending June 30, 1974, and
6 \$100,000,000 for the fiscal year ending June 30, 1975".

7 (b) Section 224 of such Act (42 U.S.C. 2688d) is
8 further amended by adding immediately after the first sen-
9 tence thereof the following: "For the purposes of assessing
10 local mental health needs, developing necessary resources,
11 and involving local citizens in the development of mental
12 health programs, up to a maximum of 5 per centum of the
13 appropriation authorized for each fiscal year under section
14 224 of such Act (42 U.S.C. 2688d) shall be available to
15 the Secretary for grants to local public or private nonprofit
16 agencies or organizations to cover up to 100 per centum of
17 the costs, but in no case to exceed \$50,000, for initiation
18 and development of a program for delivery of community
19 mental health center services, for one year only running from
20 the first day of the first month for which such a grant is
21 made with respect to such a local public or private nonprofit
22 agency or organization. In no event may such grants under
23 clause (3) with respect to any local public or private non-
24 profit agency or organization be made for any period after
25 such one year."

1 (c) The second sentence of section 224 of such Act
 2 (42 U.S.C. 2688d) is amended by striking out "seven" and
 3 inserting in lieu thereof "17".

4 COST OF COMPENSATION OF STAFF

5 SEC. 205. (a) Effective with respect to costs of opera-
 6 tion of any center for any period after June 30, 1970, for
 7 which a grant has been or is made under subsection (a) of
 8 section 220 of such Act (42 U.S.C. 2688), such subsection
 9 is amended by striking out "compensation of professional and
 10 technical personnel for the initial operation" and inserting in
 11 lieu thereof "compensation of personnel for the initial
 12 operation".

13 (b) The heading of part B of such Act (42 U.S.C.
 14 2688 et seq.) is amended to read as follows:

15 "GRANTS FOR INITIAL COST OF PERSONNEL OF CENTERS"

16 TITLE III—AMENDMENTS RELATING TO COM-

17 MUNITY MENTAL HEALTH CENTERS AND

18 FACILITIES FOR THE MENTALLY RETARDED

19 COST OF LAND INCLUDED IN COST OF CONSTRUCTION

20 SEC. 301. Effective with respect to projects approved
 21 after June 30, 1970, under part C of title I or part A of title
 22 II of the Mental Retardation Facilities and Community Men-
 23 tal Health Centers Construction Act of 1963, section 401 (e)
 24 of such Act is amended by striking out "architect's fees, but
 25 excluding the cost of offsite improvements and the cost of

1 the acquisition of land" and inserting in lieu thereof "archi-
2 tect's fees and the cost of the acquisition of land, but exclud-
3 ing the cost of offsite improvements".

4 FEDERAL SHARE TO BE MAXIMUM; HIGHER SHARE
5 FOR DISADVANTAGED AREAS

6 SEC. 302. Effective with respect to projects approved
7 after June 30, 1970, under part C of title I or part A of title
8 II of such Act, section 402 of such Act (42 U.S.C. 2692)
9 is repealed, and section 401 (h) of such Act is amended to
10 read as follows:

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

15 "(2) The Federal share with respect to any project
16 in the State shall, except as provided in paragraph (3), be
17 an amount equal to $66\frac{2}{3}$ percentum of the Federal percentage
18 for the State, or, if lower, the amount determined by the
19 State agency designated in the State plan. Prior to the ap-
20 proval of the first such project in the State during any fiscal
21 year, such State agency shall give the Secretary written
22 notification of the maximum Federal share established pur-
23 suant to this paragraph for such projects in such State to be
24 approved by the Secretary during such fiscal year and the
25 method of determining the actual Federal share to be paid

1 with respect to such projects; and such maximum Federal
2 share and such method of determining the actual Federal
3 share for such projects in such State approved during such
4 fiscal year shall not be changed after such written approval
5 has been given.

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

15 PERIOD FOR PROMULGATING FEDERAL PERCENTAGES

16 SEC 303. Section 401 (j) (1) of such Act is amended by
17 striking out “August 31” and inserting in lieu thereof “Sep-
18 tember 30”.

The CHAIRMAN. I introduced S. 2523, the Community Mental Health Centers Amendments of 1969, on July 1, 1969. This bill extends, amends, improves, and enlarges legislation under which millions of Americans who are touched by the tragedy of emotional and mental illness may find new hope and through this the country may move toward preventing mental illness.

This country cannot afford to neglect the mental health of its citizens, whether sickness take the form of a major affliction, violence, delinquency, family disruption, drug abuse, or alcoholism.

The original Community Mental Health Centers Act grew from an urgent need in this country to end the neglect of the mentally ill and to start toward prevention of mental health problems. Since the adoption of this legislation, \$125 million in Federal construction aid has stimulated the community mental health movement in the United States; \$93 million has been used for initial staffing of the centers. As a result, at present there are more than 350 community mental health centers in the 50 States, Puerto Rico and the District of Columbia.

However, Dr. Stanley Yolles, Director of the National Institute of Mental Health, who is with us today, has stated that a total of 2,000 centers are needed throughout the country if we are to adequately treat the problem of mental health. Thus, I have proposed substantially increased authorizations for both construction and staffing. The total proposed authorizations are \$155 million in 1971, \$175 million in 1972, \$195 million in 1973, \$215 million in 1974, and \$235 million in 1975.

Because urban and rural poverty areas have been found to need a larger measure of Federal assistance to develop and operate their mental health centers, I have proposed Federal funding of up to 90 percent for construction costs and staffing grants in these areas. The program faces serious hurdles in financing the continuous operation of centers locally. Thus, I have proposed that the present limit of 51 months for staffing aid to all centers be extended to 10 years. We know without the staffing the centers would be built but no people would be there.

Finally, I have proposed that each application for Federal staffing aid give assurance that persons broadly representative of all elements of that area's population be given opportunity to participate in developing programs for the delivery of mental health services. This is a reflection of a most heartening development in the progress of our national community health program, for I am advised that the most successful of the new mental health centers are those with broad and active community participation. This has proven essential not only for targeting services directly at the community's specific needs, but to obtain the wide community support eventually needed to fund and support the services.

In the final analysis, these centers represent people. In them, we see the participation of thousands of citizens who have worked to bring services to their communities. In them, we see new affiliations among local agencies and organizations, joining to combine their facilities, their talents and their resources. We see newly created mental health boards of citizens, new legislation at State and local levels,

new action stimulated by the national community mental health programs.

One example of such a center in my home State is the Mid-Houston Community Mental Health Center, which is an activity of St. Joseph Hospital, the oldest voluntary general hospital in Houston. I think that one of the best things about this center is that it comes very close to realizing the expressed intention of the Congress in making treatment available in the community and therefore cutting down the numbers of persons in State mental hospitals, the former residual place where mentally ill people went.

In addition to inpatient, emergency, and partial hospitalization services, the Mid-Houston Center has an outpatient service which focuses on short-term therapy, family-oriented therapy, and group therapy. This service is decentralized with the objective of providing more immediate, community-based services in conjunction with several other agencies that have joined with the Neighborhood Centers Association, a United Fund agency.

Furthermore, the Mid-Houston Center has a consultation and education program which is carried out in collaboration with the Neighborhood Centers Association. The center uses the Neighborhood Centers staff as liaison and catalyst between itself and community agencies, neighborhood people and volunteers. Agencies and people working through Neighborhood Centers with the mental health center include ministers' school principals, counselors, and school nurses, the Day Care Association of Houston and Harris County, Houston Junior Forum, a community house, public health nurses, visiting nurses, and county and State welfare departments. In other words, there is almost total community involvement.

Few measures can be of higher priority than that which seeks to strengthen the mental health of all our citizens. I believe this bill deserves enactment by the Congress because it is directed to this need.

My home counties of Houston and Harris get better information, receive more communications in our home area than others. I do not mean to imply that there are not other centers in the cities and counties as fully developed in the community involved as Houston or maybe even more so. I happen to know of that one and I think our Houston result has resulted from long work by the whole foundation of the University of Texas which gave that State a long start in this program.

This Federal legislation has been very successful in organizing volunteer units in the State which were in operation before the first Federal legislation was passed.

Senator Javits, our distinguished ranking minority member who has been very active in health matters before this committee, will present his statement.

STATEMENT OF HON. JACOB K. JAVITS, A U.S. SENATOR FROM THE STATE OF NEW YORK

Senator JAVITS. I am pleased that our Health Subcommittee has begun hearings on the chairman's Community Mental Health Centers Amendments of 1969, S. 2523, of which I am a cosponsor and pleased to support.

The original Community Mental Health Centers Act of 1963 heralded a new era in the compassionate treatment of the mentally ill—an era focusing on the concept of providing care to the mentally ill in the community where they live—where they will have the support of their family and their friends—and be more quickly restored to a meaningful role in society. The community health center with a local program of mental health services offering a broad spectrum of types of care and capable of using any combination of a variety of facilities is designed to overcome prolonged treatment in an overcrowded, overburdened, and less effective State hospital, which often has offered little hope of recovery for their patients and in too many instances, were primarily institutions for quarantining the mentally ill, not for treating them. We became committed, at the inception of the Community Mental Health Centers Act, to an important struggle to develop a broad range of services for promptly diagnosing mental disorders and treating them effectively; for rehabilitation of those suffering from mental illness; and for preventing the occurrence of mental diseases whenever possible. This is not to say we have guaranteed cures for mental illness—for the history of the treatment of mental illness has been all too full of overenthusiastic devotees of one “cure” or another—but we do have far better means of dealing with mental illness than ever before.

The community mental health centers program, despite its relative newness, is already demonstrating its effectiveness in bringing mental health services to people who previously had no access to mental health services at all. As of December 31, 1968, 351 centers had been funded estimated to serve more than 53 million people when fully operational. This achievement has required the development of innovative programs and facilities, as well as the relocation and reorientation of professional health manpower. New and extended functions are making use of nonprofessional community residents who receive training on an inservice basis to complement their knowledge of the community.

The most recent report of the Downstate Medical Center of New York City announced the construction of a community psychiatric center designed to bring mental health services out of the traditional hospital setting and make them readily available to the people who most need them. It is a pioneering community health program dedicated to experimentation with personnel and therapeutic programs for treatment suited to the needs of the community. I ask unanimous consent that the entire text of the article be printed in the record at the conclusion of my remarks.

In many hospitals, such services as aftercare and partial hospitalization are emerging as valuable treatment methods, by providing care to patients while, at the same time, allowing the patient to continue productive lives in the outside community.

However, 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. I support S. 2523, which provides for substantially increased authorizations for both construction and staffing of community mental health centers, both so urgent and necessary. We cannot allow the important work initiated

by these centers to be stifled. Our long-term goal of approximately 2,000 community mental health centers still remains. The promise of a new era in mental health, a bright new era providing aid and hope to millions of Americans, cannot be threatened and ignored. I urge us all to listen to the needs of our communities, and seek to strengthen the mental health of all our citizens.

[From the Downstate Medical Reporter, Brooklyn, N.Y., May-June 1969]

COMMUNITY MENTAL HEALTH PROGRAM TO BE INITIATED IN FALL

Starting this fall, mental health services for some Brooklyn residents will be no further away than the nearest church, YMCA, or synagogue, because of a pioneering community mental health program to be initiated by the Downstate Department of Psychiatry.

The program, according to Dr. Marvin Stein, Chairman of the Department, is designed to bring mental health services out of the traditional hospital setting so that they are readily available to the people who need them most. The Downstate effort will also serve as a training ground for physicians and other medical personnel in the new and fast-growing field of community mental health.

Heading the program is Dr. Alvin Mesnikoff, newly appointed Professor of Psychiatry. Dr. Mesnikoff, who was formerly Associate Clinical Professor of Psychiatry at Columbia University, previously organized and directed the Washington Heights Community Service, a project of the New York State Psychiatric Institute of Columbia-Presbyterian Medical Center, which developed some of the concepts that will be used in the new program.

A key part of the new program will be the South Beach Psychiatric Center, the first mental health institution to be built by the State Health and Mental Hygiene Facilities Fund and one that will use radically new concepts of patient care. Although the South Beach Center will not be completed until 1971—construction is scheduled to start this fall—it eventually will serve as the home base of a community mental health program serving not only Staten Island, but sections of Brooklyn as well.

The entire program is an effort to break away from the constraints that have limited the effectiveness of mental health efforts, Dr. Mesnikoff said. One of those constraints is the limited number of psychiatrists, which has restricted the availability of psychiatric care largely to those who could afford its relatively high price. At the other end of the spectrum, the poor have been served largely by public mental hospitals, which usually are miniature cities holding thousands of patients in hundreds of wards, where care has often been custodial. Patients needing only minor therapy—for example, elderly persons who had difficulty coping with life—have often found themselves consigned to such an institution because there has been no other method of treatment available. By contrast, the new Downstate program will attempt to give each patient a course of treatment tailored to his needs.

Dr. Mesnikoff explained that the problem is not in using other trained personnel to fill the gap due to the shortage of psychiatrists, but the need to explore new roles for people with various levels of training, for example, a new role for nurses in carrying out the therapeutic programs at community clinics. "The community clinics' staff will include a group of nurses and nurses' aides, working under a psychiatric consultant. The nurse will be the clinician. She will evaluate the patient in consultation with a psychiatrist and carry out the treatment, including supervision of medication, individual counseling, or group therapy."

In addition, the clinics will be available for training of medical students and psychiatric residents from Downstate. "They can participate in the evaluation and treatment program, and as they gain experience they can serve as consultants," Dr. Mesnikoff said.

The treatment program using the inpatient facilities at Downstate will be as flexible as possible. Some patients will spend the day at home but will stay at the clinic at night, some will come to the clinic for treatment and evaluation periodically, and some will stay at the clinic full-time.

The same flexibility will be true in the operations of the South Beach Psychiatric clinic. That flexibility is reflected in the unique architecture and interior planning of the clinic. Instead of the monolithic high-rise buildings and ward orga-

nization typical of state mental institutions, South Beach will consist of a series of relatively small buildings on a well-landscaped 40-acre site at the corner of Seaside Boulevard and Seaview Avenue on Staten Island. "We want people to be able to relate to a small-scaled environment, a neighborhood community in which they can be comfortable," Dr. Mesnikoff said.

The South Beach Clinic will be affiliated with Downstate and members of the South Beach staff will receive appointments on the Downstate faculty. Dr. Mesnikoff will serve as head of the clinic as well as a member of the Downstate faculty.

The new program probably will also bring an evolutionary change in the Kings County Psychiatric Hospital, Dr. Mesnikoff said. The hospital now serves as a receiving and disposition facility, holding mental patients only long enough for them to be assigned elsewhere for long-term treatment. Eventually, Dr. Mesnikoff said, its patient population will drop, and it will evolve into a treatment center.

The first patients for the community clinics will come from the Kings County Psychiatric Hospital. Starting this fall, Dr. Mesnikoff said, patients will be screened to select those who can be treated in the community.

"We will focus on the treatment of the seriously ill," Dr. Mesnikoff said, "using the clinics as an alternative to State hospitalization. The plan is to expand operations to treat those who are less seriously ill and to prevent further elaboration of their illness. Later we can shift to other community needs, as the community clinics become well established."

One of the most important aspects of the overall program, Dr. Mesnikoff said, is its educational function. In addition to training psychiatric residents in community mental health—"we must have medical students and residents participating so they can develop an interest and have the opportunity to make this field a career choice he said. The program will also include a training program for other medical personnel.

"We will experiment with the best use of different kinds of personnel so we can make an informed decision on how to best use our scarce resources of trained people," Dr. Mesnikoff said.

Dr. Mesnikoff brings unusual qualifications to the program. Now 43 years old, he received a B.A. in economics with highest honors from Rutgers University and entered Yale Law School. After one year, he left law school to study for a career in psychiatry. He took pre-medical courses at Stanford University and then entered The University of Chicago School of Medicine, where he received his M.D. degree in 1954. He interned at the University of Chicago Hospitals and did his residency at the New York State Psychiatric Institute. He is a graduate of the Psychoanalytic Clinic for Training and Research of Columbia University. He joined the faculty of the Columbia Department of Psychiatry in 1958.

The CHAIRMAN. Senator Hughes, do you have a statement?

Senator HUGHES. No, Mr. Chairman.

The CHAIRMAN. We are glad that you are here.

Senator Hughes is chairman of the Special Subcommittee on Alcoholism and Narcotics that was formerly under the jurisdiction of this Health Subcommittee, but we had few hearings on it over the years because of demands which consumed the time of the Health Subcommittee. We created this special subcommittee and Senator Hughes has given it very able, dynamic direction.

The first witness this morning is the Assistant Secretary for Legislation of the Department of Health, Education, and Welfare, Mr. Creed C. Black.

Mr. Secretary, will you proceed, please.

STATEMENT OF CREED C. BLACK, ASSISTANT SECRETARY FOR LEGISLATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY JOSEPH ENGLISH, M.D., ADMINISTRATOR, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION; STANLEY YOLLES, M.D., DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH; GLEN E. WEGNER, M.D., DEPUTY ASSISTANT SECRETARY FOR HEALTH LEGISLATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; AND IRVING J. LEWIS, DEPUTY ADMINISTRATOR, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. BLACK. Thank you, Mr. Chairman.

I want to assure you first that we in our Department share your sense of importance of this legislation in these hearings.

Secretary Finch has asked me to convey to you his personal regret that he could not be here today to present our Department's position, but he is keeping a long-standing commitment to the Western Conference of Governors.

I have with me Dr. Stanley Yolles, on my right, who is the Director of the National Institute of Mental Health; Dr. Joseph English, next to him, who is the Administrator of the Health Services and Mental Health Administration. On my left is Dr. Glen E. Wegner, Deputy Assistant Secretary of Health Legislation; and to his left Mr. Irving J. Lewis, Deputy Administrator, Health Services and Mental Health Administration.

Mr. Chairman, this program as you know is now less than 5 years old but in that time it has already demonstrated its effectiveness in bringing mental health services to people who previously had no access to such services. When the present authorization expires on June 30, 1970, about 500 centers will have been funded to provide services for more than 75 million persons. The areas served range from the very poorest counties in Appalachia to the affluent urban-suburban fringes of our major cities.

In addition to making services available, the program has had other significant benefits, some of which you mentioned in your opening statement.

Communities across the Nation, for example, have had an opportunity to demonstrate their interest in shouldering as much program and fiscal responsibility as they can 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 special priority needs such as those concerned with the severity of mental health problems of the poor, alcoholism and drug abuse. They also have come to realize that these critical areas are complex and demand specialized, high-quality long-range programs.

Other benefits have included the development of innovative models of prevention and ambulatory mental health care which have reduced the need for more expensive long-term hospitalization and custodial care.

These programs have also redistributed mental health manpower into communities which have lacked this resource. The centers have become training settings for professional and allied health manpower, increasing the total pool of mental health manpower. All of these factors enhance the effectiveness and efficiency of mental health services and result in better utilization of scarce manpower.

All in all, the results of a this Federal partnership with State and local resources, both public and private, justify 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 patterns of organization and delivery of health services. This administration, I want to emphasize, is committed to its continuation.

The experience to date, however, does suggest that some changes are needed to meet problems which have been encountered.

Across the Nation, many communities which have been 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, because they fear they cannot marshal the necessary local resources within the period of initial Federal support now existing.

Other communities that 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 for 3 months), are experiencing serious difficulty. It appears clear that a number of these programs will substantially retrench, cutting back to that portion of direct services which will permit fiscal integrity. When this occurs, it will be at the cost of those elements most needed to solve the present severe problems—educational and preventive efforts that will make the most of 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 Federal 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.

Another critical error as we look back now was an underestimation of 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 responsi-

bility 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.

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 continue to increase in the State.

It is recognized that there is an urgent need for even more extended assistance for services to urban and rural poverty areas as you have mentioned in your statement, Mr. Chairman. 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. It has become increasingly clear that those in greatest need of community-based mental health service, the urban and rural poor, have been the least able to effectively organize, plan and raise sufficient funds to compete effectively for Federal grant support.

Before addressing myself to specific proposals for dealing with these problems, Mr. Chairman, I want to place my comments in a larger setting within which this program, and many others, are being 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 this 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 the reviews which are underway 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 other social services which the National Government promises to the people. A principal need today is to improve our deliver systems: To insure that the intended services actually reach the intended recipients.

To achieve this goal, the administration has a basic objective, first, of not proliferating and adding to existing grant authorities; second, of employing broader purpose authorities so that there is flexibility to respond as conditions and needs change so that the localities and the States themselves may have a voice in using the Federal funds.

In addition to this general concern with respect to the problems of managing our Federal, State, and local system, and truly strengthen-

ing our capacity to deliver services at the point of impact, we are also concerned about the economic constraints deriving from the present inflationary situation. This administration is firmly committed to control of this inflationary situation by using all tools at its disposal, including strict control of governmental expenditures. Under such resource constraints, the requirement that we choose our priorities among the host of desirable and sometimes even necessary programs become ever greater.

Recently the Congress enacted an expenditure ceiling for fiscal year 1970 which will make unpleasant choices even more unpleasant. The impact of this very restrictive ceiling is now being studied in the administration, including its implications for fiscal year 1971. These implications are not yet clear but when they are determined and assessed they will surely have a bearing on authorizations and budgetary levels for the community mental health centers program and many other programs in 1971.

The administration, therefore, is actively working on legislation for extension of the community mental health centers program in the context not only of the needs of the program itself but also the larger administration legislative program. I would anticipate that within several weeks firm legislative proposals can be transmitted to the Congress. I might add here, Mr. Chairman, that our review embraces all the major health legislation scheduled to expire next year. We hope we will be able to work with this committee on a schedule that will enable us to have our proposals before you as the various measures are taken up.

In the meantime, I am in a position to advise the committee of a number of key principles governing our deliberations on the program under consideration today.

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 funded 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 realistic 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. This view accords with the general concern, expressed by Secretary Finch in his report of July 10, that the expansion of private and public financing for health services has created a demand for services far in excess of the capacity of our health system to respond.

In the long run, we would wish to look to great improvements in health care payment mechanisms to cover the costs of services in new modes of delivery of health care, such as the community mental health centers. Here, too, I would note that the Secretary's recent report calls upon the health insurance industry to mobilize itself to expand coverage to additional groups, to provide broader, more effective coverage.

to change their coverage to encourage preventive services, and to provide incentives to keep people out of hospitals and high-cost facilities. The challenge of the Secretary to the health insurance industry is fully applicable in the field of mental health, and the response of the insurance industry is essential if we are, in the long run, to achieve the benefits of the community mental health centers program.

It is clear that the present 51-month period of Federal funding of mental health centers is inadequate. Whether financing should be extended for as long a period as the 10 years proposed in this bill before us is difficult to say. The answer certainly depends upon, in considerable measure, the willingness of the health insurance industry to meet the Secretary's challenge, and some such condition of funding might be useful to employ in situations where the 51 months is extended.

Two major mental health problems have emerged in recent years requiring strong and continued Federal support. These are drug abuse and alcoholism, as you mentioned earlier. The present mental health centers legislation provides for separate authorizations for construction and staffing support in these two areas. We are firmly of the view that these two special-purpose programs must continue, but we are equally of the view that Federal support should be, as at present, provided as an integral part of the network of community mental health centers.

We would be opposed to any legislation or any more that would depart from the present concept of integration. 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 centers 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 illnesses live and to which they will return. The coordinated network of mental health and social services in the centers provides treatment to be modified to fit patients' needs and allows for a rational 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 have earlier pointed out, few communities are able or willing initially to devote limited resources in these two problem areas. Americans have very ambivalent feelings about alcoholics and narcotic addicts. The patients are very difficult to treat. Professional interest needs to be stimulated.

We believe, therefore, that preferential matching and a longer period of support than 51 months will be necessary. The necessary matching ratio will have to be determined eventually in the context of the administration's overall posture of grant-in-aid reform as well as the individual program needs, but it is clear that such preferential matching is essential.

With respect to matching ratios for construction grants under the regular program, we do not believe that any change is necessary.

As to operating costs, however, the present arrangement of supporting only technical and professional staffing costs is administratively unsound. In principle, we would be prepared to support all operating

costs in order to, at a minimum, bring about substantial administrative simplification. Beyond this, budgetary considerations would probably have to determine the extent to which the matching ratios would be adjusted.

We have already discussed the needs that appear in areas of urban and rural poverty, Mr. Chairman. In other Federal programs designed to deal with the social conditions in poverty areas differential matching and other special incentives have been found to be necessary. This is generally true with respect to the poverty program, and it is reflected in the model cities program of supplemental grants.

The chairman will also recall that the administration proposed a differential in its legislative proposal on extension of the Hill-Burton Act. We believe that such a differential should apply for the community mental health centers program in rural and urban poverty areas both with respect to initial construction and subsequent operating costs.

Reflecting the administration's concern for improved delivery of our social services authorized through different programs, we believe that the extension legislation should provide for improved planning coordination. In S. 1733, a bill to amend the Hill-Burton program, the administration recommended that each construction project application be submitted to the appropriate areawide planning agency established under section 314(b) of the Public Health Service Act for review and comment.

The administration further proposed that Hill-Burton construction plans be approved by the State's comprehensive planning agency established under section 314(a) of the Public Health Service Act. We believe that similar provisions should be made in the extension of the community mental health centers program.

In order to make the most effective use of public and private resources in the administration of the centers program, it is necessary to insure that other health and related planning on a State, interstate, and local level are taken into account. In addition, it is essential that we strengthen the capacity of each community to review and integrate all health services impinging upon it.

Finally, at least in poverty areas, grants for a short period of time are probably desirable for initiation, development, and planning of a community mental health center program. Relatively few community organizations or institutions who are potential applicants for community mental health center funds have professional staff with the necessary experience for effective mental health program development. This barrier to sound project development has been overcome elsewhere by the use of the developmental grant, for example, in the model cities program and in the neighborhood health center program. Such a grant greatly facilitates the task of assessing local health needs and developing the necessary resources at the local level.

Mr. Chairman, as I said at the outset we appreciate this opportunity to present to the committee our views with respect to extending the legislation for the community mental health centers program. I regret that time has not yet permitted us to furnish the committee with detailed legislative proposals. However, I am confident that these will be forthcoming shortly so that you may have them in time to help you

complete the committee's deliberations. Meanwhile, my colleagues and I will be glad to try to answer any questions that you may have.

The CHAIRMAN. Mr. Black, as I follow your statement, to me it is a statement of retrenchment and pullback and not of expansion with the delivery of this health service. While it talks about performance, it talks of the budgetary limitations and how we have got to spend less money on this.

Now I realize that the Congress passed a very tight budget. In the previous Congress I opposed the limitation of the number of people who could be employed, a rather ridiculous arbitrary limit which impeded the Federal service. Congress has said, here is the money, there must be great entrenchment. As I see it, the first entrenchment we need is the \$36 billion we are wasting on the war in Vietnam. All of these programs have been cut back. The Johnson budget of January was bad enough, but the Nixon budget was even worse on education, health, poverty, all the services to the people of this country.

We have talked a lot, the administration has. I am not saying this as partisan; my position has not changed about the waste and resourcefulness of money for years. While we talk about pulling 9,000 men out of South Vietnam, we have more military personnel in Vietnam now than we ever had under the previous administration. We have a big buildup and then little pullouts and the people just are not going to buy that. There is no real deescalation because the facts are otherwise. We talk about here the continual bombing and wasting of our resources there of men and material while we are pulling down on the services to the people of this Nation.

I have noted that you have talked about how disappointing it was that the local agencies have not put up the money, third party payments have not been made. In one place you say that you will have to concentrate this and support those centers picked as the ones that you think are the most viable. You have the statement in here, "the administration would prefer to have fewer centers."

The whole statement is wonderful. This Nation has for too long done too little. You have talked about the need for the program on alcoholism, yet you cut even the \$4 million out of the Johnson budget, take it all away. When the administration announced that it was going to close the only two Federal research and treatment centers for narcotics in this Nation and I started holding hearings here, at Fort Worth and other places, as chairman of this subcommittee, I asked why on earth they were being closed, the only two in the Nation. The response was that this was not a Federal activity; it should be done by the local States and communities.

When I said that 47 States had no such facilities, the answer I received from the administration was, "Well, if they won't build them, we will close them up and make them build them, and end the treatment and destroy these centers." One of the most valuable things they learned was that there were virtually no trained people.

As you point out in your statement here, alcoholism and narcotics is a field into which the researchers do not readily go because of the pure financing. They have found the lack of sufficiently attractive programs over a long period of time.

Now you point that out here, yet you propose cutting back on that. I hope that you will reconsider, that the Secretary will reconsider

and that the administration will reconsider these national priorities and let us have a little money. The development of these things is so badly needed, but the budget in January provided for \$5,200,000,000 for ammunition alone in South Vietnam for the coming year. I have gotten from the Defense Department that there are 240,000 Vietcong and North Vietnamese either in South Vietnam or just over the border in North Vietnam in Laos where they can come over the border in a few hours, so they counted it as part of the military forces in South Vietnam.

If you take that \$5,200,000,000 asked for just for ammunition this fiscal year that we are already in and divide the 240,000 Vietcong and North Vietnamese into it, you see the budget asks for \$21,666 and two-thirds cents for ammunition for the coming year to shoot at each Vietcong and North Vietnamese.

So if you take the \$36 billion cost and divide by 240,000 Vietcong and North Vietnamese who are in South Vietnam or on the borders ready to come over if they get a chance, then you have a cost of \$150,000 a year that we are spending to catch, kill or capture each Vietcong and North Vietnamese taken. I think it is economic folly. If we killed or captured all of them, I think the cost to us has already been too great. The war having cost over \$100 billion, it is worth many fold more than capturing or killing all the Vietcong and North Vietnamese in South Vietnam because it is too dire for us to think that those people are going to ever love us with all the villages we have burned, the areas of forest we have desolated and the lands we have sowed with chemicals to keep them from growing anything, all the villages burned to flush out the Vietcong. I think the objections to what we are doing destroys any hope of achieving its objectives.

So in coming back here and saying we got too many centers, I think that you are straining out of the net. We see this all through this. The administration did not originate this, we saw that start back 2 or 3 years ago. Including all that, this administration is accentuating a bad trend instead of reversing it. This administration has picked up the worst parts of the previous administration and is trying to pull down the good things of the previous administration. You are escalating the worst features of the past and pulling down from the best. I think you have reversed your order.

Mr. BLACK. Mr. Chairman—

The CHAIRMAN. Let me say one reason this bill does not cover alcoholism and drugs is that Senator Hughes is considering this problem separately on legislation that is to be completed after he has completed his hearings.

I would like to have your comments generally on my comments to your statement.

Mr. BLACK. If I may reply generally, I would first repeat something Secretary Finch has said before this committee and others, which is that HEW does not have a foreign policy; we have enough problems of our own. I can assure you that we certainly share the desire to see the war in Vietnam ended as quickly as possible, and my own feeling is that we are a good bit closer to the end of that war now than we were a year ago.

The CHAIRMAN. That is not much hope because a year ago we were many years away from an end. So if we are not much closer now than a year ago, we are in a status quo.

Mr. BLACK. I think we are closer. In the meanwhile we do have a commitment, we have American soldiers over there. I am not an expert on ammunition.

The CHAIRMAN. I have voted for all this ammunition. I am not going to have the presence to send them over there and then say the Congress would not arm and equip them. I pointed out how foolish I think it is but I am not going to be put in a position putting soldiers over there and not equipping them. I think the decision to send them and keep on escalating is foolish. That is an Executive decision. I hope that somewhere somebody will prevail on the administration to use some rational thinking in this American foreign policy. As you say, your division does not control it.

I became in January for the first time chairman of the Subcommittee of Appropriations that passed on the Bureau of the Budget request and found that they did not have a trained educator in that whole Bureau of the Budget down there which was slashing away the budget who was an expert on education. I did not ask them whether they had a person trained in public health or not—I should have. I will next year.

Out of 178 examiners working on the multimillion dollar budget, maybe by next year we will employ one man that knows something about education, one that knows something about health. If they did, that would be a gain of two in that Department badly needed.

Mr. BLACK. Our position reflects the overall thinking of the administration, not just the Budget Bureau.

To get back to your general observations, in our Department we certainly recognize a lot of needs in our area of responsibility which certainly could use more money than the present economic constraints will permit us to devote to them. I would say first of all that I do not regard this proposal that we are making today or these general comments as necessarily retrenchment. If my figures are correct, the total money we have budgeted for this program for fiscal year 1970 is more than the amount of money obligated in 1969. I think the history of this program since it was started will show that the previous administration did not propose nor did the Congress ever see fit to fund this program at the level authorized.

As I said, we are proposing to spend more money in 1970 than was spent in 1969. I think that we do want to move as realistically as we can with this, which is why I said we would prefer to move at a pace that will enable us to make sure that the centers which are existing and the new ones we fund are on a sound basis rather than to go ahead and just give a little bit of money to a lot more centers and get them started and find them in the same kind of trouble that those now existing are running into.

It would be a wonderful experience for us if the 500 centers that we hope to have by the end of this fiscal year were all on a basis where they could be self-sustaining and we could pull out the Federal seed money and start on another 500. Realistically, as you stated in your statement and we indicated in ours, this is not the way it has worked

out, so we have to take a look at the program within the constraints of the money that will be available.

Now as to the comment that we are picking up the worst of the things that have gone before, again I think that we would challenge that. One of the big problems we found in the health area, as in all areas, is the extent to which our resources are being diluted by inflation. The problem has become particularly acute in the health areas so that you do have this special problem of a vast new demand far exceeding the supply.

Since we came in this administration has been concentrating on trying to stop inflation. If we cannot stop inflation, then our programs are going to have to be retrenched. We think that we have got to bring inflation under control and to bring some of the medical problems under control if we are going to have money that can be spent on the things where we think it should be spent.

For instance, we inherited a very serious problem in the medicaid area. In the present year just the Federal Government's share of the cost in excess of earlier estimates will be more than the total annual budget of the National Institute of Mental Health, \$350 million. That is just that much more than was originally estimated for the cost of medicaid.

The CHAIRMAN. How many people participated in that medicaid program over that year, Mr. Black?

Mr. BLACK. You mean how many patients?

The CHAIRMAN. Yes; how many patients?

Mr. BLACK. I am sorry, I do not have that figure.

Dr. English says about 3 million. We will get the correct figures for the record.

(The following information, subsequently requested, follows:)

SRS indicates they do not have specific estimates for fiscal year 1969 for number of mental patients covered by MEDICAID. The states have just been contacted to get this information and it won't be in for two or three months.

In fiscal year 1968 a total of 74,203 patients over age 65 received benefits under the Long Amendment and Titles I, XVI, and XIX. This was for 75.6% of all patients in mental hospitals over age 65. Figures for mental patients outside of hospitals are not available.

In November 1968 vendor payments were made for 3,722,000 patients of all kinds under Title XIX (plus payments to pool funds and insurance programs for another 1,533,000).

The vendor payments for 3.7 million patients of all kinds are as close as we can come to any 3 million figure.

The CHAIRMAN. That would be an increase then of \$3 million. At this date that would be an increase of about \$118 or something like that more than estimated, or maybe more people participated than you have estimated. Or if the same number of people, that would cost, say, \$350 million more than estimated. That would have gone up at the rate of \$118 and some odd cents per patient if the original budget estimate—what were the estimates on that, Doctor?

Dr. ENGLISH. I think the point, Senator, that Mr. Black is making was that the medicaid program which provides purchasing power without regard to what health resource there is out there to provide care contributed to an inflationary trend in health care costs. So it is now at the rate of about 12 percent a year, which is the reason the States are making their estimates calculated by a margin that large

for fiscal year 1970, this means that over and above what the costs of medicaid were anticipated to be in earlier budget formulations, another \$350 million may have to be added to the Federal share just to make up for what we thought we were going to be able to do without that much money. That reflects the increase in cost alone, not an increase in services.

The CHAIRMAN. That is the same number of people, that is an increase in cost of that service.

Dr. ENGLISH. That is correct.

The CHAIRMAN. Well, I read many articles in the papers, editorials, and all that, about how horrible this is that medicaid is costing more, we have to do something about it, we have to cut it back, we have to cut it out. If a member of my family is sick, I do not see any need for reducing the medical service because it costs more than I had hoped it would cost. I do not see why the Government says it is horrible that it is costing more, we are going to cut down, we are not going to let them have that much medicine, that much hospitalization, we are not going to spend that money helping those people get well. You read in all the papers, magazines, my goodness, this medicaid costs more, we have to cut it. It is ridiculous.

Mr. BLACK. We are not trying to deny medical service to people. What we want to do is improve the whole system of medical delivery so we get more service for the money we are spending. If we continue to build up only the demand, we could continue to spend more money without providing any more service, millions of dollars more. We have projections which show that if medicaid costs continue at the present rate, why soon we will have a budget for that alone which is more than our total expenditures in the health area.

The CHAIRMAN. As you point out, inflation is cut down on what could be delivered for x dollars but in my opinion when you try to cure inflation by raising taxes and raising interest, you are just pouring fuel on the flames. If it does not pour fuel on the flames, it just put sand on top of a surface fire that is an indication of deep-seated disease. That deep-seated disease here is the war. That is what is running the interest rates up, that is what is causing inflation.

Senator Hughes, any questions or comments of the witnesses?

Senator HUGHES. Should we go into the philosophical questions of why we are here, where we are at or what the inflation is or anything else. Do you want me to get into my total questions on this statement now, Mr. Chairman?

The CHAIRMAN. Well, whatever questions you care to ask.

Senator HUGHES. That will take a little while.

The CHAIRMAN. We do not limit any Senators here. Senator Javits has a proposed rule that we all agree to limit each other to 10 minutes but we do not invoke it, he just suggests it. We generally have five or six before he brings his rule up; we only have three Senators here.

Senator HUGHES. Being a man with the least seniority, I usually wind up the victim of not enforcing that rule, Mr. Chairman. Today since there are only a few here, I might concur. They say after you are here a few years you like the system. I will wait and see, I hope.

The CHAIRMAN. Go ahead, Senator.

Senator HUGHES. If I might, Mr. Black, ask a couple of philosophical questions before we get into this. I take it from the nature of your

formal statement and the nature of your response to the chairman's questions that philosophically you do not view your position as one of attempting to recommend to the administration everything that is needed to meet the health needs of this country but rather first receiving from the administration the limitations they have financially and then making a recommendation within that financial limitation to meet the health needs of this country. Am I correct?

Mr. BLACK. I do not think so, Senator. That is a very chicken-and-egg question. The process actually worked this way: In reviewing the budget we inherited when we came in we were asked to make our recommendations. The President had—

Senator HUGHES. I am asking about your philosophy, not the previous administration or anything else. I just want to know what your position and your intents are.

Mr. BLACK. Well, as a practical matter, as I was trying to explain, we reviewed the budget and we made certain recommendations. Our original recommendations were sent back, we were asked to review those, there was a good bit of negotiation back and forth. I think the same process will prevail as we put together our budget for 1971. It will be our responsibility to say what the Department of HEW would like to do. I assure you that we are going to press our case just as vigorously as we can.

Senator HUGHES. You will pursue it then in your executive capacity with the administration?

Mr. BLACK. We certainly will. We did for 1970 and we will for 1971, but again realistically I do not think it can be expected that we will win all of our battles or that HEW will get every dollar that it thinks is desirable or could be well spent.

Senator HUGHES. Did you win any battles this year when you presented your recommendation?

Mr. BLACK. Yes; we won some and lost some.

Senator HUGHES. That is par for the course, I think. In my executive capacity in a State I know the obstacles you are up against when you come up with a budget.

The only question I asked, I determined from your prepared statement some philosophical beliefs that I did not like if true.

No. 1, do you feel that it is your job in your capacity to look at inflation in the country as you present your recommendations other than trying to meet the health needs of the country within the limitations of your budget? Naturally you have to look at it if you think your dollar next year is only going to be 80 cents. In order to stand still then you have to increase your budget 20 percent.

Mr. BLACK. Well, I think the job of determining economic policy, is of course, one that belongs elsewhere in the administration. I think, as I indicated, it is our job to express our case as vigorously as we can. On the other hand, I think if the President tells us in advance, as the budget process begins to take place, that this is going to be another very tight budget year, we should be realistic in our recommendations. We are spinning our wheels and deluding ourselves and a lot of our constituents if we think we are suddenly going to have billions of dollars that previously had not been available.

What we are trying to do to come up with a program that we think is realistic within the present economic situation, a program that we think

is credible. We do not want to promise a lot more than we can deliver.

Senator HUGHES. I think that explains basically your statement in the line that you intend it and that is the only way I was trying to interpret it, Mr. Black. I was not trying to pursue philosophy of anything, I was just trying to determine the nature of how you were calculating. I think that is just about the basis that everyone operates on, general guidelines, make your general recommendations according to the thinking.

If I might then go down through your statement with you. As Chairman Yarborough indicated, and I think as you indicated, this particular bill does not include any funding in the field of alcoholism and narcotics, is that correct?

Mr. BLACK. The bill that you have before you does not. Our proposal as now contemplated will put these together.

Senator HUGHES. Have you reached any conclusions yet about what you are going to put together in these areas?

Mr. BLACK. Not yet. Except as indicated in the statement, Senator Hughes, we are very strongly convinced that as much integration as possible is desirable. One of the reasons we are taking a look at this legislation is to see if still further integration of these various facilities and purposes is possible.

Senator HUGHES. In your prepared statement, in the third paragraph, you say: "The centers have become training settings for professional and allied health manpower increasing the total pool of mental health manpower."

Does this include paramedic and supplemental medical assistance?

Mr. BLACK. Yes, that is basically what we are talking about here. One of the innovations that our professionals have found coming from this program is an increase of paraprofessional personnel. That has been especially true, I am told, in the ghetto areas where a number of excellent programs have been developed, using people right from the community and giving them inservice training.

Senator HUGHES. This should stretch your dollar considerably, should it not, in the future as well as increasing the percentage of services you can deliver for the dollar?

Mr. BLACK. It should, which is another reason that we propose later in our statement that we include for matching purposes all personnel, all operating costs. As it is now, you know the bill is restricted to only professional and technical personnel, which as I indicated in my statement presents administrative problems. But when you can use more paraprofessional personnel, it makes sense to us to include the cost of that personnel in the total operating cost and to help pay for it with the staffing grant.

Senator HUGHES. I think generally in your statement you have recognized the problem that faces every State in the Union and every city in the Union, they are all broke. You will concur with that, would you not? As far as they have got their back against the wall for resources primarily, they are not all using equally, naturally, the basic pool of resources that they have available to them. Yet at the same time when we develop a program like this, no matter what percentage the State seems to be doing, let's say, in getting into their pool of resources financially, you equally apply your resources across the Union whether a State is equally using theirs.

Now you have no choice in this so I am not critical of it, Mr. Black; I am simply emphasizing one of the real problems that is faced by the States. The State budgets and the State personnel and the State services have increased disproportionately in the last decade to the National Government. It does not make any difference to a Governor what your politics are, their problem is money, dollars and cents. Every mayor in the country is up against the same kind of a question, dollars and cents.

I think you recognize this in here when you say if you are going to go on a matching fund basis, then you are going to run on the short cutoff date. We are going to have to have services undoubtedly which will cut back, be discontinued in some areas of the country, and they will not be picked up in other areas of the country because there is no money available.

Mr. BLACK. That is undoubtedly true. I want to emphasize here, though, that it is not our position that the Federal Government should make a long-term or a permanent commitment to subsidize these community mental health centers. We are sticking with the original concept that the Federal money is seed money to get the centers started.

We are convinced on the basis of the experience to date that the original period for the seed money was too short for a number of reasons. We hope that by extending this period and taking a look at other resources, particularly the third-party payments, and giving the communities more time to develop their own resources, they will ultimately be able to keep these centers going without continuing, permanent Federal support.

Senator HUGHES. We are just postponing the judgment day.

Mr. BLACK. I don't think so.

One of the other factors that has to be taken into consideration in this program and in our whole review of grant-in-aid funds is that the President as you know has committed himself, as one of the major initiatives of this administration, to a program of revenue sharing, and this of course is directed to the problem that you mention. At this point the substance and details are not known, but it has to be a part of answering the kind of question that you raise here about the long term.

Senator HUGHES. Part of the problem of discussing legislation is that the program of revenue sharing is not a part of your Department so there is not much we can do about that in the hearing here. For example, again then we get back to what is a State doing for itself. You find one State that has a very high State income tax, has a very high property tax, has a very high sales tax, has all the nuisance taxes to maximum levels and delivering services that range within the top five States of the Union whereas its neighbor may not have any sales tax, a very low State income tax and delivering very poor services and yet you want to go to proportionate sharing by the State. You are going to have to determine when you get to that on the basis of what are the States doing for themselves as well as we have just handing back a percentage of Federal revenues. If you don't then you destroy the incentive we are trying to create. It is a very delicate problem.

All 50 Governors favored this type of thing and we all do. I still favor it. But if you are immediately saying to me you are going to give back to the State of Iowa 5 percent of the State revenues that go into it,

it would be no solution to our problem, none whatsoever. We have a maximum saturation.

The only point I want to make is that we are going to have to deal with the population the way we see them today if we ever get to that point; that the policy of the administration matches the hope of the American people. We are still going to have to deal with conditions as they exist today which means disproportionate effort locally all over the country, different priorities. Just for a moment on that basis I would like to go to the State planning agencies. To your knowledge, do you know when State planning began?

Mr. BLACK. Well, specifically when this Community Mental Health Centers Act went into effect the comprehensive State planning agencies and the areawide agencies were not in existence. There is, as you know, language in the act now which says that the planning should be conducted in conjunction with other appropriate agencies and the like, that these specific ones have not been in existence. They have come into existence since then which is why we are suggesting that it now be specified that the community health center planning be coordinated with the comprehensive State plan.

Mr. HUGHES. It is not a fact that many States do not yet have a comprehensive State plan?

Mr. BLACK. I would defer to Dr. English on that. It is my understanding that most of them do.

Dr. ENGLISH. All of the States have organized comprehensive statewide planning agencies, Senator.

Senator HUGHES. You gave it a different title. A State health planning agency is a different thing than the comprehensive State planning agency.

Dr. ENGLISH. What I think Mr. Black was referring to was an agency under the partnership for health bill which provides for comprehensive health planning agencies for the States which in relationship to this program, in accord with one of the principles we are suggesting here, would actually review the plans for construction of community mental health centers as it would other plans of the community. We think it will help considerably the States to utilize their own resources better, more effectively, in relationship to this program.

Senator HUGHES. Well, there is no reason for me to belabor that point, either. I just want the record to show, however, that the States of these United States are in the very embryonic stage of mental health planning. They are in as high a premium as psychiatrists and doctors. Plagiarism and robbing one another of State planners is one of the greatest practices that I know of in America today. If you hire a good one, you are not going to keep him very long in all probability because he has 25 people looking for him, at him, and trying to him.

So we are going to be in great difficulty in this planning process for a long time. Many State general assemblies have not even conceived or authorized State planning; some of them are set up in the executive offices, they will be transferred at a later time. We are in a reformation process in this, in other words. I realize that you are working with the State health planning agencies which in most

instances is a separate thing from the State comprehensive planning agency. They may be reporting to but they are not identical with.

Most State planning agencies, including our own, don't know a damn thing about State health planning, I might add, which creates a further problem within the State and you have to get down. The only thing I am talking about is the machinery that can make the programs work. Apparently we are doing the best we can but here again the need for this seed money and the continuing of it is the thing I want to get to even in State planning.

We had one of the earliest grants in State planning and I was highly criticized for settling it up in my own State. It took us a year and a half to get the thing even set up to where it could be functional, where we could hire the employees. So you well realize what we have been coping with; you have been coping with it longer than I have.

Dr. ENGLISH. Just to make your point, Senator, in a slightly different way, let me mention again the problem that Mr. Black alluded to before: the \$350 million slippage over and above what was estimated in the medicaid, that is just the Federal dollars. As you know, there are almost as many local and State dollars involved in those miscalculations. The point being that there is not only a serious problem at the Federal level when we are faced with that kind of overrun but it is a major factor in why the States and localities are not able to contribute to the support of these programs.

I would simply say that to the extent the Department under the leadership of the task force which the Secretary has set up to look into the problems of medicaid, to the extent its efforts help on the Federal level, I think it will also help us at the level of the States and the localities as well.

Senator HUGHES. There is going to be a great problem in this partnership of government—Federal, State and local—trying to work through and I think it has improved greatly in the last 5 years. I don't know what your opinion of it is but I think it has improved greatly in spite of the great problems we still face. I think, for example, you and I were able to get into communication and were able to do some things in a State that 5 years ago were impossible. So we are making a great deal of progress.

I do not want to be highly critical, I just want to point out the problems that still exist. We cannot think of funds like this in the early future. It is going to have to require a heavy partnership of the Federal Government in order to enable the States and localities to even organize themselves to the extent that they can pick it up.

Dr. ENGLISH. Yes; I think the principles that Mr. Black described are going to make us do that even beyond the extent to which the legislation presently permits, and particularly in poverty areas and in areas where additional centers are required. Not only community mental health centers are going to come into existence but programs on alcoholism and drug abuse as well, which in reading this statement seems to be consistent with other statements that this Secretary has made.

The reason that this program is being endorsed in contrast to medicaid, which simply increases purchasing power, this program is the kind of program which the Secretary described as "increasing

the capacity" of a community to provide resources when purchasing dollars are made available. So I think the reason why this program is receiving the priority which it does in Mr. Black's statement this morning is because it is recognized as very different than just buying services that may not exist. This program helps to create services in critical areas where they are needed.

Senator HUGHES. I think you very excellently pointed this out, Mr. Black, on pages 4 and 5 of your statement in which you cover the recognition of all of this. I just wanted to further emphasize it to be sure we had it clearly understood.

If I might then go back to the—again I will leave those areas alone, there is no use in us arguing philosophy here this morning on priorities. We are obviously in disagreement on some of those and you obviously have no choice. So I will let that part of it go myself.

If I were in your capacity, I would not have either, I might add; it is just simply a problem with which you have to cope.

Mr. BLACK. I just want to assure you again, Senator Hughes, that we are going to pursue these just as vigorously as we can within the administration.

Senator HUGHES. I want to assure you, Mr. Black, that we will probably pursue them in an exceeding manner than you desire appropriate at this point. So respecting our positions, we are both going to do the best we can—I hope we win and that you will be better off as a result of it if we do.

Mr. BLACK. Well, you had Dr. Egeberg before this committee.

Senator HUGHES. A delightful man.

Mr. BLACK. He appeared last week. I don't think you can doubt that he is going to be a very articulate, outspoken, aggressive—

Senator HUGHES. I think you have a great group of men over there; I wish some of them were in the White House instead of in the Department.

I guess that is not out of order, is it, Mr. Chairman, to express my hopes in that way.

The CHAIRMAN. Each Senator is the judge of his own conscience.

Senator HUGHES. I again want to compliment you on your recognition of the problems of the health insurance industry and the needs to get out in that area—too broad and too late and too little. We have got to get into it. I think every encouragement in this particular you can do to bring it about is certainly in the best interest of the people of this country as well as in the administration. I think the recognition of this is very important.

If I may go back to the point at the bottom of page 11 where you point out the two major mental health problems emerging in recent years require strong and continual Federal support, which is a good statement, that is the recognition of the fact that it is going to take continuance for drug abuse and alcoholism.

Then you say:

The present mental health centers legislation provides for separate authorizations for construction and staffing support in these two areas. We are firmly of the view that these two special purpose programs must continue but we are equally of the view that Federal support should be, as at present, provided as an integral part of the network of community mental health centers.

I want to tell you that I have not been firmly convinced of that myself. I have indicated that in the subcommittee hearings we have had previously but not in some of the others here. I hope that my prejudice is not such that I am not open minded against this regardless of my personal views on the subject matter. I recognize the need of coordinating these programs centrally in order to have them all be effective, and they are all going to have a basic structure in the country. That can be utilized as long as we do not move into the area of professional jealousy which concerns me in these areas more than anybody else.

I think probably you men would all agree with that. If we can open this up and we can do something with it, a lot of my fears would be alleviated. I am more concerned about that than anything else in relationship to community health centers.

We noted again, and I understand how these things can happen, that the administration budget as it came over knocked out the \$4 million total in the construction funds in the alcoholism. I have expressed privately, and I will express publicly, that I doubt the President even knew this happened. I know the problems that he faces in the budget and the way things happen; somebody probably knocked this item out and he was not able to personally look in detail at this. I would hope that you would continue to support this whether it has been knocked out of the administration budget or not because we have a useless piece of legislation unless we can fund it.

Mr. BLACK. Well, the budget that went up for this year, as you know, does not include that \$4 million. The Department is committed to the support of that budget. The money has been, as you know, restored on the House side. But we are emphasizing it here because I am sure you gathered from your conversation with Dr. Egeberg in his appearance before you last Friday that he has a very strong feeling about this problem, as does our Department and I am sure the administration.

We are talking here now about legislation which would become effective in 1971. Despite the fact that it was knocked out this year as one of those very unpleasant choices which I described in my testimony, it does not mean that it is not going to be funded in the future. We are very concerned that when we again come in with some dollars to support this program that we have the proper mechanism for it. Meanwhile, of course, as I am sure you are aware, it is possible for the community mental health centers now to undertake alcoholism work if they want to. As Dr. English and Dr. Yolles have indicated from time to time, there is a reluctance on the part of the communities to do this, which is why we are proposing when we get to it on the program we have undertaken—

Senator HUGHES. Let's stop right on the but of reluctance because you have in your prepared statement some sentences which say this: "Americans have very ambivalent feelings about alcoholics and narcotic addicts. The patients are very difficult to treat."

Now we have had testimony from a dozen psychiatrists and doctors that alcoholics are no more difficult to treat than patients in a hospital or any other setting. I 100-percent disagree with your statement in this testimony that they are any more difficult to treat than anyone else. You may have some different meaning in the sentence than I have

interpreted. Now maybe you mean that over a long period of time they are more difficult to treat or something, but I would like for you to clarify that for me unless you just mean from the day they come into a treatment center on through they pose a greater problem.

Mr. BLACK. I would like for Dr. Yolles to answer that. As a layman, the only treatment I ever administered was hot coffee and cold showers.

Senator HUGHES. You have a couple men in your own Department who said they were not any more difficult to treat.

Mr. BLACK. I think Dr. Yolles could comment much better than I.

Dr. YOLLES. I think the sentence here refers to the chronic nature of the disorder, it is a long term. As you surmised that, it is a long-term problem, it is not amenable to quick, rapid treatment and you do not get all the results immediately. It is difficult to treat simply because it is a chronic lapsing disease where you have to be prepared to have patients relapse again and again and again. This is what makes it difficult.

Senator HUGHES. But as far as the physical handling of the patient in the ward or in the hospital, is he difficult to treat any more so than anyone else?

Dr. YOLLES. No. As a matter of fact, this is one of the reasons why we state that there should be higher incentives not only to encourage communities to develop treatment facilities in these areas but it is also in the development of such facilities communities will learn to treat the situation. There is a popular misconception that a narcotic addict or an alcoholic will disrupt all treatment services and it is just not true. But there are many communities that still believe this and there are still treatment facilities that will not handle this type of problem simply because of that misbelief.

Senator HUGHES. A sentence like this is likely to add to that problem, Dr. Yolles. That is why I am challenging that they are difficult to treat. They are difficult due to the problem of relapse, yes, but you might have a man with six heart attacks and you don't give up.

Dr. YOLLES. That is quite right, sir.

Senator HUGHES. I think the fact that we find a lot of these people in problems that may stay sober or may stay off the narcotic for a year or 3 months or 6 months is quite a major step in their improvement. I myself had chronic malaria during the war, it had a habit of coming about every 60 days, but they did not take me out and shoot me because of that, though some days I felt I would have been better off if they had.

As we look at these problems I urge you to be careful of statements like that because it contributes to the problem. In your very next sentence you say, "Professional interest needs to be stimulated."

We have had pages and pages of testimony from people who represent hospitals and medical societies and everything else that say they endorse alcoholics, that they endorse the doctors treating them, and yet in everyday practice you know we still have about a 90-percent failure in this area. So we have got to recognize from our standpoint that we need to make positive statements rather than negative statements which is my concern here at this point.

You are just talking about community health centers here.

Dr. YOLLES. Any specialized facilities that would be needed in the treatment of alcoholism or drug abuse would be incorporated into the network which is known as a community mental health center.

Senator HUGHES. All right. That brings me to the point of the detoxification centers and half-way houses because they are definitely a part of the recovery system, they have been proven beneficial. There is enough history of them to show that they are absolutely essential if they are going to recover chronically ill patients in these areas.

Dr. YOLLES. You are quite right, Senator. As a matter of fact, there is a high priority given in funding federally to those community mental health centers which are affiliated with general hospitals. We insist that in terms of the alcoholism program and narcotic addiction programs that there be an affiliation of the general hospital because of this acute medical treatment which is needed from time to time. So we have a higher priority in funding for those centers which are associated with general hospitals.

Senator HUGHES. How much totally?

Dr. YOLLES. In the area of narcotics there are \$8 million for 1970, the same as 1969.

Senator HUGHES. Does that include alcoholism?

Dr. YOLLES. No, sir; it does not.

Senator HUGHES. Do you have any money in here for alcoholism?

Dr. YOLLES. No, sir.

Senator HUGHES. No money whatsoever?

Dr. YOLLES. No.

Senator HUGHES. How many drug addicts are there in the country?

Dr. YOLLES. Well, the Bureau of Narcotics and Drug Abuses estimates about 65,000 in the United States. I think because of the limited reporting on that a better estimate would be somewhere in the neighborhood of 100,000 to 150,000 now hard narcotics addicts. Then if you get into the area of drug abuse you go up into the millions.

Senator HUGHES. How many alcoholics do you estimate are in the country?

Dr. YOLLES. Somewhere between 5 and 6 million.

Senator HUGHES. We have 65,000 drug addicts and 6 million alcoholics and we have no money for alcoholism specialized treatment and only \$8 million for drug addiction.

Dr. YOLLES. Part of the explanation for that, Senator, is the fact that there were commitments made for programs in 1969 which had to be carried over into 1970, they were continuations of funding. There were no programs in 1969 to deal with alcoholism.

Senator HUGHES. Are you ready to make a commitment for 1970 on alcoholism?

Dr. YOLLES. Within the limits of our budget that will allow us. We consider this to have a high priority.

Senator HUGHES. That would mean that you have to take away from something that you already got in the program?

Mr. BLACK. Not necessarily. I think it is a little too early to make that kind of judgment, Senator. We certainly have not been told yet that we will be operating with the same dollars next year that we have this year or that if anything is added something has to be subtracted. I think, as Dr. Egeberg's comments last Friday indicated, we do attach a great deal of importance to this subject and certainly it

will be high on our list of new programs we want to try to fund next year.

Senator HUGHES. As near as I can tell from the testimony we have had there cannot be over six detoxification centers in the country that are probably situated and operating. Would you agree with that, Dr. Yolles?

Dr. YOLLES. Yes.

Senator HUGHES. And that probably in every major city in this Nation there is a very critical need for one or more of these centers, do you agree with that?

Dr. YOLLES. Yes, very definitely.

Senator HUGHES. Which runs into not just \$8 million, it runs into millions of dollars if they are properly set up. Do you concur with that?

Dr. YOLLES. Well, largely unmet at the present time.

Senator HUGHES. Very large?

Dr. YOLLES. Yes.

Senator HUGHES. Let us say 99 percent unmet.

Dr. YOLLES. Well, largely unmet at the present time.

Senator HUGHES. Let us say 99 percent unmet.

Then if we went into the field of halfway houses which is your ambulatory type of services which can be served through the community health centers continuing counseling, continuing psychiatric services, continuing the needs and the training you were talking about in these areas, this is now just about the same way unmet, is it not?

Dr. YOLLES. Yes, sir.

Senator HUGHES. We also had a lot of testimony indicating that an alcoholic in a family has a definite effect on the children and the other members of that partnership if they happen to be still together. We had one mother testify that she had four children before her husband sought recovery; was pregnant during the recovery period with one; and had four after and that, there was a 100-percent difference in the children born after the recovery than before; and the one carried during that period of time had some very critical problems.

So when you are talking about the community mental health centers you are talking about the effect of one alcoholic patient and, in this instance, on 10 others—the need for counsel or training in schools, for example. Of course, you do not get into the field of education.

Do you also get into the field of money for medical schools? Dr. Egeberg testified to the total need of education all the way through medical school in the field of drug addiction and alcoholism, yet it is just barely being touched on, is that correct?

Dr. YOLLES. That is quite right.

Senator HUGHES. Did any of you have any training of this when you were in school?

Dr. ENGLISH. In medical school as a part of general psychiatric teaching, Senator, alcoholism was covered but I do not think quite in the sense that you mean. For example, I think at the time that I was in medical school the related social conditions that are important to the understanding of the problem of the alcoholic and his family were not adequately covered.

I think we are beginning to see some changes in that—the students themselves as well as the faculty. For example, the tremendous interest

that has developed over the last few years of the young medical students in the poverty areas in social issues related with drug addiction, is going to be a great spur to what Dr. Egeberg described as being needed in medical teaching on this subject.

Senator HUGHES. Every medical school in the country ought to be involved in it if they are going to have any connection with the problem. If they are going to do that, that means that you are going to have to have some available wards right there so you can actually have patients that you can be exposed to, work on, and do research with, is that correct?

Dr. ENGLISH. I think that is how the service centers contribute to the teaching program that can go on when they exist in an area of a medical school's concern.

Senator HUGHES. That is the point I am trying to get to.

Dr. ENGLISH. Yes, sir.

Senator HUGHES. That these would be in conjunction with medical schools and you would have an additional benefit, too, as a result of this if it were properly funded, is that correct?

Dr. ENGLISH. Yes, sir.

Senator HUGHES. We could then get into the related fields hopefully of psychology, psychiatry, nursing, clergy, internship, and so on, in the same manner and also for our teachers colleges wherever they might exist if we are going to get down to the real problem of alcoholic prevention.

This does not include any funding for any of that; does it?

Dr. ENGLISH. Not in this year's budget, Senator, because of the reasons that Mr. Black talked about, but I would not conclude from that that the priority placed on this need which you are describing does not exist within the Department. Personally it would be my hope that some of these other adjustments that we are talking about this morning, particularly in medicaid, Senator, will help in this regard. The problems associated with that program are giving us tremendous problems within the Department on every kind of program that tries to increase capacity.

We could sit here and go through the same story with you concerning the neighborhood health centers that we would like to be able to support that are also related to the teaching of the medical student; they are also related to drug abuse and the narcotics problem, and alcoholic problem, as Mr. Black mentioned in his statement; the relationship between the community mental health center and programs such as there is tremendously important.

Senator HUGHES. I certainly do not want to be trapped in my statement, Dr. English. I support everything you say all the way through, but in not one of these areas do I see mentioned the fact that they are totally ignored except in the area outline. Would you agree with that?

Dr. ENGLISH. Yes, sir; I think the budget this year would—

Senator HUGHES. One hundred percent totally nothing.

Mr. BLACK. Well, for this particular program there are, Senator, some other activities within the Department in the area of alcoholism which are on going.

Senator HUGHES. Yes; I understand that, Mr. Black. I realize that they are there. I am talking about this particular program and this particular recommendation.

I am very pleased with the emphasis that you have placed on this, so please don't read me as saying I misinterpret your statement, that you don't express the concern. I have had beautiful cooperation from Dr. Egeberg, your whole Department.

I am trying to supplement that in the record with the need. I know Senator Javits and everyone else is interested in that need around here. I feel every time we get the opportunity I am going to have to bring this in or I am not going to be able to build the general public support. Just as Senator Yarborough brings up the war in Vietnam, I am going to bring up alcoholism and narcotics until something somewhere some day is done about it if I last long enough.

Senator JAVITS. Would the Senator yield?

I would like to affiliate myself, identify myself with the Senator's statements and comments. We have by the same technique gotten money for other things. I thoroughly agree with the Senator and will do my best.

Senator HUGHES. I thank the Senator from New York very much.

I don't want to belabor this much longer but I do note in your prepared statement, and I want to emphasize this, "but it is clear that such preferential matching is essential." I want to reinforce that because it is going to have to be preferential and they are going to have to be looked at specifically and we are going to have to make a special assault on that.

I am very encouraged by your statement, Mr. Black, and of your colleagues here because I recognize the handicap you have faced. I recognize the point in looking at this problem. I am not trying to embarrass anyone, I am simply trying to reinforce what I think is both your position and mine and our hopes and desires by pursuing these points as much as we can. So don't misinterpret what I am doing, please.

Mr. BLACK. Thank you.

Senator HUGHES. With respect to matching ratios for construction grants under the regular program you say you do not believe that any change is necessary. Now this does not relate to that alcoholism, that is not the reason the bill is not funded at all?

Mr. BLACK. Well, we think on construction grants for alcoholism we are not at this moment inclined to favor preferential matching or any change.

Senator HUGHES. Do you sort of find a conflict of interest? In your prepared statement you say, "We need preferential treatment," and then you say you are inclined not to do anything.

Mr. BLACK. We are talking about the on-going staffing support except we also point out here that we do favor preferential matching, both construction and staffing operation for the poverty areas. This, of course, would apply to the alcoholism and narcotics centers in these particular areas.

Senator HUGHES. It is my hope, Mr. Black, and the members of your staff know it, that at the time we get down this road a little further in the hearings of narcotics addiction, drug abuse and alcoholism that we can more intelligently supplement what we have already presented in everything that we have done. I hope these hearings will be very helpful to you and to your staff in the analysis of what we are attempting to do. I want to tell you that I personally have been pleased and

have had 100 percent cooperation from your Department in these pursuits in the seeking of these things and that they have been very cooperative.

I again want to state my position that I believe that we have totally been left out in these areas while relentlessly pursuing other areas. I want you to know it is not my intention to detract one whit from all the other programs you have going but rather to strengthen and add to those as you go along.

I have a very strong feeling that our health priorities are being left out when we shake up the overall budget dollar. I am not blaming you for this or anyone in your Department, it is just that we have got to do a better job of fighting for it if we are going to get the job done.

Thank you very much for your patience.

Mr. BLACK. Thank you. I just want to say before your questioning closes, Senator, that we certainly are aware of the need and want to meet it as adequately and as quickly as we can. As I indicated, it is our expectation that the legislation which will be submitted quite soon will include our proposals on the alcoholism and narcotics centers.

Senator HUGHES. Whatever you do won't be enough to satisfy me.

Mr. BLACK. We will try.

Senator HUGHES. Do the best you can on it.

Mr. Chairman, thank you very much.

The CHAIRMAN. Senator Dominick.

Senator DOMINICK. Thank you, Mr. Chairman.

Senator Bellmon has asked me to have included at the appropriate place in the record a statement introducing Dr. Donahue who will be appearing before us as a later witness.

The CHAIRMAN. I order that statement inserted at the time that Dr. Donahue is introduced and begins to testify. Dr. Donahue is the third witness down the list from the present witnesses.

Senator DOMINICK. Mr. Chairman, I want to congratulate Mr. Black on his statement. This is a difficult decision to make in view of the current financial condition of the country. The statement indicates the administration is committed to the continuation of the mental health incentive program, even though we find that we do not have enough money to do all the things we want to at the time we want to do them. This is a tough one and I am delighted that you affirm your commitment to the continuation of the community mental health centers program. I think this is going to be helpful.

A little further down on that same page and succeeding ones you point out, Mr. Black, that some communities which have developed programs are experiencing real difficulty and a number of them will have to retrench. Is there any pattern as to where this has occurred? Is there any pattern geographically or in types of communities or in States as to the commitment of their resources by taxation?

Mr. BLACK. I would like for Dr. English or Dr. Yolles to answer that, Senator Dominick.

Dr. YOLLES. Senator Dominick, there is no particular pattern with those centers having difficulty in continuing their financing. This has occurred in areas in low socio and economic circumstances, occurred in rural areas and it has also occurred in some suburban areas. Now the high expectation at the beginning to have third-party payments and

patient payments was severely overestimated by communities and also by the Federal Government in this.

Senator DOMINICK. Does this occur because of lack of funding in the Federal program or the lack of resources at the local level.

Dr. YOLLES. There has been a lack of resources at the local area. Communities have not only been running into financial difficulties in picking up increasing matching that they must do with the Federal matching decreases, but many of them are postponing coming in because they cannot see their way clear to find the money and be able at least to predict that they will find the money in increasing amounts within that 4 years and 3 months period which we have as the time for staffing.

Senator DOMINICK. Is there any showing in those areas where you say they have been reluctant to start or are finding increasing difficulty that the States that find themselves in this position are ones that do not have an income tax or do not have an excise tax or do not have a high property tax or anything of this kind?

Dr. YOLLES. It occurs in some States. One example is very clear. In Pennsylvania, for example, there are presently some 29 community mental health centers, some of which without going into detail are in financial difficulty, maintaining their services. The State has been bailing them out, so to speak, but we have been told by State authorities that they are finding it increasingly difficult to do that as the number of centers increases. The State has applied for some 80 centers for the State and obviously would be unable to bail out the centers if they all get into financial difficulty or at least a large percentage of them.

Senator DOMINICK. Let me backup a little bit and say that I endorse what Senator Hughes has said. In my own State of Colorado we have every conceivable tax that you can think of. Some States don't. I know how hard pressed we are in our budget, both from the point of view of programs such as this and many other facilities which the people are asking the State governments to provide. So it is a tough problem and the resources are really being stretched.

I was interested in the colloquy on the amount of money that we have in the budget. I think the record should be complete on this point since the community mental health center program does not expire until the end of June 1970. In 1969 for construction purposes the actual appropriation was \$15 million. President Nixon's budget request of fiscal year 1970 is \$29.2 million, or almost double the current figure.

For staffing, the fiscal year 1969 appropriation was \$49,699,000, but in fiscal 1970 the Nixon budget requests \$51,300,000. So once again the President has increased the program over last year.

In the third category—narcotics and alcoholism, \$8 million was spent in 1969, and \$8 million is requested for fiscal year 1970 by the President. It is my understanding the House has raised this to \$12 million already, is that correct?

Mr. BLACK. That includes the \$4 million that the House put in for alcoholism. The \$8 million was for narcotics, yes.

Senator DOMINICK. In the figure actually appropriated last year under the Johnson administration was there any money for alcoholism?

Dr. YOLLES. In the community mental health centers appropriation?

Senator DOMINICK. Yes.

Dr. YOLLES. No, sir; there was not.

Senator DOMINICK. So we are not improving the situation except for the \$4 million the House has put in, but President Nixon has not cut anything from on on-going program either on that comparative figure?

Senator HUGHES. Would the Senator yield?

Senator DOMINICK. Yes.

Senator HUGHES. Nothing from nothing is still nothing.

Senator DOMINICK. You are absolutely correct.

Senator HUGHES. For alcoholism.

Senator DOMINICK. You are absolutely correct. I am happy, if I may say so, \$4 million has been put in.

Senator YARBOROUGH. Will both the Senators yield? Sounds like the old song about "I've Got Plenty of Nothing."

Senator DOMINICK. Mr. Black, you refer to the effort of the administration to reform the grant-in-aid system and move to a grant consolidation program. Is my understanding correct that this would be also true in the mental health centers program—that the funding would be applicable to various components of mental health problems, including alcoholism and eventually the narcotics problem?

Mr. BLACK. Eventually. It is indicated in the testimony right now because of the very special problems that you have with alcoholism and narcotics. We favor integration of those programs in the total program. We do intend to favor a separate authorization for them and some preferential matching just so we can get these programs underway when money becomes available. But it is our hope that certainly over the long haul that the more we can simplify all of these programs, the more consolidation we achieve, the better off we will be. This is why I indicated on another point that when looking at the community mental health centers you also have to consider comprehensive neighborhood centers. It may very well be in some localities that putting the whole business together will make more sense than having one separate center for mental health and certainly more than having one for alcoholism, one for narcotics, one for general health, and one for mental health.

Senator DOMINICK. What you are saying is you want to pinpoint the problems of alcoholism and narcotics addiction but that in the establishment of centers we should provide facilities for those type of problems as well as others; is that correct?

Mr. BLACK. That is correct.

Senator DOMINICK. I am in total agreement with you. As a matter of fact I am vigorously against legislation which proliferates the expense of State governmental programs. In many cases the budget for the State for the year has already been completed and acted upon. Then they get hit with the problem, either they provide matching funds which they had not anticipated in their budget or everybody jumps down their neck by saying, "You are letting the Federal funds go to waste." So they have a terrible problem in the State legislative system in trying to match these grants-in-aid. I think this is extremely important and I am glad you are moving toward consolidation.

You were referring to State comprehensive planning agencies in a colloquy with Senator Hughes. On page 15 you refer to those that

have been established in the Public Health Service Act, 314(a). These are the health planning agencies; right?

Mr. BLACK. That is right.

Senator DOMINICK. Do you know how many States have these? Do all States have them?

Mr. BLACK. Dr. English addressed himself to that before.

Dr. English. All the States are now covered with such agencies.

Senator DOMINICK. And they have been created largely by virtue of this 314(a)?

Dr. ENGLISH. That is correct, sir.

Senator DOMINICK. That would have occurred when?

Dr. ENGLISH. Over the last year and a half most of the activity has occurred. The legislation has been on the books a little longer than that.

Senator DOMINICK. Are they actually functioning or are they kind of a letterhead?

Dr. ENGLISH. It varies, Senator, from State to State. The great majority of them really are just getting underway.

Senator DOMINICK. In the process of putting these together, is the medical profession an integral part, or are they regional planners, administrators, or what?

Dr. ENGLISH. The intent, Senator, is not only to involve in the planning people from State health departments and official agencies but the medical profession itself as well as consumers. Again there is great variation from State to State. How this is done, in general has been a great step forward in involving that full range of participation and planning.

Senator DOMINICK. Actually, the act itself requires a pretty broad application?

Dr. ENGLISH. Yes, sir; I believe it specifies 51 percent consumer participation.

Senator DOMINICK. So there is a partnership between public health and private medical experts and the public as well working together within these agencies?

Dr. ENGLISH. It is beginning to develop; yes, sir.

Senator DOMINICK. Mr. Black, in the process of this you say that the administration is developing legislation with respect to community mental health centers programs and other mental health programs. Just for the record can you give me some idea of when you think this might be available? I have discussed with you in my own office the need for moving on these particular programs that will be expiring next year.

Mr. BLACK. Well, as I stated here, Senator, not just the mental health program but all health programs. I cannot give you a definite answer when all these will be ready. I think on this particular one we should be ready, I hope, by the time the Congress comes back from the recess. We would have that one ready and possibly sooner if the committee is planning to mark up and act on this bill beforehand.

We would, as I indicated in the statement, like to work out a schedule of some sort with the committee because we do have this very heavy legislative load in the health area coming up next year. We are trying to look at all of these measures to see what opportunities there are

for consolidation, for simplification in the grant programs. We have been delayed to some extent because of the urgency and attention we have given to other areas such as medicaid, because we are convinced if we cannot bring that under control we are not going to have any dollars left for these other programs.

We have announced some action on medicaid. We are giving our attention now to these other bills. We would hope that this committee would like to have our proposals for consideration.

Senator DOMINICK. I might say that from all the signs at the moment it looks as though snow is going to be flying in Washington before Congress adjourns this year, so there is still time ahead. But the sooner we can start considering them, of course, the better off we are going to be in evidencing the commitment that you have expressed here in your own statement.

Mr. BLACK. We do have, of course, in this one and the other one, 11 months yet before they expire. We are aware of the urgency of moving ahead so we do not end up with all of them at one time several months from now. Perhaps we can work out an agreement with the committee on taking them up in some order, although as I indicated we are trying to look at all of them as a package insofar as possible rather than looking at each one individually.

Senator DOMINICK. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Dominick.

Mr. Black, though these programs expire, this one and the one you mentioned next year, actually the Bureau of the Budget will do most of its work this year on what it recommends but the fiscal year begins July 1, 1970; won't it?

Mr. BLACK. That is correct.

The CHAIRMAN. So as soon as the Congress can decide on what programs it will have for the future, the better chance you will have to present a real case on behalf of the Bureau of the Budget?

Mr. BLACK. That is true, and knowing the precise form of our program before we make our submission to the Bureau of the Budget is to our advantage.

The CHAIRMAN. The Department of Health, Education, and Welfare in the past has been far more amenable to the realistic programs than the Bureau of the Budget?

Mr. BLACK. I am sure you recognize—

The CHAIRMAN. I told Dr. Egeberg privately that he was dealing with a tougher group than he was with General MacArthur. I served with General MacArthur also. So I wish you well in getting realistic requests of what people need.

I have only one other question.

You have a general statement on this subject. I ask you to examine the bill that we have here. A number of us cosponsored S. 2523. File a statement giving me your comments on the various provisions of the bill. If you agree with any part of it, put that in the statement as well as the parts you do not agree with. I would like to have your comments on each specific section. I am not going to take time to ask it now.

Incidentally, Senator Javits' statement has been handed in. He planned to read it but time ran out on him and he did not have that

opportunity. I am advised here that he announced in that statement his cosponsorship of this bill, S. 2523. We already have a number of cosponsors; he was not the first cosponsor from his party. As ranking minority member we welcome his cosponsorship.

Thank you.

Any further questions, Senator Hughes?

Senator HUGHES. No, sir.

The CHAIRMAN. Thank you very much, gentlemen. Thank you for your patience in answering all the questions of all the Senators. Thank you for your testimony.

Mr. BLACK. Thank you.

The CHAIRMAN. The next witness is Mr. Mike Gorman, executive director, National Committee Against Mental Illness.

Mr. Gorman, if you prefer, I will wait until this afternoon but I would like to finish one more witness unless you have a preference.

Mr. GORMAN. I have no preference, I will make it as quick and painless as possible.

The CHAIRMAN. Mr. Gorman is Executive Director of the National Committee Against Mental Illness.

In your capacity as Executive Director, Mr. Gorman, we look forward to your statement with great interest here.

STATEMENT OF MIKE GORMAN, EXECUTIVE DIRECTOR, NATIONAL COMMITTEE AGAINST MENTAL ILLNESS

Mr. GORMAN. Mr. Chairman, Senator Hughes, this is my 24th year before this Committee. I am running out of gas but——

The CHAIRMAN. What year?

Mr. GORMAN. Twenty-fourth year. I testified first on the creation of the National Institute of Mental Health in 1946.

The CHAIRMAN. You must have found the Fountain of Youth; you still look young.

Mr. GORMAN. I thank the Senator from Texas, but I started in when both Lister Hill and I were young. I know you served as a mighty right hand to Mr. Hill on many pieces of mental legislation and other legislation.

I have a prepared statement. If I may, with your permission, Mr. Chairman, just file my statement for the record and highlight it because of the exigencies of time.

The CHAIRMAN. I am going to read some of your memberships since you are too modest to.

Mr. Gorman is a member of the Joint Commission on Mental Health of Children; a member of the National Mental Health Advisory Council, U.S. Public Health Service; a fellow of the American Psychiatric Association; and a fellow of the American Public Health Association.

For 24 years you worked with Mr. Hill before this committee with these memberships and these fellowships. I think the record should show your knowledge and competence as well as the long years of experience you have.

Mr. GORMAN. I thank the Chairman.

The CHAIRMAN. Your statement will be printed in full in the record, and you may proceed and make your presentation as you wish.

You have doubled my service; I have been here only 12 years. So I will expect you to be twice as efficient in this presentation.

Mr. GORMAN. Just one advantage, I don't have to get elected each time. I am also a member of the Ancient Order of Hibernians.

(The prepared statement of Mr. Gorman follows:)

PREPARED STATEMENT OF MIKE GORMAN, EXECUTIVE DIRECTOR, NATIONAL COMMITTEE AGAINST MENTAL ILLNESS; MEMBER, JOINT COMMISSION ON MENTAL HEALTH OF CHILDREN; MEMBER, NATIONAL MENTAL HEALTH ADVISORY COUNCIL, U.S.P.H.S.; FELLOW, AMERICAN PSYCHIATRIC ASSOCIATION (Hon.); FELLOW, AMERICAN PUBLIC HEALTH ASSOCIATION

Mr. Chairman and Members of the Committee, I am delighted to appear here today in enthusiastic support of S. 2523. It is the first legislation since the passage of the original Community Mental Health Centers Act in 1963 which is equal to the dimensions of the problems of mental illness in this country.

I speak from a background of 24 years in the mental health field, first testifying before this Committee as a newspaper reporter in 1946 on behalf of the legislation which created the National Institute of Mental Health. The National Committee Against Mental Illness, of which I am Executive Director, has 47 State Governors as Honorary Chairmen.

Since it is my understanding that other witnesses will deal with the specific innovations contained in S. 2523, I think it will be most useful to this Committee if I reviewed very briefly the genesis and development of the community mental health center concept.

For almost 200 years, going back to the establishment of the first public mental hospital in this country in 1773, we regarded the mentally ill as pariahs and sent them off to state mental hospitals far removed from their communities and their loved ones. In touring more than 100 state hospitals as a newspaper reporter in the period from 1945 to 1950, I was shocked to see thousands of mental patients manacled, living in filth and subsisting on less than \$1 a day. As I saw it then, the major problem was isolation—these mental institutions were so far removed from the community, from the mainstream of medical practice and even from the families of patients that they fell outside the conscience of the people and of their elected representatives. Out of sight—out of mind.

In the early 1950's, some of us began a search for an alternative to an out-moded custodial system which was adding thousands and thousands of patients each year and was costing the several states 100 million dollars more each year for capital construction and operation.

In 1955 this very Committee, under the magnificent leadership of Senator Lister Hill, provided the funds for a non-governmental Joint Commission on Mental Illness and Health to examine the existing system and come up with realizable alternatives.

Its final report in 1961 proposed a clear alternative to the warehousing of the mentally ill; two years later President John F. Kennedy, in his historic message to Congress recommending the new community mental health center legislation, exorciated the custodial concept and called for a revolutionary change in these eloquent words:

"Every year, nearly 1,500,000 people receive treatment in institutions for the mentally ill and the mentally retarded. Most of them are confined and compressed within an antiquated, vastly overcrowded, chain of custodial State institutions. . . . This situation has been tolerated far too long. The Federal Government, despite the nationwide impact of the problem, has largely left the solutions up to the States. The States have depended on custodial hospitals and homes. Many such hospitals and homes have been shamefully understaffed, overcrowded, unpleasant institutions from which death too often provided the only firm hope of release. . . . The time has come for a bold new approach. . . . When carried out, reliance on the cold mercy of custodial isolation will be supplanted by the open warmth of community concern and capability. Emphasis on prevention, treatment and rehabilitation will be substituted for a desultory interest in confining patients in an institution to wither away."

In the two years subsequent to the Kennedy message, more than 30,000 people in all parts of this land participated in an unprecedented citizen effort in planning and designing mental health services at the state and local level.

In his 1963 message, President Kennedy proposed a national network of 2,000 community mental health centers by 1980. The dimensions of this legislative proposal were buttressed by documentation pointing out that two million Americans seek psychiatric treatment each year, but are turned away because of lack of personnel or facilities. Furthermore, various estimates by professional organizations in the field pointed out that there are four million children in need of some kind of psychiatric help because of emotional difficulties. Of this number, less than 500,000 are treated in any one year, and most of these are seen in out-patient mental health clinics where the waiting list is a year or more. As a result, thousands of these children are confined in massive state mental institutions. Statistics from the National Institute of Mental Health document the point that one in four of these children confined in state mental institutions remain there for anywhere from 30 to 50 years.

In very simple terms, the goal of this revolutionary legislation was to detect mental illness in children and adults in its early stages and treat it in a community setting in order to prevent the onset of chronic mental illness and a subsequent lifetime of custody in a state institution.

The dream was a noble one, but the history of the appropriations for community mental health centers since 1963 is a series of heartbreaking cuts which have emasculated the thrust of President Kennedy's great message. The final bill which came out of the Congress in 1963 provided only 150 million dollars over a three year period for construction of centers—less than one-third of what President Kennedy had requested. Furthermore, the legislation eliminated the most essential part of the program—partial federal support for the operation and staffing of these centers. In 1965, the Congress did add a modest amount of money for the staffing of community mental health centers, but nowhere near what President Kennedy had proposed in 1963.

By late 1965, the inadequacy of federal appropriations had reached such a critical point that the Council of State Governments convened an unusual special National Governors' Conference in Chicago in December, attended by many Governors, state legislators and city and county officials. I would like to quote just a portion of the unanimous resolution passed by the 400 officials and citizens attending that conference:

"It is imperative that the federal government, which receives the largest share of the tax dollar from our people, provide critically needed additional seed money for the centers program. It is the consensus of the conference that the national goal of 2,000 new community mental health centers to be established by 1980 as envisioned by the landmark 1963 and 1965 federal legislation, will not be realized without expanded federal, state and local support."

Who is responsible for this crippling of a program which originally had such enormous potential? Have the 30,000 citizens all across this land who participated in planning these centers lost their enthusiasm, or is it our national government which has reneged on its obligations?

In order to answer some of these questions, the Joint Information Service of the American Psychiatric Association and the National Association for Mental Health in 1967 began a survey in depth of the problems underlying the slowdown in the development of a network of community mental health centers. After visiting a number of these centers and talking to key federal, state and local officials, the Joint Information Service several months ago released its report: "The Community Mental Health Center—An Interim Appraisal."

I commend this carefully documented report to all members of this Committee. It points out that federal support for the construction and staffing of centers combined came to only \$232,000,000 for the first four years of the program (fiscal years 1964-1968). Noting that this is several hundred million dollars under the original projections, the JIS report states that "this is approximately the amount of money required to run the New York State Department of Mental Hygiene for five months. The total federal expenditure for community mental health centers over these four years averages out to thirty cents per capita per year—or slightly less than five percent of the annual per capital expenditure by the states for state mental hospitals alone".

Since the inception of the Community Mental Health Center Program, the Federal Government has contributed only 30 percent of total costs for the centers, as against 54 percent from county and private resources and 16 percent from state government. With regard to the 16 percent contribution from state government, it is important to note that the several states contribute 1.5 million dollars to

the support of state hospitals and an additional billion dollars in support of mental retardation facilities, mental health clinics, and so on.

Mr. Chairman, I say with all the conviction at my command, that this entire community mental health center program would be in danger of collapsing completely were it not for the continued, sustained, and almost miraculous interest of citizens at the grass roots.

I could give you enough documentation on this point to fill a book. We are supposedly witnessing a taxpayers' revolt, and the slogan "No More Taxes" permeates the land. According to a recent issue of *The Wall Street Journal*, taxpayers in local elections are turning down 55 percent—and as high as 75 percent in some states—of local bond issues for schools, sewage works, and the like. In vivid contrast, citizens asked to contribute additional tax monies out of their own pockets for community mental health centers approved *more than 90 percent* of local referenda over the past four years.

In North Dakota, a state with a small population and a low income base, voters have approved 13 out of 14 referenda on county ballots for construction and staffing of community mental health centers. In Illinois, 26 counties and one municipality have now successfully passed Community Mental Health Center Acts known as "708 Referenda". In last November's election in Illinois, voters in all ten counties in which it was on the ballot approved the proposition that communities underwrite a part of their local mental health costs through the levy of an additional mill tax.

In the face of this so-called taxpayers' revolt, the amount of citizen organization, sacrifice and effort necessary to pass an additional mill levy is enormous. In a recent trip to Illinois, I was given some material on the successful battle for a new tax levy by the doctor who lead the drive in Coles County—Mattoon pediatrician Stanley W. Thiel. I present just a few excerpts from his report to give you the feel of what this community mental health center program means to the good people out at the forks of the creek:

"We had our association built up to 700 members with a minimum annual membership fee of \$2. Some people gave \$100. This gave us some financing. We appointed east and west side county committees. Local political party heads put ads in the paper saying they were for the tax. They told their precinct committeemen to tell voters the parties were for this.

"The medical, dental, and ministerial societies published resolutions . . . Doctors are a hardheaded bunch and hard to reason with, but one doctor at a meeting said this was the best thing he'd ever heard of and he came up with \$100. The doctor next to him said he guessed he could do the same and he did.

" . . . Eastern Illinois University people out of Charleston helped. The League of Women Voters put in a tremendous amount of time. Of course we don't know what really put this across. We can't read the voters' minds. But something helped.

"We sort of fumbled through this. I guess the key is to get the right people behind you. Like a lot of others, Eugene Hogan, manager of a local plant, did a beautiful job. He pitched in and organized the west side to a gnat's eyebrow and these industry people know how to organize. Hogan talked to the man who heads the Central Illinois Public Service Company plant here, and he opened up inplant presentations.

"The unions helped throughout the county. A union man is on the Board of Supervisors. He sold the union stewards . . ."

"And the Oakland Corn Bread and Bean Festival . . . about 25,000 people came and we had printed napkins for every one of them. They said: 'One out of ten Coles County residents needs mental health help.' This was just one of the gimmicks . . ."

How do we reward these thousands of good citizens of Illinois for their truly heroic efforts in trying to establish a new era of compassionate treatment for the mentally ill in that State? They have done more than their share locally, and state government has appropriated more than \$10,000,000 for new community mental health and mental retardation centers. We reward them, Mr. Chairman, by allocating \$1,427,000 in federal grants in fiscal 1970—one million less than we allocated to Illinois three years ago. I have recently checked with officials of the National Institute of Mental Health, and they inform me that the projected allocation for Illinois in 1970 will fall at least 1.3 million dollars short of meeting the matching obligation of the Federal Government.

We have treated the citizens of Pennsylvania in an equally "generous" fashion. Pennsylvania still holds the lead among the larger states in the number of centers

per population. As a result of a public mental health law passed by the Pennsylvania Legislature in 1966, community mental health services are now mandatory in all counties in the Commonwealth. Since the inception of the community mental health center era, state government in Pennsylvania and local communities have combined in raising funds far in excess of the federal contribution for the support of these centers.

Since fiscal 1965, the State alone has put close to \$40,000,000 into the support of a variety of community mental health services.

For the coming year, the Governor of Pennsylvania has recommended 34 million dollars for the financing of community services—21 million dollars over the sum appropriated by the Pennsylvania Legislature for the current year. It is a bitter piece of irony that this recommended sum of 34 million dollars for one year is seven million dollars more than the entire investment by the Federal Government since 1965 in the construction and staffing of mental health centers in Pennsylvania.

However, the Federal Government has allocated only \$1,698,000 to Pennsylvania in fiscal 1970 in matching money for the construction of the centers—as against the \$2,802,000 which it allocated in fiscal 1967. At this rate, it will take Pennsylvania until the year 2000 to build the 83 community mental health centers planned by the 4,000 citizens of the Commonwealth back in 1964.

Mr. Chairman, I could list comparable figures showing severe cuts in federal allocations in all the 435 Congressional Districts represented in this distinguished body. I am frankly worried about the impact of these cuts in the federal obligation with regard to the centers program. How long can the citizens keep pushing local referenda and ringing doorbells when they are told that the federal percentage keeps going down each year? In a number of our larger cities and in rural areas too, I find an increasing reluctance to go through the agonies and frustrations of local fund raising when the federal matching is so uncertain. This is particularly true of low-income areas in our inner cities, and in the countryside, which need these centers most. Their local tax base is severely limited; their opportunities for raising private monies are almost nil.

STAFFING OF COMMUNITY MENTAL HEALTH CENTERS

For fiscal 1969, the Congress voted 64.3 million dollars in appropriations to support the federal matching share of the operation of community mental health centers. Although that was not all that we wanted, we felt that it would at least give some momentum to the centers program.

However, the Institute was not allowed to spend the 64.3 million dollars which had been appropriated. Through a series of intricate and devious maneuvers, which included delaying awards for continuation grants which had an adverse ripple effect in a general slowdown of payments, the Institute was cut back to \$46,000,000 for the staffing phase of the centers program.

For fiscal 1970, the Administration proposes 51.3 million dollars for staffing activities in the official budget, which lists this as an "increase" of \$5,000,000 over the current year. This is the same old budget shell game I complained about in my testimony last year. In actual fact, the proposed \$51,000,000 is \$13,000,000 less than the amount appropriated for the same activities last year.

It is a very simple matter to expose the specious nature of the Administration's so-called "increase." For example, for fiscal 1970 the amount of money for new staffing grants is cut sharply back to 17.4 million dollars, as against the authorization of \$32,000,000 for new staffing grants unanimously passed in 1967 by the Congress. In addition to being far below the authorized level, the amount of money allocated for new staffing grants is approximately \$8,000,000 below the amount available for this purpose during the current year. This year, the Institute will be able to make 77 new staffing awards, but for the fiscal year beginning July 1st, it will only be able to make 51 starting awards—the second lowest number of new starts in the five year history of the program.

Again, time does not permit the detailing of more than just a couple of examples of the impact of this kind of severe cut upon the projected goals for centers set by the citizens of each state themselves in their 1963-1964 planning efforts.

Through an intensive two-year study of its community mental health needs, the citizens of Texas in 1964 projected a need for a minimum of 75 mental health centers. At the present time, there are only 15 centers in operation in Texas covering approximately 20 percent of the 11 million people in that State. If the

Administration recommendation is sustained, the Institute will fall more than one and a half million dollars short of providing the federal share of new centers planned in Texas during the coming year.

In like manner, these Administration cuts will hit hard at Pennsylvania, which now has 27 centers covering about 35 percent of its people; if the Administration figure is sustained, the estimated \$2,000,000 shortage in federal matching monies will prevent the initiation of six or more new centers in Pennsylvania.

Even Kentucky, which has 21 centers covering 90 percent of its population, will lose the momentum necessary to finish the job on schedule. The Administration recommendation for fiscal 1970 will force the Institute to default in meeting its matching obligation by a minimum of \$750,000 for additional centers in Kentucky.

Despite my previously expressed reservations about the lag in the timetable for these centers, the disappointing level of state support and the restrictive nature of some of the services provided by the centers, I must tell you in all candor that I am exhilarated by so many of the things the most progressive centers are doing. They are not waiting passively for patients, as the traditional mental health clinic used to do. They are reaching out into the community, they are leading neighborhood group therapy sessions, they are working with the teachers and the parents in the schools, and so on. Because they exist, families in trouble, for the first time in this country, have a place to go in their own neighborhood and obtain help during the initial manifestations of an emotional disturbance.

In visiting many of these centers all across the country, I have verified the evidence that they have already prevented thousands of patients from going on to jails and then to state hospitals. In cities where there are no such centers, patients are still being jailed awaiting admission to state hospitals. On December 13, 1968, the Dade County jail in Miami, Florida, held 77 mental patients awaiting hearings for admission to South Florida State Hospital. Many of these patients had been in the jail for four weeks or more.

In Philadelphia, there are seven centers serving the entire city. Several of these centers are located in ghetto areas; they serve the poor and minority groups who have never been touched by psychiatry before. Many of the caseworkers from these centers are neighborhood people who have been trained to go into the homes and work with the families. They have initiated a number of training courses for the police in the handling of disturbed individuals—the same police who just a few years ago used to arrest a disturbed individual, handcuff him and rush him to Philadelphia State Hospital. Today, Philadelphia State Hospital has a joint administrative arrangement for the treatment of mental patients in its area with a medical school and a local community mental health center.

In Brooklyn, New York, where a few trees still grow, there is a magnificent mental health center whose director is a psychoanalyst. He has 35 psychiatrists and an additional staff of 200 social workers, nurses, community organizers, and the like. The center serves a very poor neighborhood populated largely by Italians, Puerto Ricans and Jews. The Maimonides Center takes on all comers. Many of its patients have been hospitalized one or more times in the past in state mental hospitals. Its professional personnel practice what they call street psychiatry; they pick up most of their clients by immersing themselves in the life of the neighborhood. There are no locks or bars on the doors at this center; the patients wear their own clothes, and they can go out to work, or to shop, in the neighborhood.

Despite the fact that most of the centers have been in operation for only a couple of years, we are beginning to accumulate increasingly impressive data on the effectiveness of the centers in preventing mental patients from going on to state hospitals.

Just a month ago, I spent a day touring three community mental health centers in San Francisco. During the last fiscal year, these centers saw and treated more than 20,000 patients. During the four year period since the opening of the first center in 1965, there has been a 40 percent reduction in admissions of mental patients from the San Francisco area to adjoining state hospitals.

In Beaumont, Texas, a group of psychiatrists set up a community mental health center that serves both private patients and—under contract with the state and county—indigent patients who otherwise would get no care or else, in their words, “a questionable combination of local jail and state hospital”. Before the Jefferson County Community Center for Mental Health was organized, both court committed and indigent patients were jailed—often as long as a month—until they could be admitted to the nearest state hospital, 165 miles away. As the Director, Dr. Winston Cochran, pointed out:

"The community was indignant, the county judge was frustrated, the state hospital staff was helpless, and we were embarrassed."

The first public monies for the center came from the Jefferson County Commissioners, who contributed the \$17,000 they had been spending every year just to house the mentally ill in the jail. In subsequent years, additional funding came from the State of Texas and the County Commissioners of both Jefferson County and nearby Chambers County.

In the first three years of the operation of the center, state hospital admissions from Jefferson County dropped from 390 in 1964 to 192 in 1967. Dr. Cochran estimates that without the new center state hospital admissions from the county would have been close to 500 for 1967—almost two and a half times what they actually were.

I could cite many similar examples of the impact of these centers in saving thousands upon thousands of our people from a lifetime of custody in massive state institutions. But the most impressive evidence of the existence of a revolution in the care of the mentally ill in this country is the fact that our 300 state hospitals today house less than 400,000 patients, as against 558,000 a little more than a decade ago. All of this is obviously not attributable to development of community mental health centers; the new psychiatric drugs and increases in personnel have played an increasing part in this development. However, in Congressional testimony a few months ago the Director of the National Institute of Mental Health, Dr. Stanley Yolles, predicted that if we accelerated the community mental health center movement, in five years state hospitals may house only 186,000 patients—two-thirds below the 1955 peak and far in excess of President Kennedy's modest prediction of a 50 percent reduction in state hospital populations by 1973.

In that same testimony, Dr. Yolles pointed out that the National Institute of Mental Health has only been able to fund 351 centers over the past five years; when they are fully operational, they will cover only 27 percent of the people. At the present time, there are less than 200 community mental health centers in full operation as against our goal of 500 centers in the initial five years of the program.

The passage of S. 2523 is vitally important because it provides an increased percentage of federal support for the establishment of centers in rural and urban poverty areas. There is no doubt that the low level of federal support for the staffing of these centers, plus the threat of the abrupt termination of staffing support after 51 months, has prevented many impoverished counties from coming into the program.

In my travels, I talk to scores of county commissioners each year; they are generally salty in their comments on the inadequacy of the federal level of support. With their limited tax resources, they are presently supplying 54 percent of all funds for the centers; they cannot foresee supplying anywhere from 80 to 100 percent in financing when the present 51 month grants are terminated. They have constantly reminded me that the federal highway contribution is an open-ended 90 percent of costs; that vocational rehabilitation grants are an unlimited 80 percent of support, and so on. I have been frequently asked to justify the present formulas, but I make no attempt to do so. I view it as just another example of the age old discrimination against the mentally ill. We have been sitting at second or third table, or back in the kitchen, for almost 200 years—we are still a long way from the head table.

I have reviewed a lengthy document from the National Institute of Mental Health listing scores of communities throughout the country which want a community mental health center, but which don't even have the initial funds to plan it. For this reason, the provision in S. 2523 of seed money up to \$50,000 to get some of this planning under way is of tremendous importance. For the information of this committee in marking up the bill, let me cite just a few of the communities where centers are not being established because of the lack of initial development money and, equally important, the fear that the county will have to assume 100 percent of the financial burden after the 51 months federal staffing grant is terminated:

NEW YORK STATE

Plattsburgh.—Champlain Valley Physicians Hospital has its hospital administrator working on development of an application, with a public relations man. A first application was returned by the Regional Office. They are now getting some assistance from the state and the hospital, but no one is working *fulltime* on it.

Oswego County.—The Director of the Mental Health Board was too busy with his own work providing services to prepare an application. The draft application is being returned by the Regional Office.

Elmira.—The Chairman of the County Mental Health Board, a pediatrician, is knowledgeable and interested in a center, just can't afford time from his practice and other obligations. No application has been submitted.

Glens Falls.—A staffing grant was suspended by NIMH—insufficient planning went into it initially. The Chairman of the Warren County Mental Health Board, an obstetrician, tried hard, but he had no psychiatric expertise and no resource available.

NEW JERSEY

Paterson.—This community is submitting an application in April which has taken 3½ to 4 years to plan. The state made some money available for a part-time planner from the mental health agency. They needed a fulltime qualified person.

Ingleside.—The Regional Office received several applications and phone calls two years ago from people who knew little about community mental health. The Regional Office thinks they could have come up with something if they had had assistance.

MISSOURI

Joplin.—This community has a construction grant, and has submitted a staffing grant which was deferred at last review. They have a person who is skilled in community organization, but he has no time to work on this. He has worked nights and weekends on the application. He is very good, but needs someone to assist him. While some communities need a person to take over and organize, others need an additional person, who could use good, busy people as resources for consultation.

St. Louis.—There is a community mental health center in this community which is also involved in Model Cities. The center catchment area and model neighborhoods area overlap. The center wants to develop needed satellite services in five areas and submit for a growth grant. No one has time to write the application. They need a full-time person to work with the disadvantaged groups for a short time.

TEXAS

Paris.—The Regional Office provided consultation to a local group headed by a minister but hasn't heard from them since September. Previously, an NIMH architect visited a hospital to see about possible renovations. There is a dearth of services in the area and no one to coordinate the various community agencies.

WISCONSIN

La Crosse.—An application is not coming in, only because no one could work full time on its development. Both the state-aided clinic and the county hospital personnel are too busy meeting demands for direct services.

Brown County.—This community has a construction grant. A staffing grant was not developed because of the lack of community organization.

KANSAS

Wichita.—For the last two years, a number of agencies, especially the County Health Department, have been trying to develop a construction application. Because of the complexities of the health and social service organizations, they have never been able to work out organizational problems and central responsibility. A local health and welfare council could probably do so if it had the means to secure a staff person.

IOWA

Des Moines.—Exactly the same situation as Wichita.

OKLAHOMA

Lawton.—There was considerable interest 1-1½ years ago. The community was trying to see if WW II military base could be used for some of the facilities. It was difficult to bring various agencies together. There was no one available at state or community level to work consistently at bringing the program together.

COLORADO

Saint Louis Valley.—This is an area of number one priority in terms of need. There are no professionals there at all and no resources for development of program. The state, the Regional Office, and the state hospital are trying to help, but without success as yet. Rural areas always have to have help, and it is more effective if there is a full time person on the scene.

Durango.—This community has a high *Spanish-American* population and a large Indian group in *Ignacio*. They too need someone to help from within the community. The Indian population has unique problems. The state, the Regional Office, and state hospital staff are going there *two days a month to help but this is not sufficient*. In these rural areas the community needs advice on how to get organized, rather than just advice on the application. Outside agencies are unable to provide as much help as they need.

IDAHO

Sterling, Craig, Grand Junction, and Twin Falls.—All show interest but have no one to help organize and develop program. States work first with the most organized groups, giving priority to those most ready to develop program.

In conclusion, Mr. Chairman, there is a demonstrable need for the major innovative provisions of S. 2523, particularly those extending the federal staffing support to 10 years and providing preferential staffing support for centers in rural and urban poverty areas. My own real anxiety about the legislation is that the 30 percent of federal matching support from the fifth to the tenth year is not going to be enough to satisfy the county commissioners who have been really carrying the major brunt of this program since its inception. However, the provision in S. 2523 extending staffing grants to the covering of all professionals will at least make the 30 percent figure a more realistic one.

On behalf of the hundreds of thousands of mental patients incarcerated in our mental institutions who cannot speak for themselves, may I offer my fervent thanks to this entire committee for the development of this excellent piece of legislation.

Mr. GORMAN. I started out as an innocent newspaperman, if there is such a thing as that, a political reporter in Oklahoma. At that time I went to investigate the death of a mental patient in a hospital which had 3,600 patients near the University of Oklahoma in Norman, Okla. What I saw that day in July of 1945—a very hot day in Oklahoma; I have always decided my idea of hell is July in Oklahoma—convinced me that there was a problem and I became deeply interested.

I moved around from State to State in the next few years, including your State, Governor Hughes. I went to Independence and Cherokee and Mount Pleasant. I moved into Kansas and I moved into Texas. In the friendly State of Kansas I was a newspaperman walking the wards and finding out what are the problems, where are thousands of human beings, why are they in these places at less than \$1 a day. In some cases there were three doctors for 3,600, 4,000, 5,000 patients in some State hospitals.

Within a quarter of a mile of the great Menninger Clinic was a hospital with 3,000 patients and three doctors. The superintendent was 77 years of age. That was one doctor for every 1,000 patients so that meant, according to my statistical slide rule, he would see a patient 10 minutes every $4\frac{1}{2}$ months.

I offer this just as brief background, Mr. Chairman, because this is the situation that existed for almost 200 years. Put the mentally ill away. We are doing that to alcoholics today, Senator Hughes. I talked to medical societies. I talked to all kinds of people who said, "They're crazy, why do you care about them?" I talked to Governors and they

said, "Well, the best you can do is put them away in a State hospital."

We got to the point where we were building mental hospitals which had a capacity of 15,000 mental patients in one hospital as in Pilgrim State Hospital in New York. Now you would not have a general hospital that size but these people were just swarms of humanity packed away, hundreds and hundreds in wards in absolute filth, attendants paid \$60 and \$80 a month.

The CHAIRMAN. Was that at the time of the Snake Pit?

Mr. GORMAN. This was the period that I walked into it and started in 1945. I saw conditions worse than I saw in POW camps, having been an inhabitant of one for 11 months. I would rather have been a POW in a camp than be in 95 percent of the State hospitals in the United States.

One other point before going to the direct subject, Mr. Chairman. There was a common illusion that I shared that these people were the dregs of the universe; somehow the failures, the derelicts, and so forth and so on; no nice person got mental illness, no nice person was confined to a mental State hospital. I say to you that the large majority of the patients in the State hospitals—I had to dig this out from records that were originally not available to me, in many cases superintendents did not make them available to me. I had no bureaucracy available; I had a pencil and notebook. In many cases these patients were doctors, lawyers, politicians, too. At Central State, we found 77 doctors who had broken down under the wartime strain and they were patients at the State hospital which had a per diem budget of 87 cents a day for all food, all clothing, all medical, and all spiritual care.

The CHAIRMAN. Did you see anybody in there who was a combination lawyer and politician?

Mr. GORMAN. No. I saw, however, seven former members of the State Legislature of Oklahoma. I did not print their names because I wanted to protect them, the life and hard times of politicians. But I say they were there, too.

The job was one of education, of bringing these people to visibility. Here since 1773 we just shoved them off out of sight, out of mind. This was the whole bit.

Now in 1955 as a direct result of the interest of your predecessor chairman of this committee, Senator Lister Hill, we set up a Joint Commission—

The CHAIRMAN. I think Mr. Hill was one of the greatest committee chairmen in the history of this Senate anywhere at any time in the whole history of the Senate.

Mr. GORMAN. He is my idea of a god and a legislative giant. What he did for health can never be appreciated, as you well know, Senator Yarborough.

We created this commission in 1955 and we made it nongovernmental to take a firsthand look at what we were doing with the mentally ill. Why were we doing this? Why were the States spending an additional \$100 million every year building and building and building? Why were there 13,000 more mental patients every year going into these hospitals? I think some State officials had a building psychosis. Some Governors have an edifice complex, some Governors more than others. They were putting up buildings, particularly in New York

State where all Governors had an edifice complex, both Democrat and Republican.

The Joint Commission report came out in 1961, and in 1963 President Kennedy embraced the essential recommendation of the report that there was an alternative to the States incarcerating close to 600,000 patients and spending a billion and a half dollars a year. It was to hold the patient in the community where he belonged close to his family instead of removing him from the strengths of his community as we were doing by exiting him to the mental hospital 150, 175 miles away, instead of holding him where he could have access to the resources of his minister, his family, his general practitioner, and so on.

This is the essential philosophy which did not come out in Mr. Black's nonphilosophic but interesting statement. This was the whole philosophy behind the community mental health center program.

Now in essence as I deal with the problem in more detail, and I wish we all had more time but let me say this, and I want to say this with all candor and respect for this committee and for the Congress. This program has been almost totally emasculated from its inception by the previous administration, as well as by this one. We have a goal of 2,000 centers by 1980. At the present time we have less than 200 which are operating.

Now they talked here, the administration witnesses, about 350 centers funded but that does not mean anything. I have seen funded centers which are 4 years in the funding process but have not yet dug a hole because of the lack of local money or State money. So when they give you these nice glorious figures about 500 centers by June of 1970, they are taking pills. And what kind of pills? They are taking pills which preclude even reasonable forecasting. I visit these States and these centers and I do not get the same count.

Now one more point I would like to make in connection with this which relates to something you brought up this morning, Senator Hughes, in your actuarial and semiphilosophical discussion with the Assistant Secretary for Legislation, the role of the Government and the role of the communities.

In the beginning we felt the States would do much more, because in the early forties and fifties I did an awful lot of work in the care and feeding of Governors. I went to all the Governors' conferences and that sort of thing. I thought that the end result, as we finalized this Federal, State, local partnership for centers, it would run about 33 percent each in terms of support. Instead the figures, and these are hard documented figures, are that the localities and private resources are kicking in 54 percent of this and they are doing it in the hardest possible way.

The CHAIRMAN. Localities are now putting up 54 percent of the money?

Mr. GORMAN. Yes; since the beginning of the program.

Now the Federal Government, and we always talk about the heavy hand of the Federal Government and its largess, its largess consists of 30 percent. These are figures that can be documented.

The CHAIRMAN. Mr. Black's statement was they were just having to do it all, that the local communities were not coming through anything like they expected. You heard his statement.

Mr. GORMAN. I heard his statement. I have a lot of respect for Mr. Black and we know each other as newspapermen. If he had been out there and seen the struggle at the local level and seen what I have seen—I have seen doctors go out and ring bells and lead fundraising drives. We put it on the local ballot. We had a batting average of more than 90 percent for higher millage taxes.

If you want a mental health center, we told the people, it is going to cost you an additional mill or 2 mills. With education and sewage bond levies, the record was dismal, but ours was superb. I am now involved in the care and feeding of county officials.

We have a 90 percent batting average. In North Dakota, we have a State which is not affluent. On the ballot, the question was "Do the people want to pay more taxes for a community mental health center?" They do in North Dakota; 13 out of 14 local referendums were passed.

In Illinois we have been successful in some 26 out of 29 or 30, 10 out of 10 last November, which is not a bad batting average. I go into some of the documentation on how we are accomplishing this in my formal statement.

The point I want to make is that even in the bill, Mr. Chairman, which you have submitted and which I ardently support, S. 2523, the total is less than in the original bill submitted by President John Fitzgerald Kennedy to the Congress in 1963. That bill called for \$1,100 million. So we are not yet at that point in 1963 when President Kennedy, as a result of the findings of the Joint Commission, sent up a bill. Each year the authorizations have been pretty good, but when it comes to the actual funding and recommendations from the Department they have been nil.

Now I will give you an example. The Department did not exactly come clean on that one, either, when it talked about increases. I don't know how they arrive at these grandiose figures. I want to be completely fair about this, too. The Nixon budget did not change in any way the Johnson budget beyond taking out \$4 million for alcoholism. That is the only thing they did. Most unfortunate, but outside of that we had \$70 million authorized for construction of centers, but the recommendation was \$29.2 million. Staffing, where the authorization was much higher, again the recommendation was only \$51 million; \$13 million less than last year.

Last year the Congress appropriated \$64 million for staffing. So I don't know how we are progressing and escalating as these fellows said here this morning when we keep getting nowhere near the authorizations needed to carry it out. I have a book the Department puts out, and there are only 175 centers in operation after 6 years of this program. We are falling far, far behind the congressional intent in 1963 and the John Fitzgerald Kennedy message of February 3, 1963.

Therefore, Mr. Chairman, may I say I have a lot of State stories and a lot of examples, including Texas. In Texas I might point out, as an example, the State plans 75 centers. Now 3,000 citizens were involved in the planning in Texas. Medical people and commentators said that this planning effort in the field of mental health was the first genuine effort on the part of the people to plan their health services, it was really a local and State thing. How many centers do we need? How many can we afford? In Texas, the people want to build 75 centers.

Now actually they only have 15 funded, of which I can find only 10 in operation. You will hear testimony Wednesday from Sister Mary Amelia. I can actually find 10 in operation, but I find a nice plan for 75 covering 11 million or more Texans. I can do the same thing, Governor Hughes, for Iowa but I will not presume upon the patience of this committee.

Let me say one other thing about what these centers do because we talk abstractly about centers. I am not a bureaucrat. I served 3 years with Harry Truman. It was wonderful working for Harry Truman. I quit while I was ahead and I am a private citizen.

I have walked into centers where I have seen people who never touched psychiatry before, thousands and thousands of them—New York, Philadelphia, Boston, St. Louis, small cities—because up until the centers program was established, there were only two places you could go. If you were very rich and you worried about your second yacht or something like that or maybe in some cases your fourth wife, you went to an analyst for 8 to 10 years and he finally told you after all this expenditure of money, maybe \$100,000, that it was your problem, you had to live with it. So you lived with the two yachts and the four wives.

If you did not have \$50 a session or maybe \$30 out in the Midwest an hour to go through this 8 or 10 years of mutual analysis, your only recourse was the State mental hospital. That was the polarity. Now you have a recourse. You have in the community a center where you can go. I have seen centers which have established satellites right in the heart of the community—store fronts, you name it; general hospitals. They are working with the police, they are training the police. It is not magic; it is just good preventive medicine.

What I am saying, Mr. Chairman, it is an affirmation of the fact that after 200 years we have come out of darkness and isolation and we want a place at the head table along with Senator Hughes interest in the problem of alcoholism in which I am deeply interested, and I wish we had the time so that he would press me on that problem, press me on what I think about keeping the program of alcoholism in this legislation. I am not a convert to that omnibus approach, I might say.

In essence what we say is what the Europeans told us 20 years ago, what the English told me, what the Dutch told me in 1951. Why do you send these people away in the woods, away from the doctors, away from the minister? Why do you rip them from their roots and confine them like animals? These people were confined like animals in these places. I saw them in triple restriction—naked, in camisoles, and the families never visited them for 20, 25, 30 years. Some of these people were never visited, complete isolation. Talk about lepers, they were worse.

That is what we have tried to change in the centers program. We have had failures, we have had successes. I think we have established the need for the program. The very fact, Mr. Chairman, that 54 percent of these funds come from private resources, from the county commissioners—you know, I thought Governors were tough at first and then I found out they were not so tough. Then I thought State legislators were tough. Now it is the poor county commissioner who

is responsible for the snow, garbage removal, lost dogs and millage levies.

When you go to him and say, By God, I want a millage levy for mental health, he says, "You are out of your cottonpicking mind." He says that education and sewage levies have been voted down. I say, let's play Russian roulette, let the voters decide. He says, "All right, you look kind of like a madman."

So I appreciate what Government has done in its small and miniscule way. I appreciate Mr. Black's expert testimony on inflation. I wish that came instead from the Secretary of the Treasury or the Director of the Bureau of the Budget. I did not know the Department of HEW had a department on inflation, but I know and respect Mr. Black and his competence in many areas. I think he ought to address himself to what the Department of HEW ought to be doing about the major domestic problems in the country today.

Let me make one final point about the—let me talk just a little bit and then I will really quit.

I think it is terribly important that the essential innovations in Senate bill 2523 be recognized as an improvement and should be adopted. No. 1, the 51-month terminal point that we put on the legislation originally was put on by the other body, I might say, with the help of that distinguished and liberal and progressive organization, the American Medical Association. Between those two, we got a 51-month termination. In other words, we start the staffing at 75 percent but we go down to zero. For some reason, they think the mental patient must either be malingering or somehow they are suspicious of us.

Now I don't understand; I am very naive. I have not worked in Government very much. I have testified before a few committees. Why we can support highways at 90 percent with no terminal point, just 90 percent, 90 percent, 90 percent. Now if we are for concrete, that is supposedly all right. I happen to be for human beings.

Rehabilitation, which is a very important program, I think is supported at 80 percent unlimited. No terminal point. But when you come to the care of the mentally ill, you take a small step and at the end of 51 months you say to every local community, to every county commissioner, by God, you now support the program 100 percent. I would like to see some of the people who testified this morning tell this to the county commissioners.

So they give us 51 months. This is absurd. Now we propose 10-year funding. I don't think it is enough. I argued in the drafting of this bill as a member of the National Mental Health Advisory Council that passes on these things, that acts for the Surgeon General. I was asked my opinion and I said it was not enough. I said 30 percent is still right out of Oliver Twist; it is not enough. I said at least 50 percent. But I was overruled by the slide rule men. I think it is not enough, but since we have it in the bill, I ought to give it my ecumenical blessing.

The CHAIRMAN. As the principal author of the bill I do not think it is enough, either, but I have been on the Education and Health Subcommittees, both of this committee, for 11½ years and if we can get this amount, then our work just really begins.

You know, when we go over to that Appropriation Committee and I am only 23d out of 24 in seniority, they look at this appropriation

here that we have in this bill and they throw up their hands in horror. They will give \$80 billion to the Defense Department and they will cut our bill down to a token of what the Congress really authorizes. If they authorize what we have here, and I hope we have this authorization, our problem would be beginning. If we pass the bill with the authorization, our problem would be getting them to appropriate the money. These are minimal amounts here.

Mr. GORMAN. I know, Senator. I know the obstacles, but just on the basis of the difficulty, I do not feel constrained from expressing the documented need.

I think on Wednesday you will hear some very eloquent testimony on the fact that even the present starting Federal percentage of 75 percent, because it is restricted just to professional and technical personnel, actually supports only 40 percent of center costs and that is in the best year, our vintage year, our honeymoon year. When you get down to 30 percent, it is about 10 percent in terms of Federal support.

I do not think we are asking an undue amount from the Federal Government in supporting all of these things in this area.

Just one final comment on the needs of the centers and what we can do, because I do know the difference between an authorization and an appropriation. We have never received totally so far—and I will conclude now, Mr. Chairman. Roughly our track record is an appropriation level about 40 percent of authorization since 1964. If I get 80 percent of an authorization, I can go home at night and be happy.

Well, you know at night sometimes when I am dissipated and think up all kinds of bills, I think we ought to go to the Pentagon—mental health as an amendment to the Pentagon authorization.

Now I think we ought to have an amendment to the concrete bill. Highways, since a lot of people who die on the highways are alcoholics or mentally ill. But the highway lobbyists are too big, they weigh too much, and they are too heavy—they won't let us in.

Let me say one thing about authorizations on alcoholism, and I could mention others. In 1968 the Congress passed a very minuscule alcoholism amendment to the mental health center legislation. We were authorized \$22 million. I did not see that figure brought out except by Dr. Yolles. Dr. Joseph English, Mr. Black, and others I do not think answered responsively, shall we say.

We were authorized \$22 million. The first year for alcoholism we were authorized \$7 million; we got zero. The second year we were authorized \$15 million, and we got \$4 million. We got \$4 million after all the protesting and screaming and yelling that I did last year with the party then in power. We got \$4 million. Then on April 15 we were wiped out by the Nixon revision. So we have zero out of \$22 million.

Now I do not think that is terribly impressive, and to a lesser degree the same thing is true of the mental health centers program.

Now I know this can go on. Let me just make one final comment which maybe comes out of 24 years of a little aggravation and frustration, but mainly the joy and excitement of new challenges.

I hear a great deal these days about grant consolidations, and how we are going to put all the programs together under a comprehensive

health umbrella. This was passed in 1966, and I didn't like it then. I should not say this, but I think it is the legislative dog of the century because in the 3 years of the program so far it has gotten only \$30 million more than were in the categorical programs that were supposedly to be abolished.

Now let me quote a good Texan: Dr. Michael De Bakey, who was asked to testify on this bill, the partnership for health bill, and he was asked for his opinion.

Dr. De Bakey was asked this question, did he really support comprehensive health? He said, Mr. Chairman, I have yet in 35 years of medicine to treat anybody with a noncategorical disease.

That is my attitude toward comprehensive health. What is it? Is it motherhood? Is it a 9-month pregnancy? Is it free beer? I don't know what it is. It is like cotton candy at the fair. I know what tuberculosis is; I know what heart disease is; I know the agonies of mental illness because I have walked the wards.

Certainly Senator Hughes is familiar with the problems of alcoholism. I do not know how you arouse the interest of the Congress and of the people if you do not make these problems visible. It is kind of buried in Mr. Black's statement. Maybe I should not, you know, raise a snake that I cannot kill. The old southern proverb says: Don't raise a snake that you cannot kill. But I see the head of the snake in this whole business of grant consolidation and clean bookkeeping and so forth, and I see all the things we are interested in losing their clear identity.

If you move tuberculosis over from a project program to a formula plan, where does it wind up? It winds up at the bottom of the totem pole.

May I say this in conclusion. We have been at the very foot of the table, those of us interested in mental illness, for 200 years. We may eventually get to the first table.

We have just begun to build State departments of mental health over the past decade. Texas passed its first law in 1965 establishing a separate department of mental health and mental retardation. To combine us now and throw us into the whole package of comprehensive pabulum, we would lose the identity we have spent all these years creating. Maybe this is all right 10 or 15 years from now, and I say this in all sincerity, Mr. Chairman and Senator Hughes. We are just beginning to learn to walk. Let us walk for 10 years and then we will begin to run, but we don't have the capability yet. That is another reason I like the approach and enthusiastically endorse and appreciate your concern and interest in introducing and supporting S. 2523.

The CHAIRMAN. Mr. Gorman, I want to thank you for this statement. I have been reading through this very, very forceful and informative statement that you have. I wish every member of this committee and every Member of the Congress could have heard it, could see every word you have in it. I want to congratulate you for the detailed information that you have in here—appropriations, requests, moneys, how it is used, staffing, a wealth of information.

This is a most impressive paper.

I appreciate your support of the bill.

Well, Mr. Gorman, I hope that your statement here will provoke the HEW into reading your testimony, I hope that it will,

and I think that it probably will. If you do all the things you said, I think it is very educational.

I have been on this committee 11½ years and Senator Lister Hill was leading those bills. I stayed here at the hearings with him.

As you pointed out so forcefully in your statement, in 1963 when President Kennedy proposed in his 1963 message that we move to help the mentally ill, he proposed a national network of 2,000 community mental health centers by 1980. Now we have passed a good third of that time and we have less than 200 of them operative.

Five hundred. Well, I hope that we can move toward more centers in operation with supportive people like you in the Congress and the drive and not merely support the leadership. I am hopeful that President Kennedy's call in this field will be met as it was in the space field. Having put a man on the moon in 10 years, I think we should push forward in this field.

Now the major thrust of this bill, of course, is the extension of staff support. As you know, when we passed that first bill we had no staff. When we took that bill from the Senate over to the House, the House would not stand for that.

Mr. GORMAN. It was knocked out in the House.

The CHAIRMAN. They took the staffing out and took us 2 more years to get staffing.

Mr. GORMAN. Yes.

The CHAIRMAN. So the bill provides for the type of staffing that you recommend?

Mr. GORMAN. That is right.

The CHAIRMAN. In all fields?

Mr. GORMAN. That is right.

The CHAIRMAN. And provides for higher percentage of Federal support.

Now do you feel it is necessary to change the matching formulas that are contained in the present program, change them as we have them in this bill?

Mr. GORMAN. I do. And I make this one point: That it is particularly needed in the poverty urban and rural areas where you are providing 90 percent in the first 2 years. From a document that I had the privilege of looking at as a member of the Advisory Mental Health Council, it points out that in practically all the States listed, there are some 12 or 13 listed there, what they are financing is not their high priority. In other words, the more affluent areas and the areas of the medical schools are getting the centers but their highest priority in terms of need which is established by the 2-year State plan and by the people is not being funded in any one of the States—that is, in the poor areas. When it comes to the ghetto areas, it is the lack of the matching money, lack of technical personnel, and so on.

I think that is very important, Senator Yarborough, the fact that they planned for 2 years, they came out and said priority 1 is this poor area, and that is the one area that has not got a center whereas the medical school which is priority 17, has one. I am not criticizing the medical school but now we are at the point where we skimmed off the cream but we are not getting out at the forks of the creek and in the ghettos.

The CHAIRMAN. Do you think that 90 percent is necessary?

Mr. GORMAN. Very necessary.

The CHAIRMAN. You have heard it contended here that scores of communities in all parts of the country are not participating in this program because they do not have the seed money to hire the people and to plan and help develop such a center. That is the matter you just addressed yourself to.

Mr. GORMAN. Right.

The CHAIRMAN. These areas are the ghettos and poor areas.

Mr. GORMAN. Yes.

The CHAIRMAN. And here we need greater Federal participation.

Mr. GORMAN. Yes.

The CHAIRMAN. You do not need this pullback.

Mr. GORMAN. No.

The CHAIRMAN. This entrenchment which they misnamed reform.

Mr. GORMAN. Correct.

May I say this, Mr. Chairman, about this \$50,000 initiation grant. Many poor communities have got to get some, just a little bit of gasoline in their tank to move. They need an initiation grant to get moving. They don't have the high-powered medical school personnel or high-powered general hospital personnel. They don't have this. What are they going to do?

In the bill you properly suggest, sir, an initiation grant of \$50,000 so they can hire some technical people. I know some centers that have been planning for 4 years. I know some doctors giving part of their time to this thing, but it is not a part time proposition to plan a large center. This is important. Some of it is contained in the statement on page 16 and subsequent pages which I did not have time to read.

The CHAIRMAN. Mr. Gorman, I planned to be at my office to do some work there at 12:10 p.m. If I were not tremendously impressed with this statement, I would not be here at 10 minutes to 1. I thank you and congratulate you for the work you have done in this field and for your contribution here.

Senator HUGHES. I have one question which will determine whether I have any more, Mr. Chairman.

Can you be brief in answering, Mr. Gorman?

Mr. GORMAN. I shall try.

Senator HUGHES. No. 1, you know the conditions of health in this country all over. My State when I was elected Governor ran 48th in the Nation, it was one of the public disgraces, I think, of an affluent State in America. After battling that through three terms as Governor we were able to elevate as far as the averages are concerned, but averages mean nothing in this business as you know.

Mr. GORMAN. No.

Senator HUGHES. No. 2, I would like to ask you just a couple of very direct questions. Do you think that any national program for alcoholism can be handled through community mental health centers successfully?

Mr. GORMAN. I am just going to try to be brief because I have given this a great deal of thought, Senator. I think for the time being since we have a railroad track we are going to put the train on it. I think the amendments in 1968 which were the beginning, when I talked

about the \$22 million authorization, were within the umbrella of the community mental health center program because the National Institute of Mental Health had the statutory authority and the only one in HEW for research, for training, and for demonstrations in this area.

When the new bill was drafted, S. 1997, I think the thought was the same, that in this so-called period of fiscal tightness, and so forth, and so on, that to create a new mechanism when you had the existing mechanism would be very difficult, so just improve the moneys in it. So, therefore, in S. 1997 instead of being \$22 million over 2 years it is \$206 million over 5 years. OK.

Now may I say this: I have some reservations that this can be done within the National Institute of Mental Health for this reason. I think alcoholism is growing to the point where it needs greater structural visibility in the Department of Health, Education, and Welfare. I also think there are many outreach programs in vocational rehabilitation, manpower development, and so forth. I could go through a list of areas where I think the program might be restricted if held within the confines of the community mental health center.

As Dr. Yolles pointed out, in the few centers that have alcoholism programs this would be roughly the figure, Governor, less than 10 percent of the centers have any kind of alcoholism service at the present time. I think you can establish a detoxification center under the total umbrella of the mental health center, but very few centers have done so.

I don't think you get anywhere unless you have visibility, until we establish separate departments or divisions in these areas.

I will close with that, Senator, because you did ask me to be brief. I don't have the wisdom or the crystal ball to predict the legislative prognosis for S. 1997. At the present moment, it is the most viable and maybe the most passable piece of legislation. I am just expressing to you in all honesty my reservations about it, reservations which I have expressed on previous occasions.

These are the people we are interested in. I am supposed to be a spear carrier for the mental health approach; I am a member of their advisory council and have been for 7 years. But I am looking for more visibility and more spread for alcoholism; that is the best I can do in a few minutes.

Senator HUGHES. I think you and I both share the views and goals of the bill as far as it goes, and I share the consensus you expressed, in fact, more so. I doubt that if we lock ourselves in this way that we will ever in the next decade or in the next 20 years make a major assault in this area, the problem is this great.

Mr. GORMAN. I think this is a crucial problem. May I say—

Senator HUGHES. I want to study it further. I won't close my mind to the subject. I am alarmed to the extent that I think again, as I pointed out to Dr. Egeberg the other day, in a litter of 16 pigs one or two get left out, and this is the one that has been left out totally and it will almost continue to be.

Mr. GORMAN. May I say one thing on this, Governor, because I have been interested in alcoholism for many years as part of the mental health umbrella. I want the record to show my gratitude to

Senator Javits, both for support of S. 2523 and his pioneering efforts and those of Senator Moss on S. 1997. Without them, we would not have anything. They have really carried the torch for 3 years. If I have a little ambivalence it is because, you know, in a sense they have done their job. I think that in executive session when maybe another bill is forthcoming from these very interesting and profoundly important hearings that you are holding as chairman of the Subcommittee on Alcoholism and Drug Addiction, I think there will come out something that will be a better package than presently envisaged in the legislation.

Senator HUGHES. I share in your laudatory comments about these two Senators that have pioneered the field successfully into a field that had no recognition for 200 years whatsoever and they certainly deserve every word.

This bill is a fine attempt to extend that in areas of the greatest need, and I hope that working with them we can generate something jointly that will do the job. If not, certainly join with them, in what they have in the final legislation if nothing better can be done. Again I am totally open minded on the subject and I want to keep it open until we see what we can develop in these areas.

I might just ask you a couple of other questions. You related the fact that 54 percent of the funds have been local, 30 percent have been national. You left the division for the record to those that read it, meaning that only 16 percent has been handled at a State level.

Mr. GORMAN. That is right.

Senator HUGHES. And that State legislators, regardless of what the Governors may have done, lack interest, when it comes to this field of supporting matching funds.

Mr. GORMAN. In the centers program.

Senator HUGHES. I am talking about the centers.

Mr. GORMAN. Yes, sir.

Senator HUGHES. Including my own State.

Mr. GORMAN. Yes, sir.

Senator HUGHES. You suggested, and I want to support what you said, high level matching funds over a long period of time in order to get this show far enough down the road that it can fit in its stability in the future. I think you have very accurately outlined this and I think you recognized again the great problems that we have in that at the State and local level. We have so many programs now that say to the people on a county level, we authorize you to institute a program if you want to vote for the mill levy to support it.

Mr. GORMAN. That is right.

Senator HUGHES. Which in analysis is the home rule concept I guess if the people want to bear the burden they should bear it, but at the same time we follow the concept of taking all the money away from them at the top level.

Mr. GORMAN. That is right.

Senator HUGHES. And then giving a program a shell that says, now it is your responsibility.

Mr. GORMAN. I know the financial problems as a newspaperman. I am not a starry-eyed idealist. I know that the fiscal situation at the State level is critical, as Mr. Black pointed out this morning in his economic testimony.

Senator HUGHES. The point I am making is that even if we triple the funds for these programs, unless we increase the matching level, unless we extend it, the programs are not going to progress very rapidly.

Mr. GORMAN. We just want equal time with the highways. Equal matching formula.

Senator HUGHES. I think that is all I will go into at the present time. My congratulations to you for a fine presentation.

Mr. GORMAN. Thank you.

Senator HUGHES. The subcommittee will recess until 2 o'clock.

(Whereupon, at 1:03 p.m., the subcommittee recessed, to reconvene at 2 p.m.)

AFTER RECESS

(The subcommittee reconvened at 2:10 p.m., Senator Ralph W. Yarborough, chairman of the subcommittee, presiding.)

The CHAIRMAN. The Subcommittee on Health will resume hearings on S. 2523, a bill to amend, extend and improve the public health laws relating to mental health.

The first witness this afternoon is Mr. Irving Chase, president of the Massachusetts Association for Mental Health and representing the National Association for Mental Health. Come around, Mr. Chase.

STATEMENT OF IRVING H. CHASE, THE NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.

Mr. CHASE. Thank you, Mr. Chairman.

The CHAIRMAN. Proceed in your own way.

Mr. CHASE. My name is Irving Chase. I reside in Concord, Mass., and I am president of Henry Thayer Company 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, including your distinguished Chairman, 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 a State mental health association. That is Vermont, Mr. Chairman, in case you are interested.

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, nonprofit, 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 the hospitals—both public and private—and the uncounted other millions receiving treatment as outpatients. The latest figures in the U.S. Public Health Service estimate that 4.4 percent of the population of the United States are seriously mentally ill.

The CHAIRMAN. 4.4 percent?

Mr. CHASE. Yes, sir.

The CHAIRMAN. That would be roughly 8.9 million. Senator Hughes should be here. He says there are more alcoholics than anything else. Does this 8.9 million include alcoholics?

Mr. CHASE. I believe it does not include alcoholics, sir.

The CHAIRMAN. It would be in addition to that?

Mr. CHASE. Yes, sir.

This means that there are approximately 30 million American citizens who are very involved with mental illness. I speak about these figures so this committee will have a very full understanding of the larger number of our citizens who are directly involved in a familial way with this dread illness.

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 1 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, 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 interest, on the following bodies.

You heard Dr. English this morning speak of majority consumer representation on a number of these advisory committees. Bona fide consumers who has some knowledge of health problems are not too easy to come by; as a result I find myself very popular in the various Government organizations.

There are four listed in the printed testimony. One is Advisory Committee to the Commissioner of Mental Health of the Commonwealth of Massachusetts on Construction and Utilization of Community Mental Health Centers.

Second, Advisory Committee to the Governor of the Commonwealth of Massachusetts on Comprehensive Health Planning. This is the advisory council in section 314(B) of the Public Health Act.

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

I am also a member of HEW's National Advisory Group in Washington on financing care of the mentally ill under medicare and medicaid.

The chairman may recall that in passing the amendments to the Medicare Act there were some exceptions for the care of mentally ill. Upon complaint against this discrimination, the Senate Committee on Finance directed the Secretary of Health, Education, and Welfare to bring back to it a report on their recommendations as to what the coverage of mentally ill people should be under medicare and medicaid.

Secretary Cohen brought in an interim report in December of last year and the new administration is, I think, moving toward fulfilling this request of the Senate Finance Committee and this is the advisory group to the Department of HEW on this matter.

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.

Moreover, the care of the mentally ill has been a special province of government, principally at the State level.

This is particularly so at the State and county level, but its development was not motivated so much by a desire to help people who were sick as it was to provide a repository for them so as to remove them from society.

I now see some very good signs of movement from the custodial level of the past to humanitarian care of sick people through these community health centers as they are evolving.

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 as with all other diseases combined, including cancer and heart disease.

The CHAIRMAN. I think, Mr. Chase, if you will pardon me a moment, that that is one of the most compelling statements that you can add to this bill; you state that there are as many people hospitalized with mental illness as with all other diseases combined.

Mr. CHASE. Yes, sir; this is a fact that is not well known to the public but should be.

The CHAIRMAN. Proceed, sir.

Mr. CHASE. 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 ending 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. I accent the word "new." The total admissions continue to increase but as the first-time patients are being seen more in other settings.

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 public or institutional practice. The combined total of all other physicians in private practice was 174,785, compared with 48,350 in public practice.

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 mean 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; that is 90 percent, of which only \$135 million became available in the apportionment of NIMH funds, a loss of \$65 million.

The CHAIRMAN. We have had a good bit of discussion this morning of how the appropriations fell far short of what the Congress authorized but I don't believe anyone has made your point, that after the money is appropriated by Congress, then the National Institutes of Health don't allocate the money so part of it is unspent even after it is appropriated.

Mr. CHASE. That is my understanding.

The CHAIRMAN. So first you have a hard fight to get it authorized, going through committees like this, then you go to the Appropriations Committee to get the money.

As you know, we must first have a general authorization before the money can be appropriated. Then it goes to a separate Appropriations Committee. Then after it is appropriated, then the agency says, well, they have not submitted proper plans so the money is not spent or the Bureau of the Budget says it is endangering the economy and they put a freeze on it.

The person waiting for assistance has four great barriers: congressional authorization, congressional appropriation, the Bureau of the Budget's not putting a freeze on it, and then the agency's not allocating it. Each of these take tremendous, continual work to get some of this money.

Mr. CHASE. May I say, Mr. Chairman, that as a businessman I have felt sometimes as though I were Alice in Wonderland when it came to some of these terms.

The CHAIRMAN. You work in this field. Why didn't they use the \$65 million? Why did they lose it after it got through the Appropriations Committee?

Mr. CHASE. It is my understanding that the appropriations were reduced by the Bureau of the Budget.

The CHAIRMAN. With a freeze?

Mr. CHASE. I don't know. I do know that there was a freeze 2 years ago and at that time there was a considerable slice in the appropriations.

The CHAIRMAN. They deescalated everything in the country but did we hear of the Bureau of the Budget deescalating Vietnam?

Mr. CHASE. No, sir. I was doing some arithmetic this morning and I found that all the expenses in this bill could be paid for if the war in Vietnam were stopped 9 days ahead of time so let us just stop it 9 days ahead of time.

The CHAIRMAN. Yes, sir.

A member of the press stopped me outside of the hearings this morning and he said he had heard the figures about the war in Vietnam; that the budget asked for \$5,200,000,000. And he said did you say to kill Vietcong? I said, Oh, no, just to shoot at them. I don't know what the cost is to kill them. We tried to computerize it; \$200 million for 8 years and that is about 12½ cents per person per year in the United States for mental health in this country while the budget this year alone asks for enough to shoot \$236 at each of the Vietcong soldiers.

Mr. CHASE. Mr. Chairman, I am joined by Mr. Michael Freeland, associate director of the National Association for Mental Health.

I was speaking previously of the construction funds, but 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.

We therefore wholeheartedly support and urge passage of S. 2523 which we believe to be essential if we are ever to come closer to achievement of the originally projected goal of 2,000 comprehensive community mental health centers.

Only by extending the basic program for at least another 5 years, by authorizing adequate funds, and by enactment of the proposed amendments and improvements will this be accomplished. We favor all the proposed amendments.

Since the chairman seems to have a bent for statistics, I would like to point out that the importance of this figure of 2,000 community mental health centers, if we divided this figure into our population, we see the result is 100,000. It is the intention of the program that they should serve areas of no less than 75,000 and no more than 200,000. The average is forecasted at 100,000. This seems to be a logical number for a community mental health center to reach and serve.

The CHAIRMAN. It seems to me that when one health center serves 100,000, it is just about minimal when you give the figures of people affected.

Mr. CHASE. 808, sir.

The CHAIRMAN. That is about the minimum facilities you can have and say you are serving the Nation.

Mr. CHASE. My arithmetic is wrong; it would be 440 to serve on the average in each of these centers and oddly enough there is just

about one psychiatrist in the country for every 500 seriously mentally ill.

The CHAIRMAN. You said there are 8,800,000 in the country?

Mr. CHASE. Yes, sir; that is the Public Health Service figure.

The CHAIRMAN. That would be 8.8 percent out of each million?

Mr. CHASE. No, 440.

The CHAIRMAN. If you had 4 percent out of 4,000, you would have 400.

Mr. CHASE. My arithmetic is off; that is correct.

However, since your committee will have heard from numerous witnesses and since I have no desire to burden the record with cumulative testimony, I shall confine myself to a discussion of certain amendments only.

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 local affiliated mental health associations who have been in the thick of the struggle to launch such a center have reported that the 5-year 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 payment 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.

I would point out to the committee that there is one essential service for which the legislation calls, education and consultation, whose support can come only from public funds and can never come from third-party payments, medicare, medicaid or what have you.

So I believe that once Federal funding is removed entirely there is real danger in a number of these centers that this service will disappear and then the 24-hour emergency service, which is bound to be unprofitable, will next disappear and we will end up with only an inpatient-outpatient center which will not serve the community.

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 meaningful 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 than 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:

1. 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.

2. Most potential applicants lack experience in the increasingly important area of community organization—a lack most severely felt when developing community mental health centers 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.

3. 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.

4. 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 divert their 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.

5. 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.

6. 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.

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 can be taken almost as a matter of judicial notice that urban and rural poverty areas do, in fact, need a larger measure of Federal assistance to develop and operate their mental health services.

There is yet another lesson we have learned. There is just plain inertia to be overcome. It is one thing to promote a comprehensive center in a community that already has a mental health outpatient clinic or a State hospital or general hospital with a psychiatric wing and a core of mental health professionals in the area.

It is something else to go into virgin territory, such as in parts of Appalachia, 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 popular reputation as a place where they lock up crazy people and you never see them again.

It is one thing to sell a comprehensive center in a community with 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.

You heard from Mr. Gorman this morning with reference to recent referenda in States where sewer bonds have failed but mental health levies have been passed by the people.

Louis Harris, in a survey of public opinion taken somewhat over a year ago asked a representative group of the public to identify those areas in which they felt their Government should be more active. Mental health came in third behind air pollution and water pollution. The public is receptive. The public wishes these programs, Mr. Chairman.

To allow the Federal community mental health grants program to die out with the existing authorization would be to deny its benefits, in many cases, to those communities which need it most; those where it takes the longest to get started and where they have the farthest to go.

In one sense, it would reward those places which were already so far along that they could take advantage of the Federal funds with but a little extra effort, and would penalize those which need the help the most.

We strongly favor, as we have previously testified, this system which places on the local citizens the burden of initiating the program, and, once the Federal support has been phased out, the ultimate responsibility for keeping it going. The grass roots approach always takes longer. But the results are worth it.

We urge you not to penalize those communities which for one reason or another are just now beginning, or have yet to begin, to get this program moving.

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 situation.

We have concluded that our primary responsibility 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.

I would add that the Federal dollars going into this program, because they are seed money dollars, are amplified on the ratios as we have heard estimated this morning, of 3 to 1 by other dollars and, therefore, every dollar which is appropriated by the Federal Government has the strength of three.

I would also like to make an observation which bears on the testimony of the Secretary this morning on the question of inflation of costs in supplying medical services.

I submit, Mr. Chairman, as a businessman, that prices in a free economy respond to supply and demand factors. We have an item which is in short supply; that is to say, apparatus and facilities for delivery of health services of all kinds, including mental health services, and we have recently through the passage of medicaid amendments created an enormous additional demand and also because of the prosperity in this country there is an enormous additional demand placed on the sources of supply.

I submit that this program, sir, is aimed at increasing the supply of services and, therefore, should have the effect of deflating the costs of providing the medical services through increasing the supply as the demand increases.

The National Association for Mental Health, sir, urges this committee to report S. 2523 favorably and highly commends the chairman for undertaking its introduction.

Thank you, sir.

(The prepared statement of Mr. Chase follows:)

PREPARED STATEMENT OF IRVING H. CHASE, NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.

Mr. Chairman and Members of the Committee: My name is Irving H. Chase. I reside in Concord, Massachusetts, and I am president of Henry Thayer Company of Cambridge, Massachusetts, 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, including your distinguished Chairman, 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 a 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 one 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 one million patients confined in the hospitals, both public and private—and the uncounted other millions receiving treatment as outpatients.

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 1 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 (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 interest, 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.

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 ten (a total of 20,000,000 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 as with all other diseases combined, including cancer and heart disease.*

Doctors recognize emotional problems to be an important factor in many physical illnesses, even heart disease. Over 50% 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 ending 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 values 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 mean 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 six 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 four 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.

We therefore wholeheartedly support and urge passage of S. 2523 which we believe to be essential if we are ever to come closer to achievement of the originally projected goal of 2,000 comprehensive community mental health centers. Only by extending the basic program for at least another five years; by authorizing adequate funds; and by enactment of the proposed amendments and improvements will this be accomplished. We favor all the proposed amendments.

However, since your Committee will have heard from numerous witnesses and since I have no desire to burden the record with cumulative testimony, I shall confine myself to a discussion of certain amendments only.

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 five year 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 ten years, with the last six years at the level of 30%, will enable every such center, once started, to proceed with confidence and with assurance of continuing financial stability.

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, if any 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 meaningful 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 than 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:

1. 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.

2. Most potential applicants lack experience in the increasingly important area of community organization—a lack most severely felt when developing community mental health centers 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.

3. 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.

4. 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 divert their 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.

5. 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.

6. 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.

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 can be taken almost as a matter of judicial notice that urban and rural poverty areas do, in fact, need a larger measure of Federal assistance to develop and operate their mental health services.

There is yet another lesson we have learned. There is just plain inertia to be overcome. It is one thing to promote a comprehensive center in a community that already has a mental health outpatient clinic or a state hospital or general hospital with a psychiatric wing and a core of mental health professionals in the area. It is something else to go into virgin territory, such as in parts of Appalachia, 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 popular reputation as a place where they lock up crazy people and you never see them again.

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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.

To allow the Federal community mental health grants program to die out with the existing authorization would be to deny its benefits, in many cases, to those communities which need it most, those where it takes the longest to get started and where they have the farthest to go. In one sense, it would reward those places which were already so far along that they could take advantage of the Federal funds with but a little extra effort, and would penalize those which need the help the most.

We strongly favor, as we have previously testified, this system which places on the local citizens the burden of initiating the program, and, once the Federal support has been phased out, the ultimate responsibility for keeping it going. The grassroots approach always takes longer. But the results are worth it.

We urge you not to penalize those communities which for one reason or another are just now beginning—or have yet to begin—to get this program moving.

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 situation. We have concluded that our primary responsibility 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 S. 2523.

Thank you.

THE CHAIRMAN. You mentioned the comprehensive health plan. Did I understand you to say you would like to say a word about that?

MR. CHASE. I would like to comment that it would be, in my opinion, unfortunate at this time to make a requirement that grants under this legislation as it now exists or as proposed to be extended, must be cleared with the comprehensive health planning agencies.

I believe in the long run that this should be so but my observation now, and this is based both on my work at the State level in Massachusetts and the region I level which comprises all of the New England States toward HEW, my observation would be that their state of development is not such now that they could make correct judgments on these very important matters.

I believe that in some cases it would simply result in unwarranted delays with no benefit to society. I think in the long run as these comprehensive health planning operations prove themselves and as they develop, and I would guess perhaps 5 years from now, that all of these requests for Federal health funds should be channeled through them.

The CHAIRMAN. I have read these five points which you placed in the record and in the interest of time did not read. As you said they are rather complicated and involved. You have a very informative paper, very beneficial statement here. I hope that all of your affiliated units in all of the States and cities are informed about your testimony and what is in it.

Mr. CHASE. They will be, sir.

The CHAIRMAN. You expressed the fact that this program is being whittled away by littles, as Abraham Lincoln said, they are not coming out and saying we are against these programs, but that is the best description I have heard, whittling away and finally dragging it down.

Mr. CHASE. You have my assurance of our unqualified support for this bill, sir.

The CHAIRMAN. We read that and wanted to have your comments, too, on the comprehensive part of it. I believe Mr. Gorman said he had not reached an unqualified opinion as to whether the alcohol and narcotics cases should be kept in the common community health center with what we call the conventional mental health and I use that only in the term of nonalcoholic and nonnarcotic involved.

Do you have an opinion on that as to whether they should all be kept in one center?

Mr. CHASE. I have not, Mr. Chairman. It is my belief that opinions such as this better come from the practitioner who is closer to the scene of treating the sick than am I.

The CHAIRMAN. I have had objections from people in my State whose relatives were there who were what you call conventionally ill with no alcoholics involved, who complained about having their relatives put in with what they called the hopheads and the drunkards.

Mr. CHASE. I am sure this is a factor. I am sure this is a two-way street. I am sure there are some people who would go to an alcoholism clinic who would not go where the nuts are, to use their expression.

The CHAIRMAN. According to what Senator Hughes said, alcoholism should be more easily cured than mental illness. That is what he states.

Mr. CHASE. I have no knowledge on that.

I would like to state that there is nothing in the Community Health Centers Act nor in this amendment or extension that would foreclose this decision being reached one way or the other. There is nothing in the act which says what kind of people should be treated except old and young, rich and poor, black and white, and so on.

The CHAIRMAN. I don't want to close it off because I don't think we have enough evidence about the overall results. I personally have no definite opinion on it.

I have to listen to my constituents who have complained about having their relatives in a place with the narcotic addicts and the intoxicated. They might have a child who was mentally afflicted but with no alcohol or narcotic involvement and the parents were very disturbed.

Mr. CHASE. I am sure this is one of the factors, but as I said, Mr. Chairman, it is my belief that decisions such as this are better made

by practitioners in the field based on their training, and I lack that experience and training.

The CHAIRMAN. Also based on the people they serve. It seems to me that the improvement of mental illness would be weakened if they go into environments that upset them mentally.

Mr. CHASE. Yet today a large number of alcoholics are being treated in our State mental hospitals. I happen to know the figures in the Metropolitan State Hospital in Waltham, Mass., and of the 2,500 admissions they had last year, nearly 1,500 were alcoholism admissions.

The CHAIRMAN. Of course they had all there reached stages beyond the people who would be treated in one of these mental health centers.

Mr. CHASE. I believe not, sir. These are some of the revolving door types.

The CHAIRMAN. That is not the confinement stage, not that type?

Mr. CHASE. They need a period of detoxification and drying out and then continued psychiatric support and maybe drug support.

The CHAIRMAN. Thank you very much. This was a very beneficial and informative paper.

The next witness is Dr. Hayden Donahue, superintendent of Central State Hospital of Oklahoma, representing the American Psychiatric Association and also the State mental health program directors. He is accompanied by Harry Schnibbe who is the executive director of the National Association for State Mental Health Program Directors.

Come around gentlemen and proceed in your own way. I welcome my neighbor from Oklahoma. I don't think that Oklahoma-Texas rivalry is like my friend Mike Gorman says. I slept out on the plains of Oklahoma one summer and earned enough money to stay in law school for another year. That is before they mechanized the college boys out of the wheatfields.

(Statement of Senator Henry Bellmon follows:)

STATEMENT OF HON. HENRY BELLMON, A U.S. SENATOR FROM THE STATE OF OKLAHOMA

Senator BELLMAN. Mr. Chairman, members of the subcommittee: I appreciate the opportunity of making a brief statement to introduce one of the witnesses for this hearing, Dr. Hayden H. Donahue, whom I have known for several years.

Dr. Donahue served for a period of time as director of the State mental health department while I was Governor of Oklahoma and currently is superintendent of the largest mental institution in the State, Central State Griffin Memorial Hospital at Norman, Okla.

His work as head of Oklahoma's mental health program is well known in professional and State government circles. Especially noteworthy is the research he has done in the field of alcoholism.

During his tenure at Central State Hospital, the patient population has been reduced dramatically. He has actively promoted the concept of avoiding institutionalization of those who are mentally ill and to bring mental care into communities.

Dr. Donahue is highly respected in Oklahoma and I am pleased that he can come to Washington and offer comments to this subcommittee. I am confident that his experience in the mental health field will be of utmost interest and will be beneficial to the consideration of the pending legislation.

STATEMENT OF DR. HAYDEN H. DONAHUE, THE AMERICAN PSYCHIATRIC ASSOCIATION; ACCOMPANIED BY HARRY SCHNIBBE, EXECUTIVE DIRECTOR, THE NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS

Dr. DONAHUE. First I would like to say it is an honor to be here. I would like to stick to the prepared statement but there are some things that will come up in the discussion and then I would like to move from the statement.

The CHAIRMAN. You can proceed in your own way and read your statement or place it in the record.

Dr. DONAHUE. I am not without knowledge of Texas. I married a girl from the valley and also spent 2 years writing parts of the Texas mental health program.

The CHAIRMAN. Congratulations.

Dr. DONAHUE. They published my 14 points for me.

The CHAIRMAN. I hope your 14 points received greater implementations than Woodrow Wilson's.

Dr. DONAHUE. They got most of them completed and it only took from 1950 to 1969.

The CHAIRMAN. Congratulations to you and to my home State.

Dr. DONAHUE. I would like to begin with a success story.

In my hometown of Norman, Okla., a beautiful and cheerful new building was dedicated earlier this month. It houses the Central State Community Mental Health Center, which provides short-term and intensive treatment to people with mental problems from McClain and Cleveland Counties and from a portion of Oklahoma County. That is a population of some 254,000 people.

The treatment program itself, which was temporarily housed in one of the buildings of the Central State Hospital, began operating 21½ years ago. Only about half of the cost of the building and about a third of the cost of the treatment program came from Federal funds which the Congress made available under the community mental health center legislation, but it is certainly accurate to say that without the encouragement, the initiative, and the dollars themselves which the Federal program provided, this community mental health center would not exist today.

The CHAIRMAN. Were you here all morning?

Dr. DONAHUE. Yes, sir.

The CHAIRMAN. Maybe you were as shocked as I was, that the Federal programs encourage States to do things they might not do just so they get the money.

I think that is the beauty of the Federal programs, helping stimulate States to do these things.

Dr. DONAHUE. Mr. Chairman, we often need this kind of money to get things going that we know must go. We have other programs.

We need this money coming in from the outside to stimulate and get these things off the ground. I wrote a program similar to this for Arkansas in 1957 for Community Mental Health Centers.

The CHAIRMAN. Were you able to get Arkansas to do it before Federal money came along?

Dr. DONAHUE. I never was able to do it.

The CHAIRMAN. Are they doing it now with the Federal money?

Dr. DONAHUE. Yes, sir; they are.

Without this encouragement and initiative and the dollars themselves which the Federal program provides, this community project and the others, two others we already have in Oklahoma would not be here today.

I want to dwell for a moment only on the building itself, because what goes on inside is of greater consequence. But the building is so new that we are still excited about it. It is so satisfying to be able to talk about a setting for treating mentally ill people that is inviting, comfortable, and adequate to the need.

When I toured the hospitals of Texas with the gang bathrooms and now see two to a room for patients, it is unbelievable. I think you know that this has certainly been the exception rather than the rule in this country, where large numbers of the mentally ill have been and still are herded into State hospital facilities that are over-aged and woefully overcrowded and oftentimes dilapidated.

If it makes a difference to you and to me what kind of hospital we go to when we become sick, I think it matters even a little bit more to the person who must go into the hospital because of a mental problem. And that is why I am so grateful that the legislation you enacted a few years ago has made it possible for the mentally ill in my community to have access to treatment in a bright, commodious, conveniently located physical plant. This is one of the most modern things we have been able to do in the mental health field.

The CHAIRMAN. You say the difference is between what kind of hospital we go to when we get sick; I agree with you. It must be a terrible ordeal for a person with mental problems.

I have traveled in planes so often and have had a number of close calls in planes but that doesn't scare me half as much as if a doctor told me I had to go to a hospital. I guess that is the average man. It doesn't seem like a woman is as frightened of going to a hospital as a man.

Dr. DONAHUE. This new mental hospital is as different from the old operations as the day is from night. And now people come.

But far more important is the kind of program that becomes possible in a psychiatric facility that is community-based and stresses immediate and intensive treatment. We are able to take care of many seriously ill people on an outpatient basis. In fact, for every person who is hospitalized, there are two that we serve as outpatients or in our daytime program.

A large percentage of these are people who undoubtedly would have to go into the hospital if our extensive outpatient program were not operating from the same base, as part and parcel of a comprehensive treatment program. In parts of the country that do not have community-based programs, many of these very same kinds of patients are in fact being hospitalized needlessly.

For those whose circumstances or condition dictate a period of in-patient treatment, our average length of hospitalization is 10 days. This is scarcely longer than the average stay in general hospitals for patients with physical illness and it is greatly in contrast with those State hospitals where the average stay is reckoned not in days but in months and occasionally in years.

Here, Mr. Chairman, as I told you, we serve a district of 240,000 people. We have 232 beds in this unit, and we are most able to handle our load in 200 beds as contrasted a few years ago when it would have taken 800 beds to handle this same group.

Here again, because it is on my mind as to the number of alcoholics, the question keeps coming up about that. Originally 58 percent of the admissions were alcoholics. Now it is down to 40 percent. We are handling 40 percent who are alcoholic.

They come in in the evening, seriously disabled with alcohol. We are able with our drug program and other treatment programs to get them back on their feet and with a great percentage of the patients, have them back on their feet by 4 the next afternoon and we transfer them to the day-care center and then our program for the outpatients.

We are doing other things, some with alcoholics, and mostly with the other types of patients. We are doing house-to-house psychiatry. If a patient calls in and we feel we should see them, one of our people gets into a car and goes out to visit them. Sometimes in 40 minutes we are now able to do what it used to take 30 days to do.

We see the family, discuss the problems, sit down and talk to them, we can tell them, this is what you need and this is what you are going to do and you come in and see us tomorrow or the next day if you still need help. You can't solve them all obviously but you can solve a lot of them by being right in the community.

The CHAIRMAN. Of course the ones which are in the public eye are the ones where the policemen are trying to talk somebody out of jumping off a building or where somebody locks himself in a room and shoots somebody or threatens to shoot himself.

Dr. DONAHUE. Those are the extreme cases but at least now we can go to them.

The CHAIRMAN. And prevent them from reaching this violent stage?

Dr. DONAHUE. Yes, sir.

Think about Big Spring, Tex., how far it was from Amarillo. With community mental health centers scattered around in this country we will now be within 50 miles of these centers. Nobody would be more than an hour's drive away from them. So this is what we are talking about.

Those who need treatment for a mental problem seem to be far more willing to accept that need and to seek treatment when they are being served by a short-term, community-based program.

For example, in our community mental health center half of the people we served last year came to the program either at the instigation of their relatives or completely on their own. Another 17 percent came to us voluntarily because their family doctors recommended that they do so. Altogether more than 70 percent came into treatment on a voluntary basis.

However, we can and do provide a large amount of service to the public and private agencies in our vicinity. Despite the fact that our inpatient service is run as an entirely open service, never locked except during the group therapy and patient meetings, and then to keep others out instead of keeping the patients in, we are able to provide service to a large number of individuals referred to us by the courts—about 200 persons last year.

We also accept patients referred to us by a variety of other public and private agencies, these accounting for about 10 percent of our admissions. We service 85 agencies and organizations in our community area.

Beyond what goes on within our fine new building, we are taking very seriously the community aspect of the program. We know that many of the agencies of the community have clients who need help with emotional problems, and we are convinced that the expertise of our mental health professionals can be utilized to help the people working in these other agencies deal more effectively with their clients. Every week our psychiatrists, psychologists, nurses, and social workers go out for regularly programmed consultation to various schools, the juvenile court, the Red Cross, and a variety of other agencies.

In fact, Mr. Chairman, we are working with the counselors in the schools and in turn the counselor then works with 14 or 15 students and in this way we are reaching a lot of people in the community-based program and I already mentioned to you, we go house to house if we have to.

These are only some highlights of what we have been able to accomplish in the relatively short time that our mental health center has been operating. We have had our share of growing pains, and our program is not yet as broad and intensive as we are determined that it will be with time. But we have already seen some important evidence of the advantages of such a program for the people living in our community.

I repeat that neither the building nor the program would have been possible without the Federal support that has been available to us.

As you can conclude from what I have told you, things are going pretty well for us in Norman, Okla. I wish our situation were representative of the rest of the country, but I know only too well that it is not. The extent of the Federal support has fallen far short of what was envisioned when this imaginative national program was first proposed.

The program was promulgated with the intention of making intensive, immediate, community-based mental health services available to all of the people of the country by the middle of the next decade. We are very seriously off that timetable. The extent of the original legislation in 1963 and the renewal in 1965 was modest enough.

But beyond this, the appropriations have been well below the authorizations, and a substantial portion of the funds that were authorized for construction of mental health centers has been withheld in the face of economy drives.

In the first 4 years of the program, a total of \$232 million in Federal funds was provided; this is approximately the amount of money required to run the New York State Department of Mental Hygiene for 5 months.

To put it another way, for every dollar the Federal Government has been making available for community mental health centers during the past several years, the States have been spending \$20 for the necessary continued support of their State mental hospitals.

At the end of this fiscal year, legislation that was bold in design but extremely modest in implementation is scheduled to expire. You have before you a proposal which comes far closer to the original intention of the program.

It calls for a longer period of Federal support for getting the treatment programs under way. I know from my contacts with many directors of mental health centers that there will be perilous days ahead if the Federal funds are in fact permitted to phase out in the 51 months designated in the existing legislation.

Mr. CHAIRMAN. At my center, for instance, only 16 percent of the patients pay anything. I am psychiatrist to the poor. Only 16 percent pay anything. The rest of these people are poor people and we have to help them. If we don't do this, fees will have to support the centers and when fees alone have to support the centers, then the poor are going to be in trouble.

Insurance was mentioned some today and I will mention it in a moment. But these are serious problems and without your support of this bill we are going to be in trouble.

Originally it was hoped that this brief span of Federal support would prove adequate; but the revenues that the new centers were hoping to receive from health insurance and public third party payments have fallen far short of their expectations.

The provision of this legislation to provide Federal support starting at the 90 percent level for certain rural areas and inner-city slums is urgently needed in the face of the financial crisis that confronts such sections of the Nation.

We want to put a mental health center down in southeast Oklahoma. The average income there is \$1,800 per year.

The CHAIRMAN. That is Carl Albert's district?

Dr. DONAHUE. Yes, sir. We are doing well but we have to get some help.

The redefinition of the personnel whose salaries would be eligible for Federal matching funds to include secretarial and other personnel is of the greatest importance to the many centers that have been strapped of the needed administrative backup because Federal funds were restricted in these areas.

As you know they only pay now on professional and not technical help and we have many problems in trying to define who is professional and who is technical.

The American Psychiatric Association has been deeply invested in the community mental health center program from its outset. Our officials and our membership are convinced that the design and the intention of the program represent an intelligent approach to dealing effectively with the tragic disorders that plague the mentally ill and their families.

But we are also aware that the laudable intent of Congress in establishing the program has been translated into what can only in fairness be called a minor effort. Even though a superb beginning has been made, it is no more than a beginning. I have told you, at some

length, perhaps even immodestly, of the great changes that are being wrought in my own community by the Federal support that has been available to us. The entire country deserves this opportunity.

What you have before you is a proposal that would authorize the expenditure over a period of years of close to a billion dollars for the care of the mentally ill. Let me close, gentlemen, by reminding you that this sum is considerably less than the States are now spending each and every year to support the State mental hospitals.

Despite the many advances that State hospitals have made, they simply do not carry the promise of meeting the challenge of the mental illness problem in the way that community-based mental health centers can do. With a network of centers across the country, some 2,000 of them, I and my colleagues at the American Psychiatric Association believe, 17,000 psychiatrists believe, that many of the mentally ill who have previously been destined to vegetate for decades in custodial State hospitals can be enabled to lead socially useful, and productive lives in their home communities.

Mr. Chairman, speaking on behalf of the American Psychiatric Association, not only do we support this farsighted bill, Senate bill 2325, but I want to extend to you as the principal author of the bill our deep appreciation for your understanding of what is at stake in its passage.

Without this kind of support we very much feel that the bold new approach that was launched in 1963 will die before 1973. If I may quote the poet, T. S. Eliot, I feel it will die "not with a bang but with a whimper."

Thank you.

The CHAIRMAN. Thank you very much for your very informative statement, Dr. Donahue. I am very proud of the fact that someone from my area, Oklahoma, Texas, Arkansas, who has worked in all three States has added this much of the good that has been accomplished in those States. I appreciate the knowledge of this problem that you have brought to this committee, not only knowledge of the problem of the individuals suffering mental illness but knowledge of the problem of financing this needed health care and your concept of where the resources are in the Nation, whether local, State or national. I think that your knowledge will be of great benefit.

Senator Dominick.

Senator DOMINICK. Thank you, Mr. Chairman.

I am glad to have been here and I am glad to welcome my good friend Harry Schnibbe to the witness table. Are you going to have a statement of your own, Harry?

Mr. SCHNIBBE. I have a few words, Senator.

Senator DOMINICK. Good. Let me turn first to Dr. Donahue and then return.

Dr. Donahue, in your prepared statement you said originally it was hoped that this brief span of Federal support would prove adequate but the revenues that the new centers were hoping to receive from health insurance and public third party payments are falling far short of their expectations. Why?

Dr. DONAHUE. I guess we overanticipated what these incomes would be and also the fact that as we opened up and began to reach out into the communities and admit patients to centers who normally

would have been sent to a State hospital, our admissions have grown to many, many more than we originally expected.

These are people who are from the lower income brackets who do not have an ability to pay and therefore I assume that we could only say that we had hoped that there would be more insurance available.

But these are from the very poor.

Senator DOMINICK. I could see where that would be true of health insurance because you are saying that these people did not have health insurance. What about the public third party payments?

Dr. DONAHUE. These would be in the field of the aged and others we expected and also under title 19 and some of these we are not getting as much of as we thought we would when we initiated the program.

Senator DOMINICK. I was one of the originators of the first mental health clinic that we had in Colorado. We now have a number of them. We were working at that time without any governmental support but working through the school system. Do you work through the school system?

Dr. DONAHUE. We work with the school system.

Senator DOMINICK. Do you get any payment and support from the school districts?

Dr. DONAHUE. Not now.

Senator DOMINICK. Have you investigated this source of revenue?

Dr. DONAHUE. Yes, sir. I have been in Colorado and discussed it with Fort Logan and the other areas there, too.

Senator DOMINICK. And the school districts don't see it that way in your area?

Dr. DONAHUE. Not now. We are hoping that we will eventually come to this business of getting support from them. At the present time we are moving State money in to support this so it is coming out of the State to back it up. We have looked into that, Senator, and it is one revenue that we do feel we may be able to get someday.

Senator DOMINICK. I want to assure you that I think this is an extremely important program but I get a little concerned when we constantly see everybody saying this is something we need done but we have to come to the Federal Government to fund it. I don't think you are going to get the necessary public support behind it if we go that way.

Dr. DONAHUE. I think it will vary. But I have been in State government in mental health. I have been either commissioner or assistant commissioner in a number of States. One of the problems we have in the tax structure in the various States is, of course, the way the tax structure is set up and where the money goes.

It is getting very difficult at the community level to do some of the things we would like to do because of the tax base, the tax base at the community level. They say it is going to the State and the State says it is going to the Federal Government. We run into a lot of this and a lot of it is true.

Senator DOMINICK. Of course it is true and the more we do at the Federal level the less that will be done at the local level.

Dr. DONAHUE. We try to do what we can. This 51 months thing runs our pretty rapidly when you try to organize one of these things in a

community which has a low-income level. They are excellent projects. They are doing the job. But they are not without expense.

The legislators ask me at home if I am going to save money and unfortunately I cannot tell them I am because we are going to see more people. They are sick people. They come in earlier and it is a problem.

Senator DOMINICK. One of the things that the chairman and I probably would not agree on but which I think is behind some of the problems we have in the welfare programs at the moment is that the funds we provide at the Federal level never get down to the recipients, they go into salaries and administrative costs for those running the programs. This is true in the poverty program and in a lot of others. It has been a source of continuing concern to a lot of us.

Yet you advocate that we redefine so that secretarial and other services can be paid for out of Federal funds instead of putting it into the practitioners who will be aiding the people who come to seek your services and help.

Dr. DONAHUE. Senator, I have answered this question many times at home, too, as you might imagine.

Senator DOMINICK. I am sure it is not new.

Dr. DONAHUE. OK, I am a physician, I am a psychiatrist. This gal is taking my notes right now. If I had to write my notes by longhand because I don't have somebody to help I am misusing my time.

For instance, we have an arrangement made with any of the aides or nurses or psychologists or whoever picks up the telephone and receives a call from a patient calling in, they are responsible to see that the patient gets the care.

We are developing all kinds of new paramedical types of operations and we cannot say anymore who is technical and not technical. I spend a lot of my time arguing with the Federal Government over which employee is a technical employee. But I don't think you can do it this way.

A secretary is a very valuable gal to me. If she can take an admission history it is very valuable to me. We have to take a longer look at the scope of these things. If we are going to have Federal matching, why not match on the whole works and not have to worry whether Joan, who is a secretary and on the admission desk, is a technical or non-technical employee.

It gets almost facetious in a lot of areas and I think if we are going to match it on a scale anyway, it doesn't seem to me to make any difference how we did it.

Senator DOMINICK. The point I am making is that we are constantly running into increasing costs as we increase the scope of the Federal backing of the program, without improving, necessarily, the type of services that can be given to the people who need it. This is the problem as I see it.

Now, I just can't conceive of the fact that in Oklahoma you cannot get people to pay for the costs of secretarial and other services.

Dr. DONAHUE. We are paying for them now but it is extremely difficult and if you get down to some of the areas where we are trying to drive—the unfortunate thing is that the places they need the community mental health centers most are the ones that will have the most difficulty funding them.

Senator, I grew up in a town unfortunately with the name of Bugtussle, in the Pittsburg, Okla., coal-mining area. I know the people there. They don't have the money to do this.

Senator DOMINICK. I am trying to develop some ideas here. To date the only idea we've heard is to get the Federal Government to pay more money. I think there are a lot of other ways to approach this. What about the private sector, the Visiting Nurses Association, the American Psychiatric Association, do they contribute?

Dr. DONAHUE. Contribute how, sir?

Senator DOMINICK. In terms of funds or personnel or volunteers?

When Dr. Egeberg was here, he suggested maybe we should have visiting clinics with the doctors going out to areas where people don't have service.

Does the American Psychiatric Association do any of this?

Dr. DONAHUE. In my hospital a great number of doctors give a great amount of time and those who don't contribute their time, they give it at wholesale prices, otherwise I could not operate the places I operate.

Senator DOMINICK. But does the association itself do anything? These are individual doctors? Does the Red Cross contribute or has anybody asked them? Does the Catholic Welfare Association do anything?

Dr. DONAHUE. We have volunteers from the Red Cross.

Senator DOMINICK. Does the Catholic Welfare Association contribute any funds or personnel to help out?

Dr. DONAHUE. Many of these agencies support us with volunteers who are helpful and we are moving out to train volunteers to participate in this type of activity. I would say that the members of the American Psychiatric Association volunteer one whale of a lot of time. In fact I volunteer the State of Oklahoma every day of the week, practically, that I do for the good of the cause and I am sure many psychiatrists across the country are doing the same.

Senator DOMINICK. My point is this, it seems to me we have vast untapped resources. I doubt there has been any real effort to get the various groups that are interested in this to pool their manpower and resources to help out in these type of areas. Instead of just doing it on tax-collected funds, why can't you do it on tax-free funds?

Dr. DONAHUE. I think as we develop these programs that we will, through the use of volunteer people. But there is a point where the law of diminishing return sets in on this, too.

Senator DOMINICK. I am not sure—

Dr. DONAHUE. Do we have in the American Psychiatric Association a distinct program?

Mr. ROBINSON. No, not in the sense the Red Cross does.

Dr. DONAHUE. But our individual gentlemen who practice psychiatry do, I can tell you, because I use a lot of them to help us out in Oklahoma who we certainly don't pay for a lot of this.

Senator DOMINICK. It concerns me that we largely go through a governmental level to fund these programs that we all think are so important and I certainly share in that feeling. I am looking for alternative methods of doing this.

There is a great resource in this country, as a matter of fact it is unique, in these private associations where people are interested in one type of program or other, be it the mental health service, be it the American Red Cross, be it the Catholic Welfare group, all kinds of associations which are desperately interested in trying to do things for people. Yet we never seem to be able to get them to go outside their own bailiwick in order to contribute to the overall problem of mental health in this country. I wonder if anybody has worked on this?

Dr. DONAHUE. I think they have, Senator. We are trying to train volunteers to help in this, and even in therapeutic endeavors as much as we can. We are also trying to train others than the highly skilled professional to pitch in and help.

For instance, in the center we use entirely teams so we are distributing the psychiatric care across a broad base. We are doing all these things to try and come up with less expensive methods of operation.

Senator DOMINICK. You have in your statement: "What you have before you is a proposal that would authorize the expenditure over a period of years of close to \$1 billion. Let me close gentlemen by reminding you that this sum is considerably less than the States are now spending each and every year to support the State mental hospitals."

In the tenor of your remarks I gather that most of the State mental hospitals are not really equipped to handle this mental health problem, and I wonder whether anybody has tried to convince the people in Oklahoma or other States that maybe the State mental hospitals ought to be abandoned.

Dr. DONAHUE. When you think about the program you understand that these are the forerunners, that you must have a continuing care. I am sure that the State hospitals will decrease in size. That we will be able to abandon them in the foreseeable future, I doubt.

There are always going to be the very extremely difficult cases. I pick them up from this community mental health center. They go back into the hospital. In Colorado I was at your Fort Logan and they have the same problems we do.

So we are not going to abandon them. What you are doing, Senator, is reaching down now and getting people who before never were able to get any of this care. You are opening up a whole new ball park but these are sick people and they need it. Why must we wait and wait until they get so very sick? Why not try and head them off early in their disease by having this treatment program in the community?

Senator DOMINICK. I agree with that. As I said I participated in setting up the first one in Colorado. I enthusiastically supported it in my State. We reduced the size of our State mental hospital. We have other community centers around the States which are working with the school districts.

It seems to me this is the way to go. The point I am making, have we tried to educate the public that you need a smaller custodial type place such as the State hospital, and wouldn't it do better to spend money on community health centers than on the State hospitals?

Dr. DONAHUE. Senator, it is a complex thing. You cannot abandon State hospitals until we get community centers covering the whole population. Mike Gorman told you the horrors of our hospitals and I have pictures to document what he saw.

My hospital in Norman, Okla., is down to 1,600 patients. We are still getting them from the community mental health center. I think there are seven levels we need to concentrate on in the United States. We have published this many times.

The first level, if you want to set them up at parameters of defense, the first level of defense is police, schoolteachers, ministers, and people like this. We in Oklahoma trying to train these people to recognize this illness and get them to the proper people. We have police schools. We are working with the ministers, we have programs in the general hospitals and we are also trying others. With the schoolteachers we are trying to get it into their curriculum.

The second group is the court counselors and school counselors.

The third line would be the general physicians. In our medical schools, I am happy to say, most in the United States are now teaching psychiatry in the first 4 years.

Following that come the community guidance centers operating generally in the area of children and problems in smaller areas and served by the community health center.

Next are the private practicing psychiatrist. I think people forget that they are seeing a lot of patients.

Bill Manning a number of years ago did a study that found that the psychiatrist once trained saved the State \$1 million just by being in practice and keeping patients out of hospitals.

If they get through all that line of defense, then they will go to the community mental health center. If we don't win the battle there, then and only then would they go to the State mental hospital.

Senator, we are working in all of these areas to try to develop this, sometimes in a volunteer way and sometimes in a professional way. You cannot have all volunteers. You must have some professional backing.

Senator DOMINICK. What I am urging is the fact that we try to expand the parameters of some of the private associations in this country which get money from contributions which are tax deductible and see if we cannot put them into some of these programs we need.

Dr. DONAHUE. I think the point is well taken but I think we must have the solid framework, then we can nail these other things along side. But first we have to get the framework, Senator.

The CHAIRMAN. Any additional questions from staff?

I thank you again for your papers. I think, Dr. Donahue, the searching questions of Senator Dominick, your answers to them, your long involvement in this program added much to clarify how people are treated, what is needed and how to go about it.

Dr. DONAHUE. You made me feel at home, sir.

The CHAIRMAN. Do you have a statement?

Mr. SCHNIBBE. Yes, sir.

Dr. DONAHUE. I was speaking in the behalf of the Mental Health Association Directors having been one. Mr. Schibbe represents the State mental health program directors in all the 50 States.

Mr. SCHNIBBE. I had just a few words, Senator. Dr. Donahue is the dean of all ex-State commissioners. However, I don't want to upstage him in terms of his Texas credentials.

In terms of everyone having to show Texas credentials at these hearings, I want to mention I was a reporter on the Amarillo Globe News before I did what all good Texans usually do, move to Colorado, where I am still a registered voter.

The CHAIRMAN. When the Senator from Colorado was talking about Federal programs causing too great an expenditure from State funds, I was tempted to say that all the influential Texans who have moved up in the Colorado mountains, that with all those tax revenues, the Senator might not have too much trouble.

Senator DOMINICK. We are glad to have them. If we even out our mountains, we might be as big as Texas.

Mr. SCHNIBBE. Then I went into politics in Colorado and served our mutual friend, Senator Carroll, until he was defeated by Senator Dominick. My job during that senatorial campaign was to see if I could persuade Senator Dominick to continue in his position as chairman of the Arapahoe County Mental Health Association. Having failed in my assignment, Senator Dominick went on to take the Senate seat.

I want to express the regrets of two of our commissioners who would have been here had the hearings been held tomorrow. The change in hearing dates made it impossible for Dr. Alan Miller, commissioner of the Department of Mental Hygiene in New York State and Dr. Eugene Hargrove, commissioner in North Carolina to attend. They could not make it Monday or Wednesday. Tuesday they could have made it. But the hearings were changed, so we lost them.

The CHAIRMAN. Do they have prepared statements to send in?

Mr. SCHNIBBE. I have some comments that were given to me by Dr. Hargrove of North Carolina and that is what I want to give you here.

The CHAIRMAN. We regret very much to do that but we were forced to close it out by the mine safety hearing by the executive session of the entire committee.

Mr. SCHNIBBE. I understand that, Senator, but I did want you to know we are not disinterested in the hearings. It was the commissioners schedules at home that prevented them from coming.

The States are not without interest in the mental health programs of this country. I do want to mention the degree of total involvement in the States in these programs.

Last year in mental health and mental retardation the States invested about \$3 billion in all mental health, mental retardation programs. The amount of Federal involvement in these State and local programs is relatively little. It is a very small percentage compared to what the States put in.

In just three States alone, California, Illinois, and New York, the total mental health program budget last year was \$1.1 billion. In all of the States last year we put \$142 million into community programs. That money goes down to the counties and to community mental health centers.

Senator DOMINICK. That figure for those States, I would presume includes their support of a State hospital in their respective States?

Mr. SCHNIBBE. Yes, primarily State hospitals. It is a variety of things but largely State hospitals support.

What I am doing is just indicating that we have a substantial interest in this whole area, a much greater interest than the Federal Government has at this point.

In relation to centers themselves, the States are very heavily involved in community mental health centers. The centers at this point are growing but still not very large in terms of dollars in relation to the \$3 billion of State investment. For example, Dr. Hargrove from North Carolina, if he were here he would tell you that he contributes 50 percent of the operating support to 16 centers in North Carolina.

The CHAIRMAN. The State puts up 50 percent and the local and Federal Government together 50 percent?

Mr. SCHNIBBE. That is correct.

The CHAIRMAN. That is quite a change from the national average because the testimony we have had is that the national average, the Federal Government puts up 30 percent average over the Nation and the local communities 54 percent and that would leave only 16 percent for the States to raise.

So when North Carolina puts up 50 percent it is making an effort far beyond the average of American States. It must be one of the top States in the Union.

Mr. SCHNIBBE. I think you can play games with all of those figures.

The CHAIRMAN. Is it a poverty area?

Mr. SCHNIBBE. No, it is all over the State. In the States of California and Pennsylvania, the States are putting up 90 percent of local program financing and part of this will go to operation of community mental health centers, too.

I would not say that all community mental health centers would get this much money from the State, but local communities more and more, like the pattern set by Governor Reagan in California, are being given a substantial percentage of money for local programs. In California the amount is 90-10. Ninety percent State money.

The CHAIRMAN. Where does the Federal Government come in?

Mr. SCHNIBBE. When I say a local program, I am talking about a variety of things and community health centers are becoming a growing part of the local program. Community mental health centers are not the only local services, like the mental health clinic in Arapahoe County, Colo. The State is now putting money into that clinic. When they started out it did not.

Senator DOMINICK. I think most of it is going over to Fort Logan now.

Mr. SCHNIBBE. But there is State money going into all of the clinics in Colorado. Some of those clinics are developing into community mental health centers with a much wider range of services and they will, as Senator Dominick suggested, they will be drawing the workload away from the State hospitals and the State hospitals will grow smaller.

However, this does not mean that the State investment in these programs will grow smaller. The State investment continues to grow larger. \$300 million in Illinois last year and I can remember 3 or 4 years ago when the biennial budget in Illinois was less than \$200 million and now it is \$300 million for 1 year in Illinois and a substantial amount of this money is going down to the community, and it will go in greater sums in the future.

The CHAIRMAN. You mean the State of Illinois is putting in \$300 million in 1 year on mental health?

Mr. SCHNIBBE. Yes, sir.

The CHAIRMAN. That is more than we have asked for in any one year of this Federal program?

Mr. SCHNIBBE. That is also true in California and the State of New York is \$500 million.

The CHAIRMAN. So this is just seed money as far as the big States are concerned?

Mr. SCHNIBBE. That is true.

I wanted to indicate that, for example, in Indiana they passed a law last year permitting the State to put 75 percent of the matching money into the community health centers. New York provides 50 to 75 percent of the operating costs of the center, 33 percent of the construction costs.

In construction there are at least 12 to 14 States where they will put money up to construct a center. Usually we are putting money in to operate a center, to pick up costs as the Federal Government phases out. The States are getting hit hard with this cost.

The program is not advanced far enough to where third-party payments, insurance, schools, courts, and so on have picked up a substantial share of the costs. So the States are going to have to pick this up and, of course, that is part of our interest in seeing that the Federal Government does not renege on what we consider to be an obligation that they have. We are not in any way suggesting that you bail the States out of any of this program because our expenses, we foresee, going up and up. But we do ask that the Federal Government carry its share of the burden.

Let me mention two or three other things here that the State agencies support, generally speaking. I can't say that I have polled all 50 States but generally speaking the major States with the big programs all support the preferential matching provisions of your bill providing a better matching ratio for urban and rural poverty areas.

We also support the coverage of all operating costs, that is, as Senator Dominick was suggesting, the secretaries and the nonprofessional personnel. We support the extension of the staffing program to cover all operating costs.

The States also support the provisions of the bill which would provide developmental grants for developing community mental health centers in poverty areas.

We also support the provision of the bill which would increase from 2 percent to 5 percent the administration money for the agency that develops the community mental health center plan in the States. The bill recommends that. We are not about to turn that down.

Senator DOMINICK. Do you know anything that they would turn down?

Mr. SCHNIBBE. We would not suggest 4 percent, would we? Five percent sounds good.

In terms of timing on this measure, Mr. Chairman, again I think it was Senator Dominick this morning who touched on this subject. There are 11 months left before the present law expires and we are hopeful that you will act swiftly on this extension, not next February or March, not in December, but just as rapidly as possible

because any changes in formula in this program take a longtime to work out through the State with the State legislatures. These things always have to be handled with the State legislatures, who usually are the last ones to know about Federal programs that they will eventually have to finance.

In our responsibility toward these centers, in providing money for them, nobody, as all of you know, does this by himself, no State commissioner or Governor does this on his own decision. He obtains this financial support through the State legislature.

The CHAIRMAN. If you will pardon the interruption, the Federal budget will be worked out this fall and submitted to the Congress in January. So that is another reason why we should know now.

Mr. SCHNIBBE. That is right. We need leadtime on the implementation of this legislation. For example, on the extension of operating costs to a 10-year period, as Assistant Secretary Black said, the 51-month period has been found inadequate.

I want to read to you what Dr. Hargrove of North Carolina said in a memo he sent me this morning.

The funds and procedures indicated in the bill would allow for the development of mental health programs and relate such programs to existing regional hospitals and alcoholic rehabilitation centers. The experience of this project in joint programming with the community health centers indicates that a much longer period than 4 years is needed to determine and stabilize the fiscal support at the community level.

This was Dr. Hargrove of North Carolina.

The CHAIRMAN. Would you like to put his entire statement in the record?

Mr. SCHNIBBE. I will.

(The statement to be furnished follows:)

STATEMENT OF EUGENE HARGROVE, M.D., COMMISSIONER OF MENTAL HEALTH,
STATE OF NORTH CAROLINA

North Carolina is basically rural in its economy resulting in substandard incomes and a low tax base. The same principles apply to our urban poverty areas. This results in a situation where the greatest demands for mental health services are where local tax base is lowest. The effect of this is a marked decrease in the number of applications for construction and staffing funds. The discrepancy between the need for mental health services and the ability of the community to carry the financial burden (low tax base) is compounded by the fact that construction costs and salaries continue to rise. Qualified personnel are reluctant to accept and maintain positions in such areas since they perceive the possibility of local budget cuts when federal funds cease. Despite this, the local communities have continued to contribute heavily toward the funding of our jointly operated mental health programs. This is not a situation which the communities think can continue. Under the present matching formula, the federal portion of the total North Carolina mental health budget is 1%.

The increase in funds from 2.0% to 5.0% for administration of the state construction plan appears necessary for continued assurance of the wisest use of available funds. This appropriation would insure that the projected needs of the community are considered prior to initiation of the construction.

The funds and procedures indicated in the Bill would allow for the development of mental health programs and relate such programs to existing regional hospitals and Alcoholic Rehabilitation Centers. The experience of this Department in joint programming with the communities during the five year period, 1963-1969, indicates that a much longer period than five years is needed to determine and stabilize the fiscal support at the community level.

As Commissioner of the Department of Mental Health for North Carolina, I wish to endorse Bill 2523. I believe the increased benefits in this Bill will aid considerably in advancing provisions for supporting community based mental health services. In my opinion other states face similar circumstances and would welcome relief provided by increased Federal aid provided for in this Bill.

Mr. SCHNIBBE. Now, regarding another subject that Senator Dominick brought up, seed money, I can speak for at least a dozen or so States where I know the commissioners would come in here and say to you today that they have about had it with Federal seed money. What they feel is now necessary is at some small level, maybe 25 or 30 percent, continued Federal support on these programs.

The whole seed money concept has given the States nothing but an enormous headache. Colorado is a good example. The department there—our mutual friend Dave Hamil and I have spoken about this many times.

Mr. Hamil was the director of institutions for the State of Colorado. The mental health program came under him. At the urging of Dr. Hans Schapire in Mr. Hamil's agency we sat down with the Council of State Governments, the National Governors Conference and ACIR, the Advisory Commission on Intergovernmental Relations, and we hope that we can work with them and persuade the Congress and the Federal agencies here in Washington to consult State legislatures and State agencies in advance before any new Federal programs are originated which require a substantial amount of State investment.

We hope that if new programs are going to be seed money programs where you people put in a few dollars and expect the States and local communities and private agencies to use that money to get something started and then pick up the total cost of the program later, in programs of that type it is our feeling, and I am certain it is the feeling of the Council of State Governments, the National Governors Conference and the ACIR, that intensive prior consultation be engaged in with representatives of the legislature and representatives of the Governors so that the States can anticipate these programs and the amount that the States are going to have to put up over a long period of time. When the Federal Government phases out of these programs we are stuck with the bill. The States are not trying to evade responsibility for this community mental health center program, but I think you can safely say that a sizable number of States now see necessary a continued Federal involvement in programs of this type.

I realize, Senator, your bill provides Federal participation for 10 years and for a variety of political reasons, which we all understand, we cannot sit here and call for a total Federal involvement forever in this program. But eventually this is the sort of thing that is going to be necessary, continued involvement by the Federal Government because there will always be involvement at the State government level.

Short of permanent involvement at a 30-percent level, the States right now would support Senator Yarborough's 10-year provision in the bill.

That is all I had, Mr. Chairman.

The CHAIRMAN. Any questions, Senator Dominick?

Senator DOMINICK. I just want to say once again as I have on many occasions to Mr. Schnibbe that I think he has highlighted some things which are of great significance in our Federal-State relationship. This is one of the problems we face both here and in the States. We have more control of it here than the State does because they don't know what we are going to do until we have done it and they get caught in the trap.

I congratulate you in bringing this to light once again.

The CHAIRMAN. Do you think the incidence of mental illness in America has increased in this generation vis-a-vis the last generation?

Dr. DONAHUE. I think you have to take two looks at it. No. 1, the increase in the population, whenever you get an increase there is an increase in the illness. Second, the generation we know now are used to looking up a psychologist or a psychiatrist or somebody for their problem so the increase in the size of the population and this ability to seek psychiatric or psychological help which a generation ago they did not do.

The CHAIRMAN. A generation or two ago that was considered a great reflection on a person to seek psychiatric help.

Dr. DONAHUE. Yes. Since World War II when masses of people learned that there are people you can go to, it has become more popular.

Surely, I think because of the tensions of things and the modern fast-moving society, I think we are seeing more mental illness. I don't think it is a great amount but I think it is increasing.

The CHAIRMAN. Fifty years ago in American life when you dealt with horses and cattle and not machinery, it wasn't as conducive to mental illness was it?

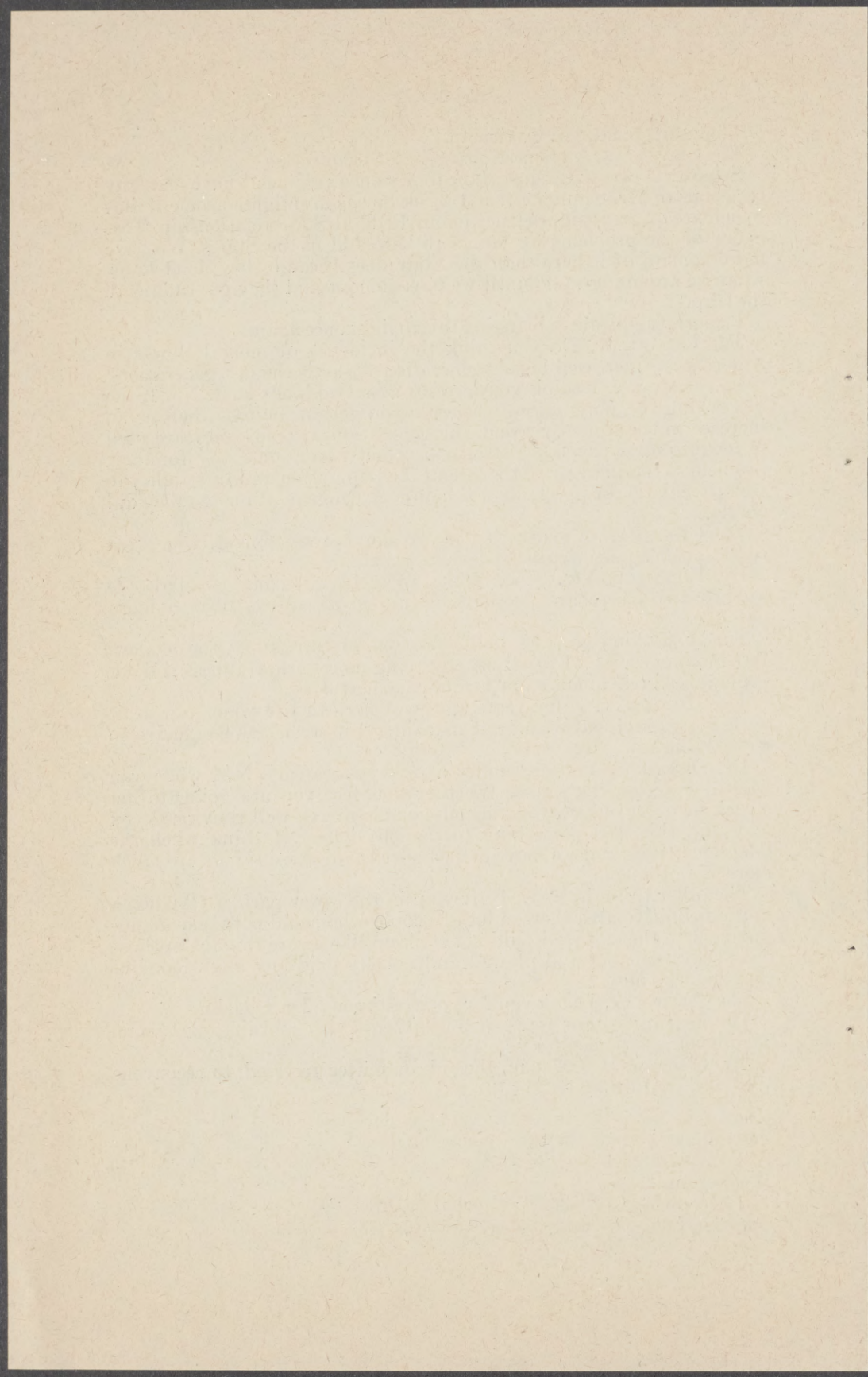
Dr. DONAHUE. You are under a pretty stressful world when you walk out across the street. Whether you feel you are going to get struck by a car or not, your unconscious is pretty well convinced you may and this does something to the physiology. I think when the telephone rings and we move at fast speeds, all these things are much more of a problem.

The other thing is, when I grew up in the lower part of Oklahoma in the primitive area there, a lot of people who could not make an adjustment in the culture would not stick up like a sore thumb. In those days they went out and plowed and nobody paid any attention. But they show up now.

The CHAIRMAN. Thank you for your testimony, Dr. Donahue.

The hearing is now recessed until Wednesday morning at 10 a.m. Thank you, gentlemen for your patience.

(Whereupon, at 3:57 p.m. the subcommittee recessed, to reconvene Wednesday, July 30, 1969 at 10 a.m.)



COMMUNITY MENTAL HEALTH CENTERS AMENDMENTS OF 1969

WEDNESDAY, JULY 30, 1969

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to recess, in room 4232, New Senate Office Building, Senator Ralph Yarborough (chairman of the subcommittee) presiding.

Present: Senators Yarborough, Dominick, and Hughes.

Committee staff present: John Forsythe, general counsel; James Babin, professional staff member; and Jay Cutler, minority counsel.

The CHAIRMAN. The Subcommittee on Health of the Senate Committee on Labor and Public Welfare will resume on the Mental Health Amendments of 1969. First witness this morning, and we will call as the first witness the witness from Senator Dominick's home State of Colorado, Dr. H. G. Whittington, director of psychiatry, Denver Department of Health and Hospitals, Denver, Colo.

Is Dr. Whittington present? Come around, sir. Take the witness chair there by one of those mikes and I will yield to the Senator from Colorado.

STATEMENT OF DR. H. G. WHITTINGTON, DIRECTOR OF PSYCHIATRY, DENVER DEPARTMENT OF HEALTH AND HOSPITALS, DENVER, COLO.

Senator DOMINICK. Mr. Chairman, I am delighted to have your thoughtful courtesy in enabling Dr. Whittington to testify first. I do have to go to an executive committee meeting and then I have another committee meeting after that.

Dr. Whittington and I have been discussing some of the conditions as far as the mental health services in Colorado are concerned. I think his testimony is going to be of great interest to this committee.

Dr. Whittington, I want to thank you for giving us your time to come back to Washington and give us this testimony. It is not easy in the job that you have, and I want to congratulate you on the fine planning work that is going on in the whole metropolitan area of Denver as far as mental health centers are concerned. We welcome your testimony and look forward to hearing it.

Dr. WHITTINGTON. Thank you, Senator Dominick and Senator Yarborough.

I am pleased to testify on behalf of S. 2523, which is vital to the success of our national mental health program.

I am Dr. H. G. Whittington, M.D., director of psychiatry for the Denver Department of Health and Hospitals.

This will not be a calm and intellectual statement, because I am a worried man. For 4 years now I have lived with continual anxiety about the future of our mental health center, dreading the day—as Federal assistance fell precipitously away—when I must tell my first staff member:

We can no longer pay your salary. I'm sorry that we had you bring your family here from Iowa, and that after working so hard we now have to lay you off. But that's the way the cookie crumbles.

Human beings work in the center, not automatons. Human beings who have abandoned many of their professional privileges and who have committed themselves to making their country a better place in which to live, to enhancing the quality of human life in this generation, to conserving our human resources. They deserve your attention and concern, for what they have done already in lifting our Nation from the most backward in the civilized world in terms of public mental health services, is truly remarkable.

The comprehensive community mental health center is the most effective mental health service delivery system that has existed in the United States. Experiences in Denver, and elsewhere throughout the Nation—as you have heard and will hear from other individuals testifying before you—indicates clearly that a national network of comprehensive community mental health centers will assure care that is more available, more comprehensive, more continuous, of higher quality, and genuinely of more usefulness to our citizens than that provided by any preexisting system.

If this legislation is not passed, the future of the mental health program in Denver, and nationally, is in grave jeopardy.

Here is our current fiscal dilemma in Denver:

Even at the maximum Federal support level of 75 percent of professional and technical personnel, only 40 percent of the total mental health center budget is covered. By the last year of Federal support, only 10 percent will be covered.

The Colorado General Assembly this session failed to appropriate sufficient funds to maintain any of the mental health centers at their present level, as Federal support declines. At present, only 15 percent of our total budget comes from State funds.

Stringent limitations on title XIX in Colorado severely limit that as a potential for income.

Blue Cross continues to discriminate against the mentally ill and alcoholics, and to encourage bed care—the most expensive and least effective modality of psychiatric treatment—over outpatient and day treatment.

Senator DOMINICK. Would you stop there and tell me what you mean by that?

Dr. WHITTINGTON. Blue Cross and Blue Shield, in many States, in many plans, will allow only a limited lifetime coverage for inpatient treatment of alcoholics and no coverage for outpatient treatment. Limitations also exist for the mentally ill, depending on what State it is; and again the treatment can occur only in a bed, in a hospital, and with stringent limitations on duration.

The limitations are more serious with alcoholics now than with the mentally ill. The psychiatric situation has improved some under Blue Cross. The alcoholic problem has not improved so far.

Senator DOMINICK. So this is part of the coverage that is offered in the group plans of the individual contracts; is that what you mean?

Dr. WHITTINGTON. That is correct.

Senator DOMINICK. So in order to change that around, you would have to get them to change their contractual agreements with the companies or with individuals?

Dr. WHITTINGTON. That is correct.

Senator DOMINICK. So we are not in fact talking about operating discrimination, we are talking about the form of coverage they are offering?

Dr. WHITTINGTON. That is right.

The CHAIRMAN. Dr. Whittington, I might say that from other testimony on health subjects and other subjects before this committee this year, there is a considerable body of testimony about how the insurance policies have influenced health care in America and actually obstructed the health care being brought to the people of America by the provision that they had to be hospitalized before the policies applied, and we have had considerable body of testimony about how many more people could be treated better if they weren't hospitalized for certain types of illnesses.

In other words, the way that the private insurance policies are written is determining how health care is operated in America, and there is considerable testimony that it is being operated too expensively and disadvantageously to the patients in many cases. The doctors can't prescribe what is best; most people have no money outside of insurance to buy this health care and if a person is going to get any treatment whatsoever, doctors have to prescribe what will come under the insurance policy.

Dr. WHITTINGTON. Quite true. In Denver General Hospital it only costs \$18 a day for day hospital psychiatric treatment, which Blue Cross will not pay for, while it costs \$48.50 for in-patient psychiatric treatment. So very often the decision made tends to be in terms of what it covered rather than what is the optimum and least expensive treatment.

The CHAIRMAN. The medical treatment either prescribes what is covered or dooms the patient to no treatment at all.

Proceed, please.

Dr. WHITTINGTON. The city of Denver is barely able to meet its current irreducible obligations. No significant increase in local support is likely, since Denver already invests more tax funds in its mental health program than does any other jurisdiction in Colorado.

Less than half of our patients pay any fee at all, and fewer than 10 percent pay a fee equal to the cost of the service.

I come to the recommendations that I make in this testimony not casually, but as someone who has spent 14 years in public service attempting to bridge the gap between our scientific understanding of human behavior, and the need of ill and unhappy citizens for effective and available assistance in understanding and modifying their own troubled thoughts, feelings, and behaviors.

When still in medical school in Houston, I became impressed with the enormity of the mental health problems in all patients—but so appalled at and frightened by the dreadful conditions that existed even in psychiatric teaching centers in Texas in 1951 and 1952, that it took me 3 years after receipt of the M.D. to gain courage to decide to make psychiatry my career.

In my training at the Menninger School of Psychiatry in Topeka, I worked in a Veterans' Administration hospital, a State psychiatric hospital, a State hospital for the mentally retarded, a State training school, an alcoholism treatment service, and a community child guidance clinic, as well as at the Menninger Foundation.

I subsequently directed the mental health program in the student health service at the University of Kansas. I then held responsibility as director of community mental health services for the entire State of Kansas, and during my tenure there established 12 additional mental health clinics, and completed the State mental health and mental retardation planning project, supported by funds appropriated by Congress and administered by the National Institute of Mental Health. And throughout these years, I have engaged in the part-time private practice of psychiatry as well.

I came to Denver 4 years ago to develop a comprehensive community mental health program for the city and county of Denver. I did this because of my belief that urban problems and urban issues are demanding of the attention of all of us, and because mental health problems and the need for improved mental health services are both great in an urban setting.

In Kansas, I had demonstrated that with sound planning and effective leadership areas of sparse populations can be served effectively. In Denver, I wanted to conduct a field experiment to determine if the strengths of the small town mental health clinic, with its availability and visibility, could be replicated in the complicated social agency structure of a major American city.

For reasons that were partly professional, but largely had to do with my own family background, I wanted to demonstrate that a high quality public mental health program could be offered the poor people living in the central city—and that they could and would utilize such assistance effectively to help them live better lives and to obtain a better future for their children.

With the help of the National Institute of Mental Health and other Federal agencies, and with the active support of city government, and of the Mental Health Association, we have developed in Denver an extremely effective community mental health program which melds local, State, and private endeavor, and utilizes Federal support and assistance from the National Institute of Mental Health, the Office of Economic Opportunity, Rehabilitation Services, United States Public Health Service—and beginning in September—the Model Cities program.

I followed with interest the discussions Monday about the proposed combination of categorical grant programs into a single system. While I do not object to efficiency and avoidance of duplication, I should like to point out that there are strengths, as well as liabilities, to our present categorical grant system.

Interaction with representatives of various programs, each in an area of special interest and expertise, enriches—as well as at times frustrates—the director of a local program. My experience is that most proposals for coordination through the establishment of some new supersystem, results either in a plan that gathers dust, or in the substitution of technocracy for democracy, or neatness for creative change.

Any competent and dedicated professional can function quite well in the existing system to develop an improved service delivery system for his community. I wonder if a new system, with a single grant-in-aid czar, would function as well.

The city and county of Denver, and the surrounding suburban counties that make up the greater metropolitan area, now have a network of fully operational comprehensive community mental health centers, each serving a defined population group living in a geographically circumscribed area.

Within the city and county of Denver, the investment of public moneys is greatest in those areas of the community having the lowest socioeconomic standing, and with the highest indexes of personal and social disability.

What does this mean for the citizens of the city of Denver?

It means that each year, over 6,000 of them will newly enter our service delivery system at some point, complaining of thoughts, feelings, or behaviors that are troubling to them or disturbing to significant others in their life environment.

It means that they will be offered service promptly, in a facility located in their own neighborhood.

It means that they will pay only if their resources permit it, and then a fee that is based upon their ability to pay.

It means that they will be cared for by professionals that live in the community, participate actively in all phases of community life, and are dedicated to assisting people maintain adequate personal and social functioning.

It means that over 400 caregivers in the city and county of Denver—welfare workers, teachers, school social workers, visiting nurses, ministers, family physicians—receive regular consultation from members of our community mental health staff, to assist them meet the emotional needs of their patients and clients more effectively.

Again, the intent is to see that assistance is delivered early, without the unnecessary stigmatization that occurs when someone is labeled a “mental patient;” and to insure that the full capability of all sectors of the community is fully utilized.

Because of our unitary administrative structure in the Department of Health and Hospitals, it means that instead of needless duplication and waste we are able to combine the resources from several Federal programs and local voluntary services, in an integrated neighborhood health system and community mental health program that addresses itself to the prevention of mental and emotional illness through such programs as improved prenatal care, well-child care, family counseling and assistance, and so forth.

Thirty private practitioners of psychiatry are members of our mental health center medical staff, and have full access to all phases of our program for their patients, for whom they continue to assume medical responsibility.

It means that individuals who experience severe emotional illness need no longer face the alternative of being hospitalized, or getting no effective help. The individual may, for example, attend the day treatment program at Denver General Hospital, and continue nights and weekends to be with his family.

Furthermore, the individual may be in outpatient care, but receive necessary assistance through regular home visits from the visiting nurse, from indigenous mental health workers, from volunteers, from homemakers, from other community caregivers, in order to help the patient maintain adequate role functioning as a parent during a period of psychiatric illness, until such time as she or he is able to recover and reach independent adequacy.

It means that even before the completion of our new mental health center, when we have only 16 beds available for a community of over 500,000 that we have been able to reduce by over 50 percent the transfer rate from our program to the Fort Logan Mental Health Center, the State hospital serving Denver.

Less than 2 percent of the patients entering our mental health system in a year require State hospital services even now. Thus, fewer people are faced with the alternative of leaving home and community, and entering a State psychiatric facility. With the completion of our new hospital within the next year, utilization of State psychiatric facilities will undergo another drastic reduction, as we treat all psychiatric casualties at the community level.

It means that the many patients who were turned out of the State hospital at Pueblo in the great hospital reform 9 years ago, are no longer abandoned to a cheerless existence in dozens of private boarding homes, where the State has chosen to subcontract its "back ward" business. Members of our teams, the Denver Visiting Nurse Service, and volunteers recruited and trained by the Mental Health Association, now provide counseling, medical and psychiatric assistance, and socialization and recreation to these unfortunate, chronically ill individuals who return to the community after years of custodial care in State institutions.

It will mean, with the arrival of model cities funding, that in Denver simple public drunkenness need no longer be cause for arrest, booking, and the degradation of a night in the drunk tank. It will mean that all cases of simple public drunkenness, or loss of adequacy because of the use of other intoxicating substances, will become the concern of the Denver Department of Health and Hospitals, rather than of the police department.

Individuals will be picked up by our own transportation system, will be housed in a medical withdrawal facility, will receive adequate medical care, and will be offered continuing medical and psychiatric treatment and a variety of supportive and rehabilitative services.

It means that mentally ill people no longer have to be housed in jail. In Denver, in cooperation with the police, a medical ward now provides a resource for diagnosis and treatment planning for disturbed individuals from city and county jails.

If this is all so good, this community mental health center, the committee may well wonder why such major assistance as requested in S. 2523 is required. The reason is very simple.

The community mental health center is such an advanced concept, so much challenges and threatens preexisting service delivery systems, that in some localities it is, as yet, lacking in support at the level of State government.

Congress, through enacting construction and staffing legislation for comprehensive community mental health centers, has chosen to truly lead the Nation, developing solutions to national problems on a national scale. I, for one, am most grateful that Congress took these steps, initiated these programs.

The psychiatric professions, and the mental health service delivery systems of this country will never be the same again. They have all been shaken and reshaped, in the few brief years that have transpired since John F. Kennedy's message to Congress concerning our national priorities for the conservation of human resources by a new mental health and mental retardation program, and the subsequent launching of Federal assistance.

The concept of the community mental health center has gained broad national support from such groups as the American Psychiatric Association, American Psychological Association, American Public Health Association, et cetera. But it has also necessitated change, and there have been—as there always are—pockets of resistance to change.

Congress has said, to the medical schools and other training programs—

You must train professional people that are more relevant, that are more capable, that are more dedicated to the public good, and less concerned about professional privilege.

To the State hospitals, and the State mental health authorities, Congress has said—

You must lower the drawbridges to your castles, and come out and mingle in the cities and in the small communities with the people.

To the national and local associations for mental health, Congress has said—

You must recognize that your years of effort to reshape the State hospital system, while yielding much good, have failed to make that system a viable or popular institution with the American people. You must develop citizen understanding of and support for community-based mental health services.

Such messages are seldom popular ones, for they mean that people must change, they mean that the old order must give way, they mean that new institutions and new leaders must and shall arise.

The comprehensive community mental health center is as popular to the child guidance clinic, as the first supermarket was to the mom and pop grocery store.

The comprehensive community mental health center is as popular to the private practitioner of psychiatry, psychology, or psychiatric social work, as the first department store was to the operator of a specialty shop.

The comprehensive community mental health center is as popular to the directors of some professional training programs, and to some State mental health program directors, as the airplane was to the Army before the First World War.

Technological innovations, and social change, always bring about resistance. If all the comprehensive community mental health centers of this country are expected to rely heavily upon support from State government, which in some States is influenced and guided by the attitudes of a reactionary State hospital cabal, many community mental health centers will die.

As I have stated earlier in my testimony, the Denver program obtains only 15 percent of its total support from State government. While \$24 million in State funds go to support State mental hospitals, only about a million dollars are allocated for the entire State in support of community mental health services.

If the centers are to rely on patient fees, they must exclude the poor. If they are to rely on medicare and medicaid, they must exclude the young blue- and white-collar worker whose income renders him self-sufficient but psychiatrically indigent.

And, if the centers rely on either of these sources exclusively, they must abandon much of their consultation and education service, and hence their potential for preventing mental illness.

I am here speaking to this committee, because I am convinced that the comprehensive community mental health centers of this country, the central facility in the first real national mental health program that our Nation has ever launched, can turn only to Congress with any assurance of reasonable understanding, of reasonable support, of adequate financial participation. This committee, in deciding whether to recommend favorably on S. 2523, is deciding, in my judgment, the future of the national mental health program of the United States.

There are, as I see it, only two ways to insure the survival and continuing necessary growth of comprehensive community mental health programs, both in the cities and in rural and small town areas.

The first approach is through passage of such legislation as S. 2523. This contains the necessary ingredient of a longer period of support, which allows the opportunity to wear down conservative and reactionary forces in the mental health establishment at the State and local level, and to present our case to the citizens, in order to insure adequate continuing support from State and local sources. It also contains allowances for a heavier level of financial participation for rural and urban poverty areas, which is essential if the needs of citizens in such areas are to be adequately met.

The second, alternative approach would be the passage of a universal medical insurance program for all citizens, providing fully adequate benefits for all modalities of psychiatric treatment. This would insure the survival and growth of the comprehensive community mental health center system, since that system has the characteristics that American citizens have always chosen when they had freedom of choice. It is convenient, located near their homes. It is dedicated to meeting their needs, not imposing values or behaviors upon them.

Because of increased efficiencies due to better utilization of all categories of personnel, the cost is less for the consumer. Because of the scale of the operation, the range of available services is greater, giving the consumer more options than he may exercise.

Because the service is located in the community, and because it serves individuals of all degrees of personal problems—ranging from parental concern about bedwetting in a child, to marital adjustment problems, to serious psychiatric illness—the individual is not stigmatized or labeled as a mental patient by utilization of the service.

If universal medical insurance were in effect, then, and the citizen did indeed have freedom of choice about where he would obtain needed psychiatric services, the State hospital system of this country would very quickly cease to exist. The State hospital system, which absorbs such a disproportionate share of the resources of State government, can be sustained only by restraint of free competition.

What citizen would choose, if given the choice, to go to a State hospital rather than to a local mental health facility? He will go to the State hospital only if the cost is less, the physical facilities of the State hospital are clearly better, if he is unaware of the existence of the local service, or if antiquated judicial procedures force him to utilize a State rather than a local service.

If universal medical insurance does become the law of the land, then, I am certain that comprehensive community mental health centers will compete effectively with preexisting service delivery systems. The private practice system in psychiatry, including the office practitioner and private psychiatric hospitals and units, will continue to flourish and will be the treatment choice of many citizens.

The comprehensive community mental health center will become the choice of many other troubled citizens. But the State hospital system, once freedom of choice is given to the consumer, will be steadily eroded and will decline.

For the present, however, we cannot rely on utopian dreams, whether they be universal health insurance or consolidation of grant programs or comprehensive health planning. Rather, a clear and effective response to the real and present danger to the maintenance of the community mental health center program must be forthcoming from this Congress.

I hope that you have heard in my comments not only the words of an idealist and of a socially concerned professional person, but also the words of a public servant and a pragmatic utopian, who has been busy all of his professional life in achieving the attainable while continuing to pursue the ideal.

Senate bill 2523 is not a farfetched scheme or the work of some visionary dreamer. It is the kind of help and assistance that I, and men like me all over the country who are running comprehensive community mental health programs, need, as a minimum, if we are to make really good mental health services—not only treatment services, but also preventive mental health services, and rehabilitation services—fully available to every citizen in every town, in every county, in every city in the United States.

Within 10 years, the United States can move from having one of the worst public mental health service delivery systems in the civilized world, to having the best. This late starting and rapid progress is characteristic of our country, whether we are preparing for war, or sending men to the moon.

If Congress gives us the mandate, and the necessary financial assistance, my colleagues and I in community mental health will deliver a national mental health program of which we can all be proud, and for which troubled citizens can be grateful to you for having made possible.

It is my earnest hope that this committee reports favorably on S. 2523.

I thank you for your time and your interest, and will be pleased to answer any questions from the committee.

The CHAIRMAN. Dr. Whittington, I think your argument is irrefutable and I thank you for taking the time to come. You might be interested in knowing that the day before yesterday, during the progress of the hearing, the ranking member of the minority party of this committee, Senator Javits of New York, joined me in cosponsoring this bill, which I think adds to the probabilities of passage.

Senator Hughes.

Senator HUGHES. I would be glad to temporarily yield to the Senator from Colorado, since the witness is from his State.

The CHAIRMAN. Senator Dominick.

Senator DOMINICK. Thank you, I appreciate that.

Dr. Whittington, in your prepared statement you say that any significant increase in local support is unlikely. What about the school system? We have been able in many areas of the State to get support from the local school systems. Is this true in Denver?

Dr. WHITTINGTON. It is not true in the city and county of Denver, Senator. It is true in Arapahoe County and many of the suburban counties. The school system of Denver is so burdened with financial and social problems that it is very difficult to get anything out of them. They are being hard-pressed to meet basic educational needs in the classroom without additional services for disturbed children, plus we have the additional problem that logistically there are simply many more disturbed children in the school system in the central city, so that the scale of financial support needed to mount a mental health program for children is much greater in the central city than in the suburban area.

Senator DOMINICK. So in effect what you are saying is that the psychiatric problems with which you are faced increase in areas of concentration of population.

Dr. WHITTINGTON. When we get concentration of population with high prevalence of disorganized and incomplete families in the central city.

Senator DOMINICK. This has been my opinion for a long period of time, which is why I have constantly been advocating decentralization of both cities and industries as much as we can. I think it would decrease some of those problems and would also increase the viability of many of our rural areas which are now in trouble. So I am happy to have some reinforcement on that.

You spoke about having some doubt about consolidating categorical grants, which is one thing we have, of course, been considering. Later on, you go into the fact that you have an unitary system in the Denver Department of Health and Hospitals which is over the mental health programs in the cities where it is consolidated. You don't really find too much problem with that, do you? As a matter of fact, it is pretty good from your point of view?

Dr. WHITTINGTON. Our consolidated system in Denver allows us to funnel the programs into a single neighborhood-based system, which is an advantage to the recipients. I might point out that even in Denver the department of health and hospitals is really only a part of the total health system. Even in Denver the private sector and voluntary sector are both large also, so we don't have anything like total control over all health activities in the city and county of Denver.

For our part of it, we have a unitary system; but not for the entire city area.

Senator DOMINICK. Your real concern for consolidation is that there might be a cutback in total funding?

Dr. WHITTINGTON. That thought crossed my mind. I have some other concerns also, though, in terms of the fact that the Federal activities in grant-in-aid programs are so enormously diverse and complex at this point, I really question how rapidly this consolidation could take place. My concern is that it would really tax the administrative skills of most people to try to put all of this into one system right now.

Senator DOMINICK. Doctor, for the purpose of the record, I think we should point out that Fort Logan, which is located in Arapahoe County and Jefferson County, right near where I live, does, even though it is a State institution, have a large degree of outpatient care. It is not a custodial type mental hospital.

Dr. WHITTINGTON. No; that is quite true, Senator. I didn't mean to give that impression. Fort Logan is an advanced hospital and participates with us and many other community mental health centers in the State in providing services.

Senator DOMINICK. As a matter of fact, what you do through your community mental health center is to have your visiting teams visit people that perhaps the center is not now equipped to handle and take them out to Fort Logan, is that correct?

Dr. WHITTINGTON. The patient who needs inpatient or day treatment goes to Fort Logan. What the centers accomplish is an avoidance of unnecessary utilization of expensive forms of treatment and also provides more convenient capability for aftercare, after people leave the hospital, after they leave inpatient care.

Senator DOMINICK. We have had quite a dramatic drop in the number of patients at Pueblo and this is also because of the institution at Fort Logan and outpatient care that you can get at Pueblo State Hospital. Is that true?

Dr. WHITTINGTON. Yes; at this point Pueblo serves the area of the State exclusive of the city and county of the metropolitan area, and the State hospital at Pueblo now does have visiting teams that provide services in the smalltown areas.

Senator DOMINICK. So our State hospital system as such, even though you point out that it gets a lot of support from the State government, is in fact providing quite a lot of services in the mental health field?

Dr. WHITTINGTON. That is correct.

Senator DOMINICK. I just wanted to make clear for the record that our State hospital system is not totally outdated and antedeluvian.

Dr. WHITTINGTON. I should have made that clear. I was not talking about the Colorado State hospital system.

Senator DOMINICK. We have some problems in our Federal budgets as well as the State budgets, and sitting as we do here in committee where we are dealing with the welfare programs, the educational programs, the veteran programs, the health programs, and variety of others, practically every witness that comes in perfectly naturally, perfectly normally desires the emphasis placed on their program. Somehow or other, we have to establish some priorities. Where do you feel that educational support fits in with the mental health programs?

Dr. WHITTINGTON. I think honestly if there were not enough money to go around, it should go first to education and not to mental health. It would be my hope there would be enough that both could take place. One of the problems that the urban schools are facing is that much of the educational effort is being wasted, because many of the children are simply not learning. A third of them never even finish high school even in a good system.

So we have a lot of evidence that education without attention to impairment of learning ability, caused by emotional problems, is probably wasted money, about a third of the kids don't learn and don't get anything out of school, they drop out, and end up as delinquents.

It would be my hope we would have sufficient resources in this country to do both.

Senator DOMINICK. I would hope we would, too. I am not sure that we do at the present time.

I brought up the point with Dr. Donahue, and I think you were in the audience at the time, on the importance of trying to get the voluntary associations involved in these mental health programs. What luck have you had in that regard? What has occurred in that effort?

Dr. WHITTINGTON. We have had very mixed success, really. We have been successful in having a private, church-related psychiatric hospital assume responsibility for southeast Denver, but only because there were available Federal construction and staffing funds to assist them to get started. So one private group has moved into the public sector.

Senator DOMINICK. That is Bethesda?

Dr. WHITTINGTON. That is Bethesda Hospital, right.

Senator DOMINICK. But they put up this facility through their own funds.

Dr. WHITTINGTON. About 50 percent of construction funds were their own funds. Our success in getting both national foundation support and local foundation support to help with relocation of alcoholics who are going to be displaced by our urban renewal projects has been less favorable, however. We have not been successful in getting a sufficient level of support to mount a program in that area.

Some of the suburban counties have also attempted to utilize voluntary giving. Adams County tried very hard to get enough money to buy furniture for their new center and had great difficulty. Boulder County has been trying privately to raise for 2 years enough funds to match a Federal construction grant, and so far has not been successful in doing that. So we have had very mixed success at this point in terms of voluntary involvement.

Senator DOMINICK. Continuing efforts are being made along that line?

Dr. WHITTINGTON. Yes, they are.

Senator DOMINICK. Do you know, and I don't know and that is why I am asking the question, whether or not community health centers form a part of the complex beneficiaries under the Mile High Fund or United Fund?

Dr. WHITTINGTON. At this point none of the comprehensive centers receive United Funds in Denver. The Denver Mental Health Center, an outpatient clinic, is a recipient of United Way assistance. The problem we run into, is that in Denver the increases in united giving each year barely keep even with the increase of cost of services. So in Denver, at least in the metropolitan area, there have been no expansion of United Way programs for a number of years now. They are just barely keeping even.

Senator DOMINICK. You indicated to me, as I understood it in our conversation, that you found some difficulty in getting voluntary funds because of the fact that the Federal Government was now involved in paying people for these services.

Dr. WHITTINGTON. That is correct. We have two problems there, which I think really have to be admitted and faced up to. One is that practicing psychiatrists are no longer willing, and I think this is probably a national problem, to provide voluntary services. They say that with third party payment systems, and Government involvement they expect to be paid on a fee-for-service basis. The second problem is that many of the volunteer foundations have gradually abandoned the mental health field, in terms of their major emphasis in the last few years, on the basis that Government funds are available in this area, and they feel there are other areas that are insufficiently supported by Government. So attempts to gain foundation funds are much more difficult nowadays.

Senator DOMINICK. So there is some correlation at least in the fact that the more the Federal Government gets into these programs, the less the volunteer associations and people are either volunteering services or funds?

Dr. WHITTINGTON. I quite agree with that. I believe that we are past the point of return in the mental health field. But I am certain this has happened.

Senator DOMINICK. I think your statement has been very helpful and I subscribe to the fact that we need to keep those programs going.

I have been in touch with the administration, as has the chairman, and I know they also feel the same way. The question is the degree of funding that we get for it and this is going to be a difficult problem to resolve. I much appreciate your thoughtfulness in coming and I appreciate the courtesy of the Senator from Iowa and the Senator from Texas in letting me interject myself at this point. I am sorry I have to leave.

The CHAIRMAN. We regret your having to leave, Senator Dominick. Thank you for coming, and for your contribution.

Dr. Whittington, I wish I could be more optimistic about the future, but the bigger war the President promised yesterday in Thailand and the bigger war he promised yesterday in Vietnam have to go ahead. But I intend to pursue this with all of the energy at my command. I agree with you that this comprehensive health insurance nationwide would be better so that these services could be distributed, and I am one of the committee of 100 in a committee supporting and trying to

advertise that plan. Unfortunately, the membership of that committee is not so extensive as 100 Members of the U.S. Senate.

Senator Hughes.

Senator HUGHES. Thank you, Mr. Chairman.

Dr. Whittington, I certainly congratulate you on a comprehensive and obviously well studied statement. I would like to ask you several questions about the general development of a program that you have pointed out. I mean the good points and bad points, and weaknesses and problems that exist in giving the services.

You did mention that you wanted to conduct a field experiment to determine what was the extent of small town mental health clinics could be replicated in the complicated social agency structure of American major city. Are there actually many small town mental health centers that are a way of life in America?

Dr. WHITTINGTON. Yes. Many in Kansas and Iowa, some in Nebraska.

Senator HUGHES. There aren't very many in Iowa. There may be a few but there aren't very many. They function, I take it, better than the city corps centers.

Dr. WHITTINGTON. That is one of the paradoxes, really. In the cities there is an abundance of professional manpower; but the person having a psychiatric emergency problem would get better care, more quickly, in many small Kansas towns than he would in a major metropolitan area. The problem is the small towns have fewer professional people, but they have a system and community care gives know how to get in touch with the mental health services. In the metropolitan areas the professional people are there, but nobody knows how to find them, they only work 40 hours a week, and other hours they are not available.

Senator HUGHES. Does your local mental health center do a great deal of work in the field of retardation?

Dr. WHITTINGTON. Not in Denver. By an accident of history, the legislature established a separate system of community mental retardation boards, and in Denver this is handled by an entirely separate operation. The citizens' mental retardation board receives and distributes State funds for mental retardation services.

Senator HUGHES. You feel they should render the services?

Dr. WHITTINGTON. That the mental health center should? I don't think it is crucial in a city the size of Denver. I think that probably the population and problems are sufficiently distinct so that two separate systems can exist. In the rural area or small town I think it should be a single system simply on the basis of economy. We in Denver are large enough so that separate systems can exist, probably.

Senator HUGHES. You mentioned the inadequacies in the field of alcoholism. You did not mention any treatment facilities at all for the narcotic user or drug abuser. Do you actually perform any such services?

Dr. WHITTINGTON. With our model cities funding we will have not only alcoholism but addiction programs, including drug abuse as well as hard narcotics addiction. The problem of course is that to simply add alcoholism and addiction to our present program, doubles our budget. This is something that really has to be faced; the programs are enormously expensive. It is going to cost another million and a half dollars a year in staff salaries simply to add alcoholism and addiction to our domain of responsibility.

Senator HUGHES. What does it cost not to do it?

Dr. WHITTINGTON. Much more, in terms of personal and social cost. I have no question about that.

Senator HUGHES. Really we ought to look at it as an investment rather than an expense; shouldn't we?

Dr. WHITTINGTON. I believe so.

Senator HUGHES. I am tired of everybody looking at the red side of the ledger and not seeing the credit side of the ledger; what we are doing with the individual when we deal with all of the problems.

The CHAIRMAN. Senator, would you yield for a moment to me?

Senator HUGHES. Yes, sir.

The CHAIRMAN. I am very pleased to hear a Senator and former Governor say that. I know Senator Hughes as Governor of Iowa lived up to that. Too often in government people say they are going to balance the budget; and when they get in, they cut the heart out of funds for health services.

Now people say medicaid and medicare are costing too much. I don't see any articles written in the paper about services the people are getting. Some elderly people are getting the chance to see a medical doctor for the first time in their lives. I think they ought to get to smell some medicine at least once before they die. And we have all of this cry about bankrupting the Government. You don't hear the hue and cry about \$36 billion a year spent in Vietnam.

Thank you for yielding for a moment. You provoked this observation with your perceptive comments.

Senator HUGHES. I agree with it 100 percent, Mr. Chairman. I was more than willing to yield for that purpose.

Without trying to move over any areas or problems you are dealing with, I would like for a moment to deal with neglected areas. We do have a subcommittee dealing in this area of alcoholism and drug addiction. I am interested in it because the typical legislation that we have been considering, is going to delegate this to community mental health centers, the treatment, services, and so on. What percentage of your patients, if you know, in your State mental hospitals are alcoholic?

Dr. WHITTINGTON. At this point they are running about 50 percent of the State hospital admissions. In terms of our community mental health center, about 30 percent of our inpatients are alcoholics, or have a problem with excessive drinking. Some people with drinking problems and drug problems are already in the system; they are not being served very well at this point, though.

Senator HUGHES. In other words, not only is Blue Cross a handicap due to the fact that they require in-bed treatment in these areas but also the State hospital requires more or less an inpatient treatment also. There is no outpatient service for this type of thing; is there?

Dr. WHITTINGTON. There is some. The State hospital serving Denver, and the Fort Logan Mental Health Center, does have an inpatient and outpatient service for alcoholics. The Fort Logan program is qualitatively a good program. Quantitatively it is a drop in the bucket. Four percent of the adult male population in Denver has a serious alcoholic problem. The existing facilities cannot treat all of the people, and I think this is true in most States.

Senator HUGHES. Do you have any alternative sentencing laws in Colorado where you can sentence a man for treatment rather than imprison him?

Dr. WHITTINGTON. Not now. People have to be committed under the mental illness statute.

Senator HUGHES. That is the only avenue that can be followed?

Dr. WHITTINGTON. That is correct.

Senator HUGHES. What about volunteer treatment, people who walk in and want to be entered into a hospital?

Dr. WHITTINGTON. With volunteer admission there is no problem, to the extent that the State hospital system, can absorb them. One of the reasons that we are trying to combine alcoholism and addiction with comprehensive community health centers is so we can provide a full spectrum of service, not only for alcoholics, but also for the spouses and the families. This is the main reason we would like to keep the two systems closely related.

Senator HUGHES. You mentioned intensive care units for alcoholics, such has a detoxification center. Do you have such a unit?

Dr. WHITTINGTON. We do not now. We hope to open it by the middle of October, if model cities funds come through. At this point 12,000 men a year are arrested by the police and booked and put in the drunk tank. And that is half of the arrests in Denver.

Senator HUGHES. That is in the city of Denver, 12,000 arrests, 50 percent of the total arrests are for alcohol?

Dr. WHITTINGTON. That is correct. They are now put in jail and we hope to take all of those people out of the police system and put them into medical and detoxification facilities.

Senator HUGHES. Isn't it a fact medically that the delirium tremens does not need to happen if we take proper medical care of these patients?

Dr. WHITTINGTON. That is correct.

Senator HUGHES. It can be made a thing of the past if we dedicate ourselves to it?

Dr. WHITTINGTON. That is right.

Senator HUGHES. What is the followthrough then from the detoxification center? You measured outpatient care and I am assuming by that you are not only talking about the man who still has a home or woman who still has a home, but you are talking about the home now such as halfway houses?

Dr. WHITTINGTON. That is correct. Halfway houses, sheltered workshops.

Senator HUGHES. Do you have any of this now?

Dr. WHITTINGTON. We have none of it now.

Senator HUGHES. In other words, you have an illness that cost the court about 50 percent of its total time in the city of Denver, and 50 percent of your total mental health problems are with alcoholics in the State of Colorado, there is no detoxification center, no halfway house, no real extensive outreach services to that type of patient?

Dr. WHITTINGTON. That is correct, except for a few facilities operating in the volunteer sector by Alcoholics Anonymous and the Salvation Army. But these are quantitatively very limited.

Senator HUGHES. It is a totally neglected area almost as far as the Government is concerned at any level?

Dr. WHITTINGTON. That is right.

Senator HUGHES. What percentage of your alcoholic patients do you find are schizophrenic or do you have any research on that?

Dr. WHITTINGTON. We have no hard research. A very small percentage, 1 percent or less have major mental illness.

Senator HUGHES. Do you believe that the alcoholic is recoverable?

Dr. WHITTINGTON. Yes.

Senator HUGHES. He can be recovered almost 100 percent with the proper treatment and followthrough. Our statistics do not indicate that, but we have very few programs where it is possible.

Dr. WHITTINGTON. I am not sure. I am convinced that the yield of treatment is as great with the alcoholic as with traditional psychiatric patients and probably better.

Senator HUGHES. I will ask you a very pointed question, Doctor, and with no animosity or personal reflection. I have a feeling against the mental health centers for treating alcoholic patients, a personal feeling. I have found with psychiatrists and doctors generally in America that they want nothing to do with this patient.

Dr. WHITTINGTON. That is true.

Senator HUGHES. They don't want to deal with him and have little knowledge of how to cope with him, and as a result, unless you get him on a private basis in your private practice, probably little is going to be done. Do you really think this is the place for it?

Dr. WHITTINGTON. I can't speak nationally. I know in Denver that the community mental health center is the place for the alcoholic, because I am committed and because my staff does not have great professional privilege to treat whom they prefer to treat. So in Denver it is the place for it.

I am not sure about the national program, because many people in the mental professions are not at all convinced that the alcoholic is treatable, nor does their personal preference lead them to want to do that. So I can't speak as to what national policy should be.

I don't know. I think ideally alcoholism and other behavioral kinds of problems can and should be treated in comprehensive community health center systems, and in the Denver it will work. I don't know whether it will work in other places or not.

Senator HUGHES. Is it your feeling that the alcoholic bears a worse stigma than the mental health patient?

Dr. WHITTINGTON. At this point in our country, I think so, yes.

Senator HUGHES. That he is a spineless and is a weakling and has no willpower?

Dr. WHITTINGTON. That is right. It is seen as a volitional condition, that the patient wills upon himself; whereas mental illness is now seen as an accidental something that someone can't do anything about.

It used to be that way about mental illness, too. Within the last 20 years the attitude has changed about mental illness, as it will change about alcoholism.

Senator HUGHES. You think that it can be done in alcoholism and narcotics treatment?

Dr. WHITTINGTON. I think so.

Senator HUGHES. Do you consider alcoholism a disease?

Dr. WHITTINGTON. I don't know. I am not sure that the disease concept applies to most of what we call mental illness, either. Certainly it is a behavioral problem that is not under the conscious, voluntary control of the individual, but is something that happens to

him because of a lot of things that have occurred in his past and/or present. It is a disease in the same sense that mental illness is a disease.

Senator HUGHES. Do you consider biochemical imbalance a disease?

Dr. WHITTINGTON. Yes, but I am not convinced that the evidence is clear that that is what is happening in many problem drinkers.

Senator HUGHES. Do you know of any research that has been done in this area?

Dr. WHITTINGTON. I know of some that has been done, yes.

Senator HUGHES. Very much?

Dr. WHITTINGTON. Yes, I think a fair amount has been done but it tends to be inconclusive just as to what the research shows.

Senator HUGHES. Do you know about vitamin B in heavy dosages in both schizophrenia and alcoholism?

Dr. WHITTINGTON. I am aware of it only from the press. I am not intimately aware of it.

Senator HUGHES. Do you think of it as a fad or do you think of it as research?

Dr. WHITTINGTON. I don't know. I am ignorant in that area.

Senator HUGHES. I think there has been a great deal of research done in this area that relates to a pretty heavy percentage. In fact, some research has been done by psychiatrists and doctors not in this country.

I might add it is frowned on by our own people in our Government and I heard it called by a very fine doctor as a passing fad the other day. Still I think there are irrefutable statistics that indicate a very high percentage of people have been recoverable and I don't count that as a fad myself due to biochemical imbalance.

It is treatable and I think we should dedicate a great deal of research in this area.

Dr. WHITTINGTON. I agree. There is very little research done on alcoholism in this country because it has not been well supported. There has been very little research.

Senator HUGHES. For a man such as yourself, you realize the nature of the disease and you certainly have accepted treatment that you think is going through. Now what do you think is needed in the way of professional disciplined people? Were you exposed in medical school to training in alcoholism?

Dr. WHITTINGTON. No, I had very bad training in medical school. My only training was watching other physicians and nurses treat alcoholics very badly when they came in the emergency room, so I had a bad attitude about training.

Senator HUGHES. In other words, you received a psychological effect as a result of seeing treatment of alcoholics while you were in medical training?

Dr. WHITTINGTON. That's right. My first adequate training related to alcoholism was in psychiatric residency in Topeka. I had a limited amount of training, certainly nothing in medical school and nothing in internship.

Senator HUGHES. Are you aware that one-sixth of the veteran patients in the United States are in veteran hospitals for alcoholism?

Dr. WHITTINGTON. I didn't know that.

Senator HUGHES. That has been the testimony. One-sixth of the total patients are American veterans, and when we have as many millions and millions of veterans as we have, we are talking about an element

that is of great concern to me and I am sure would be to most people if they were even aware of it or know that this exists because the illness is practically ignored, and I don't mean by the Veterans' Administration.

They have taken large steps in the last 2 or 3 years primarily which lead me to a great deal of hope. We are now just at the point of breakthrough just as we were 15 years ago when we were trying to break this barrier.

If I might move on from this without belaboring it too much have you ever had occasion in your clinic to treat a person using marihuana?

Dr. WHITTINGTON. Yes, we have a number of people using marihuana, who are a concern of our mental health program.

Senator HUGHES. Do you find in these instances a mental illness coupled with the usage of marihuana?

Dr. WHITTINGTON. In some instances, but by no means the majority.

Senator HUGHES. Not in the majority?

Dr. WHITTINGTON. Not in the majority, from our experience.

Senator HUGHES. These are volunteer patients that come in or do you get them from the court?

Dr. WHITTINGTON. Both. The majority of them are volunteer patients, but a few are hospitalized in our police ward because of behavioral deviations when they are picked up by the police.

Senator HUGHES. Do you follow through on those patients?

Dr. WHITTINGTON. Yes, we try to. I would like to make it clear that I don't consider myself an expert in the area of marihuana. I am frankly not quite certain who is an expert in that area at this point.

Senator HUGHES. I would like to point out I am not either certainly, but we are going to try and find out.

Dr. WHITTINGTON. What our black and Hispanic people tell us in Denver is that "You white folks were never worried about marihuana when our kids were smoking it. How come you are so suddenly excited about it?"

It is not a new habit in American society. It is only a new habit in white middle-class American society.

Senator HUGHES. I guess the word hurts so we pay a little attention.

Dr. WHITTINGTON. That is right.

Senator HUGHES. How about other abuses, and I hesitate to even know what to call them. I am talking about speed, glue-sniffing, general experimental practices that go on among elementary and secondary school children. Are you running into any of that in Denver?

Dr. WHITTINGTON. Some. Glue-sniffing has fallen off.

Senator HUGHES. Because people know it is fatal in a lot of instances?

Dr. WHITTINGTON. No, mainly because of legislation which in effect, monitors the distribution of glue through wholesalers and drugstores, so that is very tight control in the sale of glue. Methedrine, or "speed," is increasing in usage, but again it is mainly in the older population, college students, and a few high school students. LSD has dropped off markedly in usage in the Denver metropolitan area in the last few years. It is not a frequently used drug at this point.

Senator HUGHES. Do you have any mainliners that hit your clinic?

Dr. WHITTINGTON. Yes, Denver has a relatively small hard narcotic population, but we conduct a methadone substitution treatment program for hard narcotic addicts.

Senator HUGHES. I am trying to expand on this, I want to ask you now a general question: Do you think it is possible to construct legislation so that local community mental health clinics can give all-around treatment, rehabilitative services, and educational services in all of these fields that I have been talking about in addition to the services of mental health which you have already been concentrating on?

Is your competency of that quality that you can take all of these things and properly structure mental health clinics if you had the money to do it?

I am going to put the qualification in there.

Dr. WHITTINGTON. We need three things. One is the money to do it. The second is committed leadership, which we have in some community mental health centers. The third is, a national training effort, to prepare the existing professionals and new categories of personnel because, as you point out, many of the existing mental health professions are quite ignorant in the whole area of alcoholism and drug abuse.

So it takes not only money and leadership—

Senator HUGHES. Not only many, but most.

Dr. WHITTINGTON. I would say at this point most. It will take a national effort to train people. We have to have manpower resources that do not exist, whether the program is in separate alcoholic programs; we simply don't have the people in this country now to do the job. They will have to be trained.

Senator HUGHES. It requires a vast disciplined training program right in the system of higher education; doesn't it?

Dr. WHITTINGTON. That's right.

Senator HUGHES. Related to not only medical and psychiatric training, but RN's, psychologists, teachers, and the entire staff?

Dr. WHITTINGTON. That is correct. And the whole new categories of personnel is now being trained in small numbers in a handful of places.

Senator HUGHES. You mentioned about treating the family—

Dr. WHITTINGTON. Yes.

Senator HUGHES (continuing). Of the alcoholic. I am assuming this is true of mental health problems generally.

Dr. WHITTINGTON. Yes; not only of the alcoholic.

Senator HUGHES. But the general followthrough is absolutely essential with the spouse and the children in a family such as this; is it not?

Dr. WHITTINGTON. Yes; that is correct.

Senator HUGHES. If you are to be totally successful.

Dr. WHITTINGTON. That's right.

Senator HUGHES. Haven't you many times found a total family almost destroyed by the so-called sick member when you go into the home and you find that you have a compound problem with every member of the family?

Dr. WHITTINGTON. Yes, and if we really consider seriously the idea of preventing emotional illness, the focus clearly should go on alcoholism, because this is the most common historical event related by a patient in that they had a family destroyed because of alcoholism in one or more parents.

Senator HUGHES. I wish you would repeat it, because I think it is important. I think it is ignored also. Actually many of your mental health problems, not a problem with an alcoholic, the reason behind the problem is one or the other or both parents were alcoholics. Is that correct?

Dr. WHITTINGTON. That is correct. A very direct historical event that leads up to emotional breakdown in adult life.

Senator HUGHES. So if we could get at this problem, we could probably start reducing the incidence of mental illness generally, could we not?

Dr. WHITTINGTON. We believe so. Interestingly enough, the residents of our model cities program believe so also. They gave highest priority to alcohol and addition programs not only because of what they felt it was doing to the alcoholic in model cities neighborhoods, but it was destroying children and wives and husbands as a result of the effect on them.

Senator HUGHES. Could I ask you a question relating to the background of the patients? Do you have many American Indian patients?

Dr. WHITTINGTON. We have a substantial community in Denver, but this is not a large part of our patient population.

Senator HUGHES. Mexican-Americans?

Dr. WHITTINGTON. A large number of them.

Senator HUGHES. Do you find these incidences in these American Indians and Mexicans to be a greater factor than in the white population per capita?

Dr. WHITTINGTON. We don't have any hard data for Denver, but certainly in terms of utilization of services, there is no difference.

Senator HUGHES. But you don't know of any research that would indicate at all whether there is an ethnic problem relating to a group of people that seek treatment?

Dr. WHITTINGTON. I am not aware of any that would demonstrate this is a problem confined to any particular ethnic group.

Senator HUGHES. I have become very concerned, and where I first noted it was when I was Governor of my State, at the lack of any educational facilities or structural facilities where the child who is not able to compete in high school or elementary school, who may have schizophrenic tendencies, who may in fact be ill, is more or less forced out and he is not mentally retarded. His competency may be very high at a very high level and his IQ test may be very high, but where does he go? What does he do?

Dr. WHITTINGTON. Well, in Denver and in most communities, in reality he moves out of the school and into one of the deviant subcultures, he smokes pot or engages in gang activity or thievery and ends up in trouble.

Senator HUGHES. He is forced out of society, isn't he?

Dr. WHITTINGTON. Yes. Usually this begins in the second grade at the latest when he begins to have reading difficulties. The child who cannot master school has the same problem that we would if somebody made us go to work all day when we couldn't do our work and let us sit there and fail all day.

The child who begins to fail early in school must go and be a failure every day of his life during the schooltime. So by the time he gets to high school, he is ready to withdraw.

Senator HUGHES. In fact, he has already withdrawn when you get him?

Dr. WHITTINGTON. Yes.

Senator HUGHES. He is completely withdrawn and has been rejected and he is lashing out. If you could have gotten to that child when he was 7 or 8 years old, your opportunities of fitting him back into a social structure at some point would have been increased greatly, wouldn't it?

Dr. WHITTINGTON. Yes, it would have.

Senator HUGHES. Again, professionally, I would ask you if you feel we have a very high percentage of school counselors who are able to detect in young children these tendencies?

Dr. WHITTINGTON. That is hard to generalize on because it varies so much, depending on the system. Denver has historically a very well-developed school mental health program. It has over 70 psychiatric social workers in the school. But this is certainly not the rule nationally. It is very spotty. In some systems, yes; in others, no.

There also is the problem, as the Joint Commissioner of Mental Health of Children has pointed out, that even identifying the children would not necessarily result in anything, because the service delivery system for children is so poor in most communities.

Senator HUGHES. It has been totally nonexistent in my experience. It is a shocking thing to see so many of these youngsters coming up who are deprived of any opportunities or dignity and who literally destroy the family they are living in in the process of that deterioration.

And as a result, it is a very sad thing to see happen. The other children in the family, what is your professional opinion of what happens to them?

Dr. WHITTINGTON. It is very rare to find one child disturbed in a family.

Usually the family as a unit is disturbed to some extent. Not always, but usually.

Senator HUGHES. This is a very sad thing in children and I wasn't aware of it until I actually had the experience of seeing it among families of friends. I am not talking about ghetto residents. I am talking about those who have arrived, who are there, who have everything in the world. The child who has gone unnoticed and been treated with discipline without paying any great deal of attention even in school or at home. Suddenly one day they find out that the child has totally withdrawn. After long processes you find out if you had had the child 10 years earlier, you would have had a great chance to do something with them.

Then there is no place for the child to go, as you say. He reaches an age, he shouldn't be totally institutionalized. So what does he do? He can't hold a job. He tries and he begins smoking pot. He winds up in the rum cellars and flesh pits of humanity and in prisons.

And in many instances when you investigate the background of murderers, you see this history repeated.

Dr. WHITTINGTON. I think the decision we have to make is whether we are going to invest national resources in treatment or rehabilitation programs, or keep enlarging our prisons.

Senator HUGHES. The saddest thing I had to review as Governor was a man sentenced to die on the gallows justifiably. A man whose

history began when he was 6 years old for stealing a yoyo out of a 10-cent store. If you read the complete history of that child as he grew up and finally reached the culmination of murdering two people, you arrive at the conclusion that society is bearing the load of responsibility at what that child developed into because of a lack of interest, care or concern.

I point out this great void in educational capabilities, anything that exists for this child is another great void, and I think perhaps through our mental health programs and community center we could have helped.

The only reason I bring this in at such length is to finally ask you, do you think through a very comprehensive community mental health center program, can we finally begin to reach these children and do something about this problem?

Dr. WHITTINGTON. Yes, we think so. We think that this can be done if the mental health personnel are decentralized and are working in the school with school personnel in a partnership. It won't happen if they all sit in a big building someplace and ask for people to go to them. It will happen if they care and go into the school system, because this is where much of the work has to be done.

Senator HUGHES. Your terminology of pragmatic idealist is one perhaps that should be applied. We have to be out in the street doing it.

Thank you, Mr. Chairman, and thank you, Dr. Whittington.

The CHAIRMAN. Thank you, Dr. Whittington.

Earlier you referred to the school system and I understood you to say something to the effect that it was considered a failure of the school system because of the failure to treat these children. We won't belabor that point, but I do not consider the educational system of America a failure because it doesn't take care of some who should be taken care of. I think it is a problem of education of the American people.

We do have to turn to the millions who are not the norm. Before there was no such education available for any except the affluent in our society or in bigger cities that had high schools. This is the improvement that I have seen. It is incredible in the improvement we have had and with 7.8 million young people in colleges in this Nation, about 3.8 percent of the population, 1 out of 25 in college today, no nation in the history of mankind has ever undertaken the education for such a high percentage of its people at the college level.

Dr. WHITTINGTON. The schools are nice examples, because as you point out, we are more concerned about failure now because we have raised our level of expectation. The same thing happens and will continue to happen in the mental health field.

The CHAIRMAN. You didn't have the draft breathing down your neck in those days to encourage education and the ministry and other professions.

Dr. WHITTINGTON. The fact that more people see psychiatrists doesn't mean more people are crazy. The fact that more people go to school doesn't mean that more people are ignorant. It means our society has raised expectations of what being a competent citizen is.

The CHAIRMAN. That's right.

And I think it is one of the great hopes of our society that now recognizes this problem. A generation ago, I don't think the problem would have had general recognition. Maybe a few in the profession like you, but now there is general recognition in the society.

We have had testimony before this committee that 8.8 million people in America suffer mental problems to the extent that they need mental help from professionals.

Now we have the modest estimate, Senator Hughes says we have 5 million alcoholics. We have a million and a half children with learning disabilities who don't come under the handicapped definition. We have 5 million handicapped children. Maybe some of those have mental problems, part have physical handicaps of hearing, vision, and other things.

There are probably some duplications. But I haven't touched marihuana and glue sniffing and all of that. If we take what I add up here, we have over 20 million people. There are some duplications.

If we go into other things, narcotics and many other fields of disability, we have got about 20 million people out of 200 million who suffer some of these handicaps or disabilities. That is one outlet for every one of those they are averaging out four other members of the family, maybe more. Fewer in some families, eight or 10 in others. So it will average out 5 for 1.

So out of a population of 200 million, you have 100 million, or half of the people, who are immediately affected by some people with some of these problems. Now that we have schools for the normal, we have to turn around and get to the other half of the population.

I have been on this committee 12 years, but I have just started my calculated work here this year since I became chairman of the Health Subcommittee to learn that we have got half of our people who suffer. They suffer economically if they have one member of the family with one of these problems: alcoholism, mental retardation, learning difficulty, or others. It is very rare to see the rest of the members of the family not affected and that impedes their level of accomplishment in the family.

We have half of the whole population suffering from that impediment. I agree that it is time that we do something about this problem. With this bill I hope we will stop fighting so many wars so that we will let half of the people continue to suffer without the proper support from the tax base that they ought to have.

Thank you very much for your testimony here.

The CHAIRMAN. The next witnesses I am proud to welcome from my home State, Sister Mary Amelia, administrative director; and Dr. Harold Rockaway, medical director, Mid-Houston, Tex., Mental Health Center.

Sister Amelia and Dr. Rockaway, in my opening statement on this bill I described that center in two or three paragraphs of what you were doing, how proud we are of you, and what you are accomplishing there. Now we will get the real information and message and so proceed with the testimony in your own way.

STATEMENTS OF SISTER MARY AMELIA, ADMINISTRATIVE
DIRECTOR, AND DR. HAROLD ROCKAWAY, MEDICAL DIRECTOR,
MID-HOUSTON, TEX., MENTAL HEALTH CENTER

Sister MARY AMELIA. Thank you, Mr. Chairman. I am delighted that you are interested in this program, because we need you and Senator Hughes to take the interest because we are just beginning to see the light as far as we are concerned in this field.

I would like to tell you a few things about our center and then I will turn it over to Dr. Harold Rockaway, who is our medical director. As you know, we were supposed to have 10 centers in Houston. We have three operating now.

Our center particularly is in the poverty area of Houston and you, Mr. Chairman, are familiar with this area because you visited us about 2 weeks ago. We have divided our center into three areas because of the ethnic problems in these areas. We have also decentralized it into three district outposts and 11 outposts so that we have moved the treatment into the community to be closer to the people. I think I would now turn it over to Dr. Rockaway to describe what we are doing.

The CHAIRMAN. Thank you, Sister Amelia.

Dr. Rockaway?

Dr. ROCKAWAY. I have a prepared statement, Mr. Chairman, but I would request that this simply be inserted into the record and the remarks I make, I think, are more pertinent to what has been discussed and so much of the ground has been covered by Dr. Whittington.

The CHAIRMAN. The prepared statement is ordered printed in the record at this point.

(The prepared statement of Dr. Rockaway follows:)

PREPARED STATEMENT OF DR. HAROLD ROCKAWAY, MEDICAL DIRECTOR,
MID-HOUSTON, TEX., MENTAL HEALTH CENTER

It was our understanding that the hope of the Congress in funding Community Mental Health Centers was to stem the flow of patients to state hospitals, most of which were overcrowded, understaffed and in the most general terms tended to perpetuate rather than cure the ills of the patients sent to them. The most optimistic estimates were that the flow could be completely stopped and the state hospital systems would ultimately be abandoned as treatment facilities with all care being carried out at the community level.

Further it was our understanding that the way in which the grants were made i.e. of 51 months duration was gradually decreasing federal participation was by way of saying that it was the expectation of the Congress that the states and counties benefiting from the services rendered by the Community Mental Health Centers would pick up the financial slack as it arose.

In speaking to the first point some facts are emerging. These are "facts" for our catchment area because of its characteristics, the relationship we have with Austin State Hospital and the quality of care available there. The economic realities of local care vs. state hospital care. It costs approximately \$60 daily to care for patients in the hospital at the local level vs. \$7.50 daily and \$162 per patient to process them to the state hospital. It appears to make more economic sense to send the more seriously ill patients to the state hospital where it is anticipated that long-term care will be necessary. Close cooperation with the state hospital can shorten the stay there and a unified treatment plan continued at the local level as soon as the patient is judged capable of returning. Less serious illness is more quickly, economically taken care of at the local level with less disruption of family life, loss of income and emotional trauma to the family. In summary the roles that seem to be emerging would make the

state hospital a more sophisticated treatment facility dealing with the more seriously ill patient while the Community Mental Health Center would be involved more in crisis intervention, early detection, prevention, education, coordination of community resources, rehabilitation and maintenance and followup of identified high-risk individuals in the service of preventing relapses.

To speak to the second point, that of financial support by the state and county, the response has fallen short of that necessary to maintain the program. The majority of individuals in our catchment area are living at poverty levels so patient revenues have been very small and for the immediate future little change is expected from that direction.

Up until now our affiliate general hospital, St. Joseph Hospital, has absorbed the deficit but it is not likely that this will continue to be possible as the federal portion decreases and the deficit rises.

In defense of the state and county we feel it necessary to comment that full scale programs of early detection and attempts at prevention by early intervention, in our situation by identification of disturbed children in the whole school system of our catchment area, have no precedent and therefore their effectiveness must be called into question. It will be many years before an accurate evaluation of our impact will be possible and this part of the program is most accurately defined as experimental. We believe we can make a therapeutic impact on our community in this way but it is only a strongly held belief and we can understand the reluctance of state and county officials to allocate funds for anything less than proven methods of care.

Much of our efforts have been directed toward marshalling and coordinating the existing agencies in the community so as to avoid duplication and waste. These efforts are coming to fruition now, what with central files that reflect what services are directed to all families, whereas because of the singular success of this coordination of agencies we are expanding the coordination to include the private hospitals and physicians who serve our catchment area.

What is emerging now is a comprehensive health approach to the families in contact with us making available in an orderly way the resources and services of the participating agencies such as:

- State Department of Public Welfare
- Subcontract to Neighborhood Centers Association
- Catholic Charities
- Vocational Rehabilitation
- County Welfare
- State Welfare
- Planned Parenthood
- Public Health
- Day Care
- Family Service
- Big Brothers
- Council for Retarded
- Probation
- United Fund
- St. Joseph Foundation

The Community Mental Health Center has assumed a leadership role here not perhaps because it was appropriate to do so but because there was a seen need for it and we were funded.

Our major complaints about the federal funding center around its restrictions. For want of \$10 worth of bus tokens patients may not be able to come to the Day Hospital because they can not afford bus fare. No funds were allocated on an open ended discretionary basis. For the lack of approximately \$30,000 a very valuable work evaluation unit liaison with vocational rehabilitation that could forge the last links in the chain of rehabilitating patients was never able to be accomplished. Because of the experimental nature of much of the program it seems unlikely that the state and county legislators will see fit to support it at levels necessary to sustain it. If it proves effective it seems likely the support will be forthcoming. Is the Federal Government willing to shoulder the lions share of it during the interim period with high ratio funding? At present the alternative seems to be closing of our center or curtailment of its activities to an extent that would not allow us to prove or disprove its effectiveness.

MEMO

From: Michael A. Killeen.

Date: July 24, 1969.

I spoke to Mr. Jack Burton, National Institute of Mental Health, about 11:30 this morning and gave him the following information concerning the Mid-Houston Community Mental Health Center:

The official budget at opening 1967 was \$1,246,000.00; at opening 1968 it was \$1,276,000.00; at opening 1969 \$1,205,000.00. The support given by the Federal Government for 1967 was \$609,000.00; for 1968 \$466,000.00; for 1969 \$289,000.00. State support in these years is \$84,000.00 in 1967 and, so far in 1968, it is \$29,000.00. It was further explained to Mr. Burton that we have a contractual agreement with the Harris County Mental Health and Retardation Board for a total of \$100,000.00 in support money, but to date we have received only \$29,000. It was further explained that we have received monies from patients, both private and CHMC, in the amounts of, in 1967, \$510,000.00; in 1968 \$520,000.00, and it is anticipated that in 1969 we will receive another \$520,000.00. Our deficit in 1967 was \$42,000.00; in 1968 \$261,000.00 and in 1969 \$396,000.00, for a total of \$700,000.00.

It was also indicated to Mr. Burton that Neighborhood Centers for the last year has picked up St. Joseph's share on 19 positions on the NIMH staffing grant, or roughly about \$2,000.00 a month.

A brief statement concerning the financial crisis facing St. Joseph Mid-Houston Community Mental Health Center: We had to cut back on in-patient services in July and August 1968 due to two reasons: no matching monies from local support and a declining percentage of participation by the Federal Government. Also due to the lack of funds we are unable to get the total medical care, supplies and equipment essential for the patients we care for. Due to this lack of funds also 171 patients were sent to Austin Texas State Hospital last year, because of our inability to provide services.

Financial support and effects on our program: If there are no additional monies made available in the coming year, this program will not be able to continue. Presently the State of Texas is budgeting only \$3.5 million for all the mental health centers in Texas. We don't see any additional allocation of monies to the Harris County Mental Health and Retardation Board, in fact, we foresee that this allocation will be less than in previous years. It was further pointed out to Mr. Burton that the annual income of the people we are serving in the Area 10 is under \$3,000.00. If given four to five more years of stable financing or fundings, we believe local agencies, philanthropy, industry, etc. will become interested in this program and help to support it financially. It was further pointed out that the deficit that is incurred must be passed on to our private patients, as bills, payroll and other items must be paid when they come due and this can only be done by increasing overall charges throughout the rest of the hospital.

Dr. ROCKAWAY. I think one thing we would like to discuss is the financial crisis and the comparative contributions of the Federal Government, State and private, made to the center since we have been operating. We would begin in 1967. The 3 months of that year we were at 75-percent level and 9 months we were at 60-percent level. The total budget for approximately \$1.25 million, Federal support was \$609,000, which represented approximately 50 percent of that budget. The deficit of \$42,000 absorbed by St. Joseph, our affiliate general hospital.

In 1968, the budget was also approximately \$1.25 million. The deficit was \$261,000, of which the State up until now has made up approximately \$29,000, the rest having been absorbed by St. Joseph Hospital.

The projected program cost in 1969 is \$1.2 million, the Federal portion to be \$289,000. The deficit is estimated to be at about \$400,000. In 1968, then, the Federal contribution was approximately 33 percent. In 1969, it will constitute less than a quarter.

The State, by its recent actions, has indicated that little money will be available and it likely less, since they intend to continue with the

same amount of money and plan to fund 15 more centers. One of the points I think we are trying to make here is that there has been substantial contribution from the outset at St. Joseph from the private sector. I notice that this has been taken exception to in other testimony.

A colleague of mine commented several years ago that we were finding ourselves in a position where we were downriver fishing the bodies out as they floated by, and if this was going to continue to happen until we went upriver and found out where they were falling in and stopped them from falling into the river we would not be effective—this we have come to see as one of the major functions of the community mental health center.

Sister Amelia began to describe to you the programs that we have developed in the service of early intervention, detection of those people who are disturbed at an early age. It has been commented, and Senator Hughes has made the point, that it is the nature of mental illness that it seems to perpetuate itself in the progeny of those affected, and we have found over and over again, of course, that this is the case, whether it be emotional illness or alcoholism or any combination of it.

We feel like our success depends on being able to make early intervention and treatment in the young that come along. In this respect we have an interested school system in our area for detecting and treating the children so affected. I am not at all sure in every case we can succeed with all of the treatment that we have available to us in treating the families so affected.

What we may have to do, I suspect, with many of the children we find who are emotionally disturbed is find other models for those children.

We are making arrangements to do this. We are finding a situation in our area which is primarily a poverty area that poses certain unique problems in terms of trying to take care of the area. The people in our area, of course, do not have maids. Most of them cannot afford transportation even to the outpost to keep their appointments. They are living at poverty level and in order to take care of them, we have to provide transportation and we have to see that their appointments are kept.

We have to see that baby-sitting is provided, because they cannot leave their children when they keep their appointments. So a different kind of delivery of care is necessary for this kind of area. Necessarily it costs a good deal more.

An Out-Reach organization has been set up. We have been very fortunate in our dealing with agencies in the community. An agency already existed with whom we have a very strong liaison, who had grass-roots connections in the community and the trust of the community in which we worked. They are in a position to be closer to people and understand the customs and social mores here quite well.

So we are able to communicate with our identified patients through these Out-Reach workers who keep us abreast of what is going on, who make notes in the central filing system we have and allow us to maintain people in the community or identify various individuals or identify mentally ill individuals.

In this way we hope to be able to maintain them in Out-Reach and maintain them in remission and save the money that comes from a constantly relapsing patient who has to return to a State hospital.

We have set up rehabilitation facilities, working closely with vocational rehabilitation. We have created our own work evaluation. We have created our own sheltered work adjustment program.

The critical gaps in the program exist in the area of halfway houses where we are not prepared at the present time because we don't have them. Our area, because it is an inner-city poverty area, contains many individuals who have come from families where there was a great deal of turmoil and have little family structure and have little family unity.

We are dealing with a lot of people who have almost no structure in their lives when we see them and they require long term care and it doesn't make economic sense at the present time to take care of these people at the community level, because the disparity in cost between taking care of people at the community level versus the State level is extremely high, costing approximately \$60 a day at community level and approximately \$7.50 a day at the State level.

So we see our function more as taking care of those people who are acutely ill, identifying them quickly, putting them on outpatient basis quickly, putting them in a day hospital where it is quite economical to take care of them, and putting our main thrust in the area of protection and prevention in the care of children.

We come then with a different model of taking care of people, a reaching out to them, as it were, because they don't seem to be coming forward in the way more sophisticated people seek psychiatric care.

I think Mr. Gorman made a good point when he talked about the person who saw the analyst for 8 years and they learned they had to live with their problems. This may happen when we complete our system of prevention and alter the character illness of the people we are seeing.

Mr. Gorman might say that those people who went for 8 years paid their own way. That is what we are trying to do, to build into these kids more capacity for adjusting, coping, and adapting so that they can pay their own way. In the course of doing this, we have begun to work with a variety of agencies in the community.

To name a few: State Department of Public Welfare, Catholic Charities, County Welfare, Planned Parenthood, Day Care, Family Service, Big Brothers, United Fund, and St. Joseph Foundation.

This has not been without a great deal of difficulty. Dr. Whittington alluded to this in some of his comments. The sister has been most instrumental in doing this and has been the primary public relations person, as it were, in coordinating these agencies. This is coming to fruition now where we have centralized system of files so that people who are being seen who will have the services of agencies being brought to bear on them are in a central file so we know what each agency is doing, so they are not seeing four or five separate agencies separately without the knowledge of the other agency, which has been more the rule than the exception in the past.

So that we are concerning ourselves with much of the duplication and waste that has gone on because of not marshaling the resources of the community and coordinating the existing community resources of the agencies. This is not at this time, I would say, a notoriously successful operation. This is the beginning of it.

There have been many difficulties. As Dr. Whittington suggested, change is met with some resistance by some agencies and we expect this will come. But nevertheless it is well along the way and many of them are seeing the sense of doing this.

My experience with Dr. Whittington in the past has been that he is a very tough act to follow and he has said most of the things that I think need to be said about what is happening in the community and also this memo you have from Mr. Michael A. Killeen. I assume to add.

The CHAIRMAN. I am putting in the record your prepared statement and also this memo you have for Mr. Michael A. Killeen. I assume you wanted that in the record. I think it is informative here where it points out they had to send last year to the Austin, Tex., State Hospital 171 patients because of the funding down there.

Dr. ROCKAWAY. We were able to intercept some of these patients, 95 of those patients. Many of those people who go on to Austin voluntarily were people who again lost their families and jobs and positions and friends and who had such little structure in their lives, many of them alcoholics, who had so much of their lifespaces consumed by alcohol that they would require very long term treatment.

If we had halfway houses, we would have accepted them. But it would have been too expensive, prohibitively expensive to have taken them initially. But we followed them up on their return to the community.

The CHAIRMAN. Supplementing in the introduction by Sister Amelia, you point out that the Federal Government supported this in 1967, \$609,000; 1968, \$466,000; 1969, \$289,000.

I think that is typical of the Federal support of all domestic programs during the past few years. As the war in Vietnam has escalated, the quality of American life has declined. I think this is very representative from seeing many figures and many facets of Federal endeavor.

Let me read that again.

Federal support given for six biggest cities in America, largest between Washington, D.C., and Los Angeles, south of the Ohio River. Federal Government's share that they contributed in 1967, \$609,000; 1968, \$466,000; 1969, \$289,000—less than half that of the contribution 2 years earlier.

I assume from your experience that you would have some feeling about the provision of my bill that would extend Federal financing from little over 4 years to a 10-year plan. Do you think that would be very beneficial in recruiting personnel and planning for the future?

Dr. ROCKAWAY. I believe that is the only way we will survive, Senator.

The CHAIRMAN. Senator Hughes?

Senator HUGHES. Dr. Rockaway, without belaboring all of the points I went over with the previous witness, I would ask you just generally, you have heard his testimony. Does your experience parallel his in dealing with alcoholism, narcotics, and abuse of drugs?

Dr. ROCKAWAY. I would make only a few changes as I heard him talk. We have had a good deal of success treating alcoholism because we have a certain kind of emotional climate in our center which is perhaps different, as he commented, and his statements that could be only personal ones that he applied to his place. That has not been the case with us.

Sister Amelia has always had a considerable interest in alcoholism. As a result, we have an AA group which meets 7 nights a week. We have a coffee room open. We have AA counsellors as part of our program. We have psychologists that run structured group therapy for alcoholics. We have many connections with industry by virtue of the fact that many of the people who have been through the program and who are alcoholic made job opportunities available to those people so affected.

Our staff is very well trained and very sensitive to a person with alcoholic problems. So in our center, we do take care of them. I do not feel the same way about narcotics addicts. I feel they constitute a rather small number in absolute numbers of people. They require rather sophisticated treatment facilities to take care of. They are rather disruptive to try to take care of because the people that surround them are reluctant to turn them loose, as it were.

They make it very difficult to succeed with them. We are involved in the Government's after care program of addicts. We have not had many patients come to us through that program, but it was with some reluctance, I should admit, that we accepted that contract.

Senator HUGHES. Because of the difficulties in dealing with the person?

Dr. ROCKAWAY. Yes, sir.

Senator HUGHES. Do you think this needs specialized facilities and training and everything else?

Senator HUGHES. What percentage of your patients are alcoholics?

Dr. ROCKAWAY. About 35 patients would be my guess.

Senator HUGHES. What percentage of them go along with the State institutions for alcoholics?

Dr. ROCKAWAY. About 50 percent.

Senator HUGHES. Most of these are in the class of derelict?

Dr. ROCKAWAY. Yes.

Senator HUGHES. What type of an institution program do they run in the State hospital, do you know?

Dr. ROCKAWAY. Actually it is pretty good. It suffers from the disadvantage of losing whatever connections and sources of support that the alcoholic has in Austin, when he returns to Harris County because it is 60 miles away. I am not aware they have any halfway houses facilities there and they are located in the in-patient treatment which is simply not satisfactory.

Senator HUGHES. Do you have any followthrough programs when they come back to your community?

Dr. ROCKAWAY. They do with us, but when they come back they are very much in the same position they were in. They have no job, no money and no place to stay.

Senator HUGHES. You have no place to operate from. Before I end this, I would say congratulations on your Out-Reach program. I

think you have developed through your local wayside houses and one thing and another a tremendous out-reach program that ought to be used in every city of the country, because unless you reach out to these people, as you well know, you are going to miss them.

And this is a tremendous feeder program that is essential. Do you have a court Out-Reach program, too?

Dr. ROCKAWAY. We have no system that sends the alcoholic any place but to jail, if that is what you are asking. The alcoholic in Texas can't commit himself to a State hospital facility.

Senator HUGHES. You have no alternative sentencing act that gives a judge the opportunity to make a determination?

Dr. ROCKAWAY. No, sir.

Senator HUGHES. If the offender is an alcoholic, it would better serve the public by seeing him treated than in prison.

Dr. ROCKAWAY. Yes, sir.

Senator HUGHES. Your followthrough programs, then, primarily are the ones where you feel that it is absolutely essential that you have some funding for halfway houses. I am assuming not only for the alcoholic, but for the mentally ill as well, or both. I am talking about the combination.

This requires, of course, rather small units and rather widely dispersed ones or requires a number of units in a city of your size, wouldn't it?

Dr. ROCKAWAY. Of course we don't cover the whole city. We just cover the geographic area that has been assigned to us. So we could probably do it with three or four.

Senator HUGHES. You heard my comments about education and the medical training procedures. Has this been your experience?

Dr. ROCKAWAY. Yes, sir. They were exactly the same as Dr. Whittington.

Senator HUGHES. The psychological effects are negative?

Dr. ROCKAWAY. They are negative.

Senator HUGHES. And the effect it has on trainee or professional men or women coming out of that institution?

Dr. ROCKAWAY. So we would have to go to the medical schools and change the teaching and by teaching change the attitudes.

Senator HUGHES. You know I have talked to my own children and we spend a great deal of time in our educational system, we have a great deal of material that seems to have been developed in the field of hard narcotics. And now we are doing a tremendous job in the field of smoking.

We are getting into the system. When you get down to alcohol, nobody seems to want to take the chance of destroying the "happy hour" or cocktail party by developing some sort of educational program that can indicate to youngsters what the dangers are. Do you find this true also?

Dr. ROCKAWAY. So far it is. Many of the youngsters, especially these days because of the hue and cry about drugs and the result if you use them, are pointing the finger at adults who they say are drug-users in every sense of the word as much as they are, who smoke and drink. So they are, because that is what the adults do. But of course they are smoking pot.

Senator HUGHES. Don't you find, Doctor, so often about hard narcotics, mainline and this type of thing, that it began with marihuana? But when you go to marihuana, you very seldom find the statement made that before marihuana they tried alcohol.

If we are going to look at the chicken or the egg, I think we ought to follow the line back to the source.

I hope we can develop as we go. Most of that is an experimental sort of thing in my experience. I think really we are looking at alcohol as a drug and it has been ignored as such and people do not want to consider that fact basically because it destroys their own social setting and our social upbringing.

I take it your experience has been that your local community mental health program, if you had the proper funding and if you had the proper facilities, could develop adequate out-reach programs, adequate followthrough programs, and adequate systems to handle alcoholism as well as other mental health problems.

Dr. ROCKAWAY. Yes, sir.

Senator HUGHES. That is unique in my experience. Congratulations, Sister and Dr. Rockaway. I think you have done a tremendous job with what you have had to do it with. Your testimonies have been helpful to me.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Hughes.

Of course, Sister Amelia and Dr. Rockaway, you know I have many questions I would like to ask you since you are from my home State, but this afternoon we have a certain number of witnesses allocated and we have reached fewer than half of the witnesses in the allocated time, and the next witness is trying to catch a plane back to San Francisco.

I am going to place your statements in the record and forgo the questions I would like to ask and comments I would like to make about our home State. In the interest of hearing the other witnesses, and particularly accommodating the next witness before his plane leaves, I am placing your statement in the record.

If you have any supplementary statements, I would like to have those. Of course, we know our State with 11 million people has more people in gross number in the poverty bracket than any other State in the Union. I have no doubt that has added to the problems in many of these fields, plus the plight of our Latin American citizens where the language barrier has added to their other problems.

So I hope that we get the funding to carry forward this comprehensive program and I wish we had had time for you to have read all of those things you are doing, all of those agencies that you wrap into one package. Have either of you seen this film, the Public Health Service film on Information Referral Service? You virtually have that in existence now, don't you, Sister Amelia?

Sister AMELIA. Yes.

The CHAIRMAN. Thank you very much.

The next witness will be Dr. Stubblebine, program chief of the Community Mental Health, City and County of San Francisco. Dr. Stubblebine has to catch a plane and so we are calling him next.

You may proceed in your own way. We welcome you here. We are glad to have you. You have come a long distance and it is not only

expensive to travel a long distance, but it is not easy on a person when you jump all of the time zones in a few hours.

You may proceed.

STATEMENT OF J. M. STUBBLEBINE, M.D., PROGRAM CHIEF, COMMUNITY MENTAL HEALTH, CITY AND COUNTY OF SAN FRANCISCO, CALIF.

Dr. STUBBLEBINE. Thank you, Mr. Chairman. It is a pleasure to be here and be able to support so wholeheartedly the bill which you are considering. Out of interest and consideration for your time, I will not read the prepared statement, but will simply refer to certain parts of it. I will paraphrase it and try to make three or four more points, and then respond to questions.

(The prepared statement of Dr. Stubblebine follows:)

PREPARED STATEMENT OF J. M. STUBBLEBINE, M.D., PROGRAM CHIEF, COMMUNITY MENTAL HEALTH SERVICES, DEPARTMENT OF PUBLIC HEALTH, SAN FRANCISCO, CALIF.

COMMUNITY MENTAL HEALTH CENTERS—A NEW FOCUS

With the Community Mental Health Centers legislation being only five years old, it seems almost presumptuous to suggest a new focus of attention. However, many of us who are responsible for supervising and planning for Community Mental Health centers are aware that some centers may have flaws. Though they are a farsighted and major effort in the right direction, it is now time to examine some of our experience with them and see how they might be improved. From this viewpoint, let me offer some suggestions about what Community Mental Health centers can do now, what they could do with extended legislation, and lastly, what they should do with new and extended legislation.

1. What Community Mental Health Centers Can do Now

San Francisco has five Community Mental Health centers in a totally urban area. Each of the centers is in varying stages of planning or operation and each is developing a different plan according to the resources within its district. Some of the lessons learned in this urban laboratory can be useful in other metropolitan areas since San Francisco is so densely populated (second to New York City). The Mental Health services of San Francisco have been functioning on a Community Mental Health center pattern of organization since December of 1966.

With regard to the mentally ill patient population, we have found three things to be happening:

1. The number of petitions alleging mental illness being filed has dropped dramatically.
2. The number of patients committed by the courts to state hospitals has dropped more impressively and
3. Use of hospitalization for both voluntary and committed patients has dropped.

The reduction of petitions being filed means that there have been earlier interviews with some member of the family of the mentally ill person. The reduction in the number of persons committed by the court indicates a change in the mode of getting persons to State hospitals and effective court-mental health relationships. The reduction in use of hospitals as a treatment of choice means that crisis intervention has found effective alternatives to hospitalization. This can be made clear by the following figures:

- 1965—2263 petitions filed, 1528 commitments.
- 1966—1476 petitions filed, 562 commitments.
- 1967—1194 petitions filed, 126 commitments.
- 1968—581 petitions filed, 116 commitments.

The most reliable index of hospital usage is patient hospital days. During these same years, State hospital usage dropped from 1,430,975 days to 823,894, a reduction of 41.2%. These changes in number committed were inaugurated by a new administration in the mental health services in San Francisco and they were

done *without* additional staff. They could *only* have been done by reorganizing as Community Mental Health centers patterns of service. The changes in number of patient days in State hospitals is a tribute to their treatment program but also indicates effective working relationship between the State and local systems.

Present legislation permits some administrative ingenuity. In San Francisco this has taken the form of contracts or partnerships with several kinds of non-profit organizations and community agencies. The local mental health service has contracts with each of the private hospitals that have direct patient care services. It also purchases from other private groups day care services for the retarded, community organization services, and public information services. One of the most interesting contracts is between the City and County of San Francisco and the Westside Community Health Center, Inc. This latter entity is comprised of originally nine, now twelve, voluntary nonprofit medical and social service agencies. one half of the governing board of this agency is comprised of members elected from the community. This then is a tripartite partnership between State and local public resources, private resources, and the community. We would like to think this may serve as a model for other parts of the nation.

Existing legislation permits contractual relationships between local, state, and federal agencies. Examples of this in the San Francisco program are the three year old contract with State Department of Rehabilitation, the present contract with the State Department of Mental Hygiene and a contract being negotiated with the Federal Bureau of Narcotic Enforcement for the treatment of certain addicts.

Community Mental Health Center legislation tends to focus attention and resources exclusively on the direct services to the mentally ill. These services are defined in traditional terms such as inpatient, outpatient, partial hospitalization, etc., though regulations do call for continuity of care, a laudable concept. However, because of this tendency to focus on direct services to the acutely ill patient, preventive services get very little priority consideration. As there is a shift of responsibility for the mentally ill patient from the State to local resources, the local facilities are finding themselves flooded with patients for whom they have a moral and legal obligation. As public medical services, we must care for all persons who come in or who are brought to our facilities. This simply means that there is not enough time or attention given to preventive programs of consultation, public education, etc. It also means that local programs or centers are caught in the vise between shrinking dollars and rising public demands for services.

Current legislation and appropriations also tend to focus attention excessively on the hardware of mental health, i.e., buildings. Of all the identified causes of mental disorder, absence of a mental health center is not one of them. Why suppose then that the provision of a physical plant will cure illness or promote health? Persons are mentally-emotionally disturbed usually because of disordered human relationships, so what is needed to restore mental balance is therapeutic human relationships. Accordingly the general emphasis at the Federal level should be weighted strongly in favor of support for staffing.

II. *What Community Mental Health Services could do with Extended Legislation*

If the present legislation were extended in time with the same level of funding in each center, there would be more of the same. This would mean that there would be more direct services to the mentally ill persons and more of it at the local level. This is sound both medically and fiscally, but is it enough, is it a wise use of total resources?

As these local community mental health centers became more numerous and more effective in dealing with the acutely ill patients, they should be able gradually to devote more time to such things as consultation with school departments, medical societies, public agencies, etc. This would mean more or less attention to the problems of children and youth depending on the program pressures and priorities in any given area. There would be more or less attention to drug abuse problems, depending on the same considerations of pressures and priorities. This would also be true for attention to alcoholism, urban blight, mental retardation, etc.

III. *What Community Mental Health Centers could do with New and Extended Legislation*

There needs to be a fundamental change in the goals of Community Mental Health programs. Community Mental Health centers were planned to cope with the major health problem of our nation, namely mental illness, and they have

shown an exciting potential. It is however becoming more and more clear that Rene DuBois was correct when he said "No major health problem has ever been solved by treating only the afflicted". There must be a major shift of goal towards the prevention of the mental-emotional casualties. The ideas here are proposed as a way of reaching this somewhat ephemeral goal.

When you call RCA Television Repair Service, they send a truck and an experienced repairman to your home. He is trained and equipped to perform all but the most complicated procedures at the home. If he is unable to do this and your set must be taken to the shop, he fails to gain the points given for a home repair. This represents by analogy what we should do in mental health. We should see the person who is identified as the patient in his own natural setting and make every effort possible to keep him functioning in that setting. In any other branch of medicine, the patient is hospitalized or seen in the office *with his stress*, whether it be an ulcer, an infection, a deformity, etc. Only in psychiatry do we remove the patient from his stress, do something to the patient, and send him back home, frequently without ever personally identifying the stress. We should do what the television industry does: send our most experienced, best equipped person out to the home. It may be false economy to make the potential patient or family come to us in our comfortable office. By so doing we are dealing with the symptoms of stress, the fallout—but not the actual stress itself.

Accordingly, legislation should put the emphasis on and create fiscal rewards for hospitalization prevention. It would in this way give status to that most experienced person who is actually on the line dealing with the patient, his family and the stress.

There could be a far greater emphasis in legislation on rehabilitation, on job training in relevant skills. Most occupational therapy today is demeaning and literally maddening because it deals with old fashioned avocational activities. Patients do demand, need, and should have training in useful skills. In our urban areas this means principally clerical, stenographic, business machines kinds of experience and mechanical, electrical services. The whole emphasis should be not on the illness or the patients limitations, but on how he may compensate or counterbalance them, on what potential for learning he has retained.

It is customary in this country to associate illness with dependency. We are taught this early in life when we have the usual childhood diseases and are indulged and waited on by our parents, nursemaids, etc. This same pattern carries over into adult life and into hospitalization for organic illness. Large segments of the medical profession have known for some time that patients who are not infantilized get better quicker. We have for too long hospitalized our mentally ill patients as if they were totally dependent and totally incompetent. Nothing could be farther from the truth. It is absolutely essential that this illness-dependency-illness cycle be broken. It can be changed by strong, if not mandatory requirements that patients be taught useful, saleable skills capitalizing on their talents and interests.

There also must be a fundamental change in the attitude of local governmental power structures to its mental health program. The public has been led to expect its Mental Health professionals to deal successfully with the abnormal, the person who is a bother or a burden, but it is frequently true that the abnormal dramatically catches the public eye and interest. This is the foundation for the mistaken notion that mental health professionals are able to deal *only* with abnormal persons or society. The fact is that because mental health workers are able to deal with the most urgent problems in our society, these same workers can contribute to an understanding of normal persons, normal society, and its governments and administration.

For the above reason as well as for sound planning of public services, mental health consultation should be required on all major public building and service programs. While some projects of a business nature would benefit little from such consultation, others would benefit considerably. These latter would include: housing and redevelopment, urban transport systems, some educational programs, some aspects of welfare, etc.

Community Mental Health centers are currently limited to population areas of between 75,000 and 200,000 persons. Some of the larger cities feel that the upper figures should be raised. I should like to make as strong a case as possible for both limits being lowered. If the limits were approximately 30,000 to 100,000,

it might be possible for people to get the individualized services they need so that they do not have the feeling that they are being treated either impersonally by an anonymous machine. This would also make it possible to legislate into community mental health centers, programs for children and youth, mentally retarded, the alcoholic, and the drug misuser. However, this should be done only if there is the increased emphasis on rehabilitation, job training, and work as mentioned above.

New legislation, if it is to make maximum use of all available resources, must permit contractual relations between public agencies and proprietary organizations or individuals. In this same legislation a reasonable level of profit for the organizations should probably be defined. Philosophically, governments should share the burden of responsibility for the mentally ill with a variety of kinds of resources including all private hospitals and practitioners. Making it possible to contract with proprietary organizations would foster this kind of partnership. It is not a sin to make a profit, and if an individual or group is working for his own benefit while at the same time working for the benefit of patients and the State, it should be permitted.

The 20 year mandatory use of federally supported mental health centers is too restrictive. With the great ferment and many changes taking place in cities, and with the more rapidly advancing knowledge of mental health, being locked into a physical plant for 20 years creates excessive program rigidity. Rather the legislation might require a 10 year use as mental health facility plus another 10 years of use for general health, education, or similar uses. Even more appropriate in many cities would be for legislation and fiscal support for rental and limited remodeling of mental health center spaces. This would permit programs to be adaptable to their changing communities.

Two colorful examples in San Francisco illustrate the point. In 1958 and 1959 the North Beach area of San Francisco was the home of the Beatniks. There was a great influx of a visible type of young adults who presented certain health and mental health problems. Today, 10 years later the area still shows residuals of this era, but now the health problems are no different from those in any other section of the city. Two and three years ago the Love Generation blossomed in the Haight/Ashbury. There were many strident demands for health services for all kinds including mental health. Within the last two years the characteristics of the population have changed so radically that it is not the same scene. Health facilities planned and built to serve the needs of the groups at their peak would be inappropriate now and would certainly be inappropriate 10 years hence.

Flexible programming is necessary to the survival of mental health centers, since only in this way can centers be adaptable and responsive to the needs of their community. Just as necessary for survival is their ability to train personnel in all of the mental health disciplines, professional and nonprofessional. There should be also a greater effort to develop classifications and training programs for the nonprofessional in mental health, including ex-patients.

The development of descriptions of new kinds of positions and personnel should be one of the major responsibilities of public mental health. The entire mental health field must have confidence that knowledge about mental health and illness has now accumulated into a large body of fact. This information can be transmitted or taught in effective ways using modern teaching/learning techniques and devices. The Federal government should take the lead in this field by limiting its financial support of the traditional or conventional training programs and putting relatively more money into programs using the latest educational methods.

Government at all levels should as much as possible get out of the business of direct patient service in mental health fields. The government should take the lead in developing or causing to be developed prepaid medical insurance for all patients. This government underwritten insurance should have realistic, broadened mental health benefits. This then would shift the bulk of the burden of direct patient care and service to the private sector. This is probably the only way in which there will be established a single standard of medical or mental health care for all citizens. As long as there is private care and government provided care, there are in fact two systems and it is general public opinion that the private system is better.

Shifting of the direct patient service to the private sector would permit Community Mental Health centers to do the very important functions for which many of them now have inadequate time and resources. These are the functions of planning and research, training and education, funding and standard setting.

SUMMARY

In short the community mental health centers concept is basically sound but some changes are in order. Changes would include a shifting of emphasis towards the maintenance of mental health and productive social functioning. The clinical programs in centers should be more oriented towards educational-rehabilitative methods. The federal program should (a) emphasize staffing over construction, (b) provide money for planning of services, (c) be concerned more with clear statements of goals (i.e., cost benefit analysis) than with methods of operation, (d) clarify and emphasize that community mental health centers are for all persons, not just the indigent or poor, (e) financially support the newer methods of treatment, research and training.

Dr. STUBBLEBINE. Dr. Rockaway is right, Dr. Whittington is a tough act to follow, but it was heart warming to hear him and Dr. Rockaway. It is heart warming to me to see the relative unanimity of opinion being expressed here this morning by Dr. Whittington, Dr. Rockaway, and myself.

One thing which I think I would like to try to bring to the committee is the fact that the community health centers do work. We have been organized in San Francisco for about two and a half years now following the community mental health center pattern of organization.

We have five areas of which three are funded or about to be funded by staffing grants and construction grants, but in anticipation of those, we have organized all districts. We have found several things happening.

Patients are being petitioned less. Fewer are being committed and we are finding alternatives to hospitalization. At the bottom of page 2 of my prepared statement are figures indicating that the number of petitions filed had dropped to less than a fourth of what it was 4 years ago. The number being committed is at the level of about 7 percent of what it was 4 years ago.

The number of patient hospital days in State hospitals is approximately 60 percent of what it was 4 years ago. These points are somewhat dramatic, but even more dramatic is the fact that these were done without additional staff and these results could have been obtained only in our opinion by reorganizing as community mental health centers. This means that in effect then if the committee and Congress supports this legislation, it means that they have a chance to support a successful program. It isn't very often, I guess, that we get a chance to put our money on a winning horse—something that we know is a good thing.

The point has been made by both previous persons testifying that although the Federal money is very important, the States, counties, and cities are also paying.

In San Francisco our experience is that the Federal money constitutes between 30 and 40 percent of the total operating cost of a community mental health center. The balance of this money, of course, must come from local resources, must be appropriated from a local tax roll, even though some of it is reimbursed from third-party payers and from the State. This means that the local taxpayers are caught in a vise and the program at the local level is caught in a vise between shrinking local money and rising demands for services.

In order to get out of this vise, it seems to me there are several things we can do and this legislation should help us to do. First of all, there should be a coordinated use of all local resources. This includes pri-

vate resources, nonprofit foundations, proprietary facilities, and public facilities.

I think there should be a partnership of funding. I don't think we should be relying on just Federal money or State or local money or the private donations of the United Bay Area Crusade or that kind of fund-raising effort.

Some system has to be devised so that money follows patients. We in California are fortunate in having the act which is devised to do that. According to some research done on a statewide basis 2 years ago, 20 percent of the identified mentally ill patients were treated in the State hospitals, which used up 80 percent of the total department of mental hygiene budget. As a result, the Lanterman-Petris-Short Act has been enacted and in force now for 1 month and the purpose of this act is to make the money follow the patients.

The other thing we must do in psychiatry, and this has been alluded to primarily through the medium of Senator Hughes' questions and responses from previous witnesses, we in psychiatry must do something differently. Also Mr. Gorman's testimony indicated this.

I think we must borrow from the education and rehabilitation disciplines and use teaching methods in the treatment and prevention of mental and emotional problems. If it is true that we do have a body of knowledge and facts in mental health, and if it is true that we know something about the distressful times in life and various patterns with which people react to these stresses, then it seems only common-sense that these methods and alternatives can be taught, that people can have the opportunity of choosing alternatives prior to coming to a stressful point in life.

I think psychiatry must borrow from education, from rehabilitation and couple these techniques with our time-tested method of dealing with people in trouble. So I think we can get out of this vise by a combination of these several methods.

I would like not to go on and bore you by reading to you things which you can already read in my statement. The only one thing which is not clear is that these figures included the mentally ill, the alcoholic, the addicts and the mentally retarded. So what we are trying to do is to develop a comprehensive system at the local level which cares for people in all of these categories.

The figures show us as having committed in a 12-month period 116 people. This includes all of these categories. When I talk about community mental health centers, I am talking about services in all of these categories. I cannot divide people up into neurological or other systems but see them as merely people in some kind of need.

I have given these remarks and I would be pleased to answer questions.

The CHAIRMAN. Doctor, as you have given your paper, I have been following and I saw that you were going to abstract it and digest it, so I went ahead to be reading it. This is a very informative paper and the astonishing fact in it to me is this great reduction in the custodial care that came about in California as you developed these community mental health centers, the vast decline in patients where State hospital usage dropped from 1,350,975 to 823,824 days, reduction of 41.2 percent.

A preceding witness, Dr. Whittington, pointed out how the States built-in present treatment structure resisted this change, but actually the taxpayer, not only these people, would have been benefited. But with mental health centers you would actually save money for the taxpayers on that.

I think once that breaks through to the taxpayer, you can get the interest from people. People have certain built-in benefits; they build their positions up. After all, the more stars you get on the shoulder, the more people you have in command through you.

So this runs through civil systems as well as military systems. Senator Hughes has generously consented to take over and chair the hearing for the rest of the hearing today. I am going to ask him to come around and take charge. Unfortunately I have gotten myself into a commitment to three luncheons I must share time with and so to divide that time, I am forced to leave.

Senator Hughes has also had other commitments. He is working and canceling them and I think I must leave before I find out whether he was effective in getting a substitute or not.

Senator Hughes, we appreciate your diligence. I think you have spent more time here except for the chairman, whose duty it is to be here—more time than all of our colleagues on the committee combined. I am deeply grateful for your faithful attendance throughout, knowing that I leave someone who is fully informed on the proposed law.

Will you please come around and take over as chairman.

Thank you very much. I regret that I am forced to leave, but I will read all of the statements of others who have not yet testified.

Senator HUGHES (presiding pro tempore). Doctor, I won't belabor you with repetition of questions if I can avoid it. You have heard the testimony this morning. I have just a couple of questions.

From your prepared statement I read: "This would also make it possible to legislate into community mental health centers programs for children and youth, mentally retarded, the alcoholic, and the drug misuser."

You have heard these were the very points I was striking at earlier in the witness list. However, you add: "This should be done only if there is the increased emphasis on rehabilitation, job training and work, as mentioned above."

I won't bother to read the above because it is all a matter of the record. What you are speaking to here is, I think, a primary need of expansion which is going to require heavy funding, is it not, if you are able to carry out these programs to the extent you would feel them necessary?

Dr. STUBBLEBINE. Yes, sir. I think if anything, the relative expenditures at both Federal, State, and local levels in health is niggardly. I don't think we need 2,000 community health centers. I think we need about 4,500 across the country.

Senator HUGHES. Hear, hear. I agree.

Dr. STUBBLEBINE. I think if we can do that, then we can legislate into the programs for these diseases, conditions, call it what you will. I have talked to people at all socio-economic levels. In San Francisco I hear the hue and cry raised about services for children and youth, especially drug misuse, chronic illness, and alcoholism.

These are the things that people back home want and if we are not going to meet them, then I think we had better take the word community out of our community mental health center—unless we are going to be responsive to what the people want. I think we should look to ourselves.

Senator HUGHES. What we are talking about, no matter what we call it, we are talking about taking the individual personality and body and making it back into a whole unit by some process. And this is the place to deal with it, in your opinion, is at the community level?

Dr. STUBBLEBINE. Correct.

Senator HUGHES. What percentage of your patients and again I am just inquiring to know, are alcoholics, if you know?

Dr. STUBBLEBINE. We know that residents of San Francisco going to State hospital are three alcoholics for one mentally ill, almost exactly three to one.

In our local program we know that the alcoholic comprises somewhere between 40 and 50 percent of our total patient population and we are not reaching them all. We know approximately 10 percent of our current patient load are people misusing hard narcotics, that about another 15 percent are misusing the dangerous drugs as we call them.

Senator HUGHES. You have received a lot of national publicity in your fair city not only because of the forecast you are going to drop in the ocean, but because of the fact you have a lot of people that have dropped out of life and chosen this as a place to set up some sort of a dwelling.

It has been nationally publicized through the media many times about drug abuse in San Francisco. Do you find much of this deteriorating into hard narcotics? Is it mostly experimentation, or what is your professional opinion on it?

Dr. STUBBLEBINE. I have watched the drug scene in San Francisco for about 11 or 12 years now. I have watched the scene in Haight-Asbury change and as the scene changes, the population changes. Today it is largely a criminal subculture.

Three years ago it was really the flower generation, the love generation, and they were fun kids. But it is a place of great depression and great violence now.

In one 5-week period recently there were 11 murders in that district. It is a very sad thing to see, but I don't think you can call it a hippie culture today. It is just a criminal culture.

In that area the use of drugs is still not principally heroin or the hard narcotic. The major drug misused in the Haight-Asbury—and this is a great surprise—is alcohol. You can see it. I have made inspections with the building inspector. I have been in those pads and flats and residences. I have driven the street, walked the street, and the drug which is most commonly misused is alcohol.

Second is methedrine or amphetamine—the same drug. Third is LSD and the use of LSD is tapering off. And about equal with LSD is barbiturates. Really in order of rank and dangerousness, I would be hard pressed to choose between alcohol and amphetamine.

Second barbiturates, third LSD, and fourth the hard narcotics.

Senator HUGHES. Actually in my opinion there has been a misnomer in our social structure in feeling that the narcotics addict was a crimi-

nal only. It is true some criminals use narcotics. They depend on one another and, as you know, they go out and seek someone to become a user with them because they need this interdependence.

But isn't it also true that this develops in the rest of the social culture, too?

Dr. STUBBLEBINE. I am sorry, I lost you.

Senator HUGHES. My point is that not only does the criminal element use hard narcotics, probably the percentage of users are not criminals by nature?

Dr. STUBBLEBINE. This is certainly true. We do have both in-patient and out-patient treatment programs for the hard narcotic user and we find that recently, for instance, in trying to establish a research project using hard narcotic users with criminal records, we had a hard time getting 40 people.

In San Francisco we know that the hard narcotic population is approximately 2,000 or 2,400.

Senator HUGHES. How many alcoholics do you think you have in San Francisco?

Dr. STUBBLEBINE. The figure commonly quoted is 10 percent of the population, or 75,000 people, are problem drinkers.

Senator HUGHES. I heard a quote there were 240,000 in the Los Angeles area.

Dr. STUBBLEBINE. I am sure that is a conservative figure. Los Angeles County has a population of 8 million. The most conservative rate is about 4 percent of a given population.

Senator HUGHES. We are really talking about the most massive mental health problem. When you deal with alcoholism, you find a combination of problems, isn't that true, Doctor?

Dr. STUBBLEBINE. Yes, social, vocational, physical health problems. Alcoholism is a mixture.

Senator HUGHES. Do you feel if the Federal Government got into it, I haven't been sold on it but I hope I have an open mind, that the local mental health clinic is the place to really handle a massive alcoholism recovery program?

Dr. STUBBLEBINE. I have been leading the fight in California for quite some time to have alcoholism programs in the local community health center. The California Conference of Local Mental Health Directors a year and a half ago went on record as supporting this viewpoint. I would support it only if we had the manpower, only if we had the facilities, so we could deal with people properly.

I feel the same way about mental retardation. The word in the title of the problem implies that there is something to do with the central nervous system and psychiatry and neurology certainly belong in community mental health.

I think we are probably best prepared to do that job, although not totally. We would have to rely on many other agencies, many other kinds of assistance to people with this kind of difficulty.

One of the nice things that exists in California is our legislation, which requires us to make maximum use of all existing local, private, and public resources. This is the first paragraph of the Lanterman-Petris Short Act.

So we work very closely in the field of alcoholism with the National Council on Alcoholism, AA and other volunteer groups. We

have mutual support programs with the Salvation Army, which operates a couple of places, private hospitals and these kinds of things.

Senator HUGHES. The witnesses we have had today are tremendous people and have displayed a great knowledge and concern in the areas that I have generally found in this country almost totally abandoned by the professions you represent. So you will never know how grateful I am for the interest and concern of the amount of work you have done.

I feel it is necessary in building this record to ask certain fundamental questions about your own professional training. Did you have any professional training in dealing with alcoholics or alcoholism?

Dr. STUBBLEBINE. I probably had the best possible training in how to deal with both alcoholism and addiction, because I grew up in poverty. I did not get it from medical school or training.

Senator HUGHES. Did you actually find in your own training the prejudice displayed against the alcoholism that the other doctors testified to here this morning?

Dr. STUBBLEBINE. I think there is this kind of reluctance to deal with the alcoholic patient and addict and that it exists in the medical profession the same way that it exists in social work or psychology or our general society-at-large. In my view, the alcoholic has been at the very bottom of the totem pole in priority.

So it is a regrettable thing to have to admit this about medicine, but I think it is true about our general society.

Senator HUGHES. Doctor, I want to thank you very kindly for coming to testify and your very excellent statement, which the chairman has already commented on and your tremendous understanding of the overall problem in mental health encompassing these areas that have almost totally been neglected in the past. And also your willingness to deal with them.

I have a couple of final questions. Do you have a detoxification center with your program?

Dr. STUBBLEBINE. We have the availability of the general medical institutions in San Francisco, the General Hospital. We have been fighting for 2 years not only to get detoxification service, but a comprehensive alcoholic program in San Francisco.

Just this year, despite the vise I referred to, we did get local approval for a \$1.2 million program in alcoholism. In San Francisco this program is in community mental health services. Unfortunately what I am having to do at present is to develop a parallel program in alcoholism which a year or two from now will be gradually phased into the community mental health centers.

Senator HUGHES. \$1.2 million did not include anything for capital?

Dr. STUBBLEBINE. No, nothing. This is strictly for staffing and Out-Reach services, contractual services with some of the private nonprofit foundations in the city and this sort of thing.

Senator HUGHES. Does the State of California, and this relates to health indirectly, have any alternative sentencing laws that allow the judiciary the discretion of putting a man in for treatment rather than in prison or in jail?

Dr. STUBBLEBINE. No, they do not. Last year the legislature considered a bill by Allen Sieroty from Los Angeles County. It is again

up this year. What its chances are, I don't know. But they still do not have such a law in force.

In practice what most the courts at least in San Francisco do is sentence a person, hold sentence in abeyance pending his participation in a treatment program.

Senator HUGHES. Do you consider as a doctor and psychiatrist the alcoholic a recoverable patient?

Dr. STUBBLEBINE. Yes, of course, people can and do recover from alcoholism the same way they recover from mental illness. This is one of the myths of our time that these conditions are permanent when, in fact, they are, in the main, transitory. Both mental illness and alcoholism are transitory in the main.

Senator HUGHES. I thank you very much, Doctor, for your being here this morning and for your testimony.

The Chair calls Mr. Clint Fair, who is representing Mr. Biemiller.

Mr. Fair, if you would take the chair and identify your colleagues for the record and then proceed as you desire.

STATEMENT OF CLINTON FAIR, AFL-CIO LEGISLATIVE REPRESENTATIVE; ACCOMPANIED BY BERT SEIDMAN, DIRECTOR; AND R. E. SMEDLEY, ASSISTANT DIRECTOR, AFL-CIO DEPARTMENT OF SOCIAL SECURITY

Mr. FAIR. My name is Clinton Fair. I am a legislative representative of the AFL-CIO. With me are Bert Seidman, who is the director, and R. E. Smedley, assistant director, of our social security department.

We appear in support of S. 2523, Community Mental Health Centers Amendments of 1969. Mr. Chairman, I would ask that our statement be put in the record, and I would prefer to emphasize two or three points, if that meets with the chairman's approval.

Senator HUGHES. The statement will be entered in the record in its entirety and you may give a brief outline of it, if you desire, or anything in addition to it.

The prepared statement of Mr. Biemiller, legislative director, AFL-CIO follows:)

PREPARED STATEMENT OF ANDREW J. BIEMILLER, DIRECTOR, LEGISLATIVE DEPARTMENT, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

Mr. Chairman, my name is Andrew J. Biemiller. I am Director of the AFL-CIO Department of Legislation. With me is Bert Seidman, Director, AFL-CIO Department of Social Security, and Clinton Fair, AFL-CIO Legislative Representative.

We appear in support of S. 2523, the Community Mental Health Centers Amendments of 1969. The major provisions of this bill extend and increase the authorizations for the programs of construction and initial staffing grants for another 5 years beyond 1970, increase the time for continuation of staffing grants for 5 to 10 years, allow inclusion of land acquisition costs in construction grants, remove the restriction on staffing grants that limits them to "professional and technical" personnel, increase the share of federal funding for construction and staffing in rural and urban poverty areas and permit 100% federal funding, not to exceed \$50,000 per catchment area, for initiation and development proposals. The AFL-CIO believes these amendments represent a comprehensive program for continuing a successful fight against mental illness. It will particularly enable the program to be more effective in poverty areas where there is a most urgent need which has been most difficult to meet because particular difficulties have been encountered in developing Community Mental Health Centers.

Mr. Chairman, the AFL-CIO has supported the Community Mental Health Centers Program since it was first proposed. The success of the program in the few years of its existence has been gratifying to us and has increased our interest in this vital and imaginative program.

In 1955, the number of resident mental patients reached an all time high of 559,000. By the end of 1968, there were fewer than 401,000. This is about half the number of patients that would have required hospitalization if the spiraling trend had not been reversed. Reversing that trend has saved and made available an estimated \$4.5 billion to the States. This downward trend in hospitalization is now accelerating and the National Institute of Mental Health estimates that the total resident patient population will decline to 189,000 by 1973—saving even larger sums of money that will be available for other needs. There is every indication that the community mental health centers were largely responsible for the decline in the number of hospitalized patients.

In spite of this progress, the necessity to extend and expand community mental health services seems obvious when measured against the size of the remaining problem of mental illness in the United States. The mentally ill still occupy 40% of the nation's hospital beds; at least 60,000 Americans are drug addicts; and an additional hundreds of thousands misuse drugs. A third of the population suffers symptoms of depression and more than 5 million persons are unable to control their use of alcohol. Fewer than 5% of America's children with emotional disturbances and mental illness of varying intensities receive the treatment they need. Extending the program for another 5 years and authorizing \$975 million for this period—\$595 million for construction and \$380 million for initial staffing—is a modest effort when measured against the dimensions of the problem.

As the representative of workers, the AFL-CIO has a direct interest in this program. Our experience with collectively bargained health and welfare plans has underscored the urgent need for outpatient services and early care which generally are not covered in negotiated plans. The Community Mental Health Centers coordinate in one place the comprehensive and essential services that permit a worker to have his condition diagnosed and a course of treatment outlined from a wide range of therapeutic services. Community Mental Health Centers are enabling our affiliates to bargain with their employers for these kinds of services by including provisions in their agreements for contracting directly with these centers. However, though collective bargaining and other private mechanisms can and should play a greater role in meeting the financial burden of mental illness, even the most optimistic projections show only a small proportion of the required services can be expected to be financed from private prepayment, and thus a successful national program will require that mental health care combine to be largely a public responsibility.

Organized labor also is particularly concerned about mental health problems because we are aware that workers are more affected by mental illness than more affluent members of society. Research in recent years has shown that when mental illness comes to notice in workers, 80% are already psychotic; in middle class families, 55%, and in upper class families, 35%. We are also concerned that there seems to be a double standard of treatment for mental illness. The well-to-do under psychotherapy; for workers and low income groups only chemical therapy and institutionalization which are both less desirable and usually less effective. Nearly 90% of the mentally ill in lower socio-economic groups are institutionalized. Fortunately, this situation, largely because of the Community Mental Health Center Program, is in the process of change. S. 2523 contains several features which can make an important and crucial contribution to the resolution of this problem.

The bill would authorize for rural and urban poverty areas up to 90% federal funding for construction and in addition authorize a 90% federal share for the first two years and 75% for the next eight years for staffing. It also would authorize 100% funding, not to exceed \$50,000 per catchment area, for initiation and development of programs for community mental health services in these areas.

Many rural, urban, and metropolitan communities have been unable to develop community mental health centers and services because of lack of resources or because of their inability to define the problems involved. The problems are the greatest in those areas with the fewest resources—the inner city poverty and sparsely populated rural poverty areas, where the need for mental health services is the most urgent.

A recent health study of the general population commissioned by Blue Cross has dramatized this problem. The researchers making the study divided areas surveyed into subsections in order to get a more accurate picture of the problems of people living in depressed areas as compared to those living in average areas. In Appalachia, in Spanish speaking communities, and in the inner city areas, there were shocking differences in health between the poor areas and what the surveyors called average areas. The incident of heart disease in the poor areas was four times as great as in the average area. It was eight times higher for visual defects; three times higher for orthopedic defects; and which is of particular interest in the consideration of this legislation, was six times greater for nervous and mental disorders.

Effectively reaching labor and low-income groups with mental health services is crucial to the success of the entire community mental health program. But without higher federal sharing of construction costs and a higher federal percentage of costs of staffing, the marshalling of sufficient resources to build and operate Community Mental Health Centers in low income areas will be difficult and delayed. Though almost all communities are in need of assistance in setting up programs to develop comprehensive mental health services, the need is unusually acute in poverty areas as evidenced by the fact that only 7% of existing Community Mental Health Centers are located in areas with a high concentration of families with incomes of less than \$3,000 per year. Yet it is in those areas where the need is greatest. More generous matching formulas for these areas would help remedy this lack of resources in many communities.

Greater funds and a more generous matching formula for construction and staffing of Community Mental Health Centers are of paramount importance in poverty areas. But the proposal for 100% funding of initiation and development grants, though a small cost item, is also vital since it is a key factor that in many of these areas will spell the difference between getting a center started or having no mental health services at all for people in the area.

Relatively few of these low income areas which are potential applicants for Community Mental Health Center funds have the special know how or experience within the community for effective mental health program development on the broad scale required for the establishment of effective and comprehensive services. The authorization of 100% funding for initiation and development grants would fill this gap by enabling the community to contract for the necessary expertise and the employment of experienced personnel. This emphasis on program development would not only make a significant contribution to the emergence of mental health programs in low income areas but would also tend to insure the development of programs with greater relevance to the specific and critical needs of the community.

Of course, not only poverty areas, but many other communities face serious financial problems in the operation of their mental health centers and will have to curtail and even cease operation of centers when federal aid stops. If we are going to maintain the present rate of progress, it is imperative that the present limit of 51 months for staffing aid be extended to 10 years. Fifty-one months is a rather short period in which to secure adequate and new sources of funds to replace the significant amounts received from the federal government for staffing. A 10-year program would enable a center to phase out smoothly from federal assistance without the disruptions that are now occurring and will occur as federal funds cease.

Related to the financial problems of staffing is the limitation in the present law which restricts staffing grants to "professional and technical" personnel. There is no good reason why there should be differentiation between "professional and technical" and other kinds of personnel. All are essential to the operation of a center. It is not always easy to distinguish the fine line that separates a professional from a nonprofessional and whether an individual is or is not involved in the treatment and care of a patient. This often requires burdensome and time-consuming checking by the National Institutes of Mental Health. Since similar restrictions do not exist in other grant programs and since its elimination would remove an administrative hindrance, there seems little reason for its retention.

The Community Mental Health Centers program has been an outstanding success. Currently, about 54 million persons live in areas with community mental health centers or are in catchment areas for which construction and/or staffing grants have been obligated. With six years of successful experience, there is every indication that if the minimum required funds are made available, we can help

lift the heavy burden of mental illness from millions of Americans. We urge passage of S. 2523 because it will accelerate progress toward the goal of insuring every American, rich or poor, access to mental health services.

Mr. FAIR. Prior to 1960 the AFL-CIO Community Services Department published its first program or pamphlet to assist workers in the mental health field. That publication was reprinted in 1961 and is to be reprinted very shortly again, I understand.

Mr. SEIDMAN. It is being updated at the present time.

Mr. FAIR. Representing workers, the AFL-CIO has a direct interest with this program. Our experience with negotiated mental health plans have understood the need for outpatient services and general care which are not covered in plans today. The community mental health centers coordinate in one place the comprehensive and essential services that permit a worker to have his condition diagnosed and a course of treatment outlined from a wide range of therapeutic services.

Community mental health centers are enabling our affiliates to bargain with their employees for these kinds of services by including provisions for contracting directly with these centers. However, the direct bargaining and other private mechanisms can and should play a greater role in meeting the financial burden.

Even the most optimistic projections, however, show only a small proportion of the required services being expected to be financed from private prepayment. And thus a successful national program will require that mental health care continue to be largely a public responsibility.

Mr. Seidman estimates that substantially below 10 percent of our contracts provide for out-patient services in the mental health field.

The second emphasis that we would like to make with regard to this program is as follows: Effectively reaching labor and low-income groups with mental health services is crucial to the entire community mental health program. Without higher Federal sharing of construction costs and higher Federal percentage of cost of staffing, the marshaling of sufficient resources to build and operate community health centers in low-income areas will be difficult and delayed.

Almost all communities are in need of assistance in setting up programs to develop comprehensive mental health services. The need is unusually acute in poverty areas, as evidenced by the fact that only 70 percent of existing community mental health centers are located in areas with high concentration of families with incomes of less than \$3,000.

The last emphasis we would like to make, Mr. Chairman, relates to the financial problems of staffing. The limitation in the present law restricts staffing grants to professional and technical personnel. There is, we think, no good reason why there should be a differentiation between professional, and technical, and other kinds of persons. All are essential to the operation of a center.

We would conclude as follows. The community mental health program has been an outstanding success. Currently about 54 million persons live in areas with community mental health centers or in areas for which construction or staffing grants have been obligated. With 6 years of successful experience, there is every indication that if the minimum required funds are made available, we can help lift the heavy burden of mental illness from millions of Americans.

We urge passage of S. 2523 because it would accelerate progress toward the goal of accelerating to Americans, rich or poor, access to mental health services.

Senator HUGHES. Mr. Fair, I am sure the chairman would want me to thank you in his behalf and for this community the support of this legislation. The important answer of it is affecting all of our people in the social structure and particularly the laboring man and all of us who need these services.

I would like to ask you a couple of questions that may not be covered in your statement. If they are, forgive me. I would like to know if there has ever been an industrywide negotiation for alcoholism recovery program in industry.

Mr. FAIR. Not to my knowledge.

Mr. SEIDMAN. Not to my knowledge either.

Senator HUGHES. As you men undoubtedly have experienced, there has been a great deal of abrupt dismissal because of this type of an illness throughout our history. And it is continuing today and I have certainly exerted our National Government to be an example to industry and to labor to lead the way with a Federal program for all Federal employees. I would likewise encourage you to hope that we might be able to somehow through negotiation processes have industrywide programs for all of the laboring people that are represented, so that they can be stopped before they reach the dismissal and appeal point from employment.

I think it is important in prevention that labor look into these matters.

Mr. SEIDMAN. You asked a very specific question as to whether this was general in collective bargaining. And it is not. There are one or two cases, and they are important ones. An important one that I know of particularly, involves the Communications Workers and the Bell Telephone Co.

But in addition to that, I should say that the AFL-CIO has by no means not been concerned with the problem. Quite the contrary, through our community services operation, where we have community services representatives in over a hundred cities throughout the country. They do focus on this problem.

Mr. Fair has here a copy of a pamphlet, "What Every Worker Should Know About Alcoholism."

Senator HUGHES. I am well aware of that, Mr. Seidman, and I worked hand in hand with some of your people in my own State, where we have had unique problems that developed. I simply want to make the record here. This is the reason I am asking the question of the importance. Not only because the implication has been given that we are not doing too much, but I think through the means of organized labor you have a massive potential of prevention of deterioration in this disease.

So this Senator is grateful not only for what you have done, but what you have the capability of doing, by extending these concerns on into the future. I did not ask the question to imply that your concern was not there.

Mr. SEIDMAN. I quite understood that and I wanted to emphasize that we have had this concern and have a continuing concern in this area.

Senator HUGHES. I would like to ask if you know what percentage of people needing services that you would represent would be in the field of alcoholism.

I realize this is a very difficult question for you to answer.

Mr. FAIR. I would have no idea. Let me say that our community services people are chiefly located in cities, cities of 125,000 or more. They are usually representative of two groups, our craft unions and our industrial unions. These persons know the labor problem of their area. They usually sit also on certain of the social service boards in the community, so when there is a grievance it is brought to the attention of the community services people.

How many of these grievances because of absenteeism are due to alcoholism, I couldn't answer. I don't know that we have ever had any study made of the extent of it.

I do know cases arise where we have absenteeism due to alcoholism. I do know reports are made to our community service personnel, but how great, I don't know.

Senator HUGHES. I think generally your support of this particular piece of legislation and your general recognition and leadership in the field, I might add, is vitally important in Congress of the United States and in the social structure of our country. I would again express on behalf of the chairman and myself and the committee our appreciation for your social concerns in these areas.

I think it is vitally important if we are ever going to pass legislation that is substantial enough, with enough endurance that it can be effective, that labor give its unqualified support as it has in the past and I am sure it will in the future.

So we do appreciate this. I won't belabor you with a lot of questions that would be repetitious that have already been asked, but simply express my appreciation and if any of you have anything additional you would like to say in the record, feel free to do it at this point.

Mr. Smedley, would you have anything to offer?

Mr. SMEDLEY. No, Mr. Chairman.

Mr. FAIR. Thank you very kindly, Senator. We appreciate this opportunity very much.

Senator HUGHES. Thank you, Mr. Fair.

The chair would call Dr. Leston Havens, regional mental health center administrator, State department of mental health, Boston, Mass.

Dr. Havens, if you would take the chair and proceed as you desire, please.

STATEMENT OF LESTON HAVENS, ADMINISTRATOR, REGIONAL MENTAL HEALTH CENTER, STATE DEPARTMENT OF MENTAL HEALTH, BOSTON, MASS.

Dr. HAVENS. I have a prepared statement, Senator, that I ask leave to have entered in the record and I will make some brief comments by way of summary.

Senator HUGHES. We will have your prepared statement printed in the record at this point and you may proceed.

(The prepared statement of Dr. Havens follows:)

PREPARED STATEMENT OF LESTON L. HAVENS, M.D., MENTAL HEALTH ADMINISTRATOR FOR BOSTON

I want to speak to you about the mental health problems we have in Boston and the day-to-day ways in which our community mental health centers, of which we'll soon have five, are attempting to meet them. Being an urban region and having many significant areas of poverty, we too have this group centrally on our minds. The sick poor, and especially the children of the sick poor, are doubly handicapped—both from outside and from within themselves. They ask of us fresh imagination, courage, and generosity.

Unfortunately, it is not possible to report that the money already appropriated and spent for community mental health centers has completed the job. Despite significant gains, the problem remains a large one. *We have in this country today an epidemic of mental illness.* Reliable studies put the percentage of significantly ill individuals as at least 25% and more nearly 40% of the total population. It is conservatively estimated that more children die beaten to death by their own parents than died of some major infectious diseases. In one carefully-studied area of Boston, the number of children needing help exceeds the capacities of available resources by 20 to 1.

The situation in poverty areas is even worse. Every investigation I know reports higher rates of hospitalization, more psychosis, more delinquency, alcoholism, and addiction among the poor than among those economically better situated, whatever the ethnic group. (For example, a recently instituted computer program for locating psychological disaster areas in Boston and therefore indicating where we need to put our services, has shown an intense clustering, broken families, psychoses, hospitalization, low income and high welfare costs around one housing project.) Juvenile delinquency and alcoholism are the major problems concerning people in large areas of Boston. In addition, there is more difficulty hiring medical workers, less thorough-going treatment, and a greater need of long-term help in the poverty areas. And, where relatively ample economic resources don't exist already, there is difficulty collecting the matching funds that would secure federal assistance for needed programs. We see, both in the individuals' lives and in the potential efforts to assist them, a *vicious circle*, through which failure breeds more failure.

In thinking of the contribution that further mental health programs can make to remedying these conditions, I ask you to clear your minds of the old picture of psychiatry: which was one of large state hospitals locking patients away in the country or of office practitioners treating a few wealthy patients. Today community mental health centers provide *neighborhood clinics, emergency services, day and night hospitals* near the patients' homes, *vocational assistance*, and *consultation* help to welfare workers, police, adoption agencies, family services, visiting nurses, schools, churches and synagogues. Welfare workers want help with violent clients and disorganized families; the police have called on us to assist with runaway adolescents and the extraordinary numbers of the addicted, many of them children. Ministers, priests, and rabbis come to us for training in how to help with the mental and emotional disorders they recognize increasingly. Correctional officers seek advice on dealing with disturbed individuals in jails and prisons. The list grows daily and outruns our resources.

Let me describe some of the specific activities of our community centers. You will see that our twin goals are helping patients and helping others help. Thus, one center provides guidance to private charitable groups distributing money and leadership to severely disorganized families. Other funds go toward hiring group workers to help mothers who have lost husbands, to families with delinquent children, to hire expert recreational and vocational leadership for boys without fathers. By knowing intimately the helping activities of its area of responsibility, the centers are able to coordinate programs and prevent overlap of services.

We have learned, painfully, that it is not enough to build housing in rundown and overcrowded communities. Bricks and mortar are not enough. As a result, the Boston Redevelopment Authority seeks psychiatric help in its decisions and that help is best given by community centers well-versed in the needs of the people served.

Similarly, we know that finding people jobs, even training and retraining for employment are not enough. Many well-trained workers cannot work because of psychological handicaps such as needs to quarrel with bosses, inability to get along with associates, carelessness in attendance or work habits. Surprisingly

good gains have been made against these and other serious vocational handicaps once it has been possible to identify them and apply such remedies as group therapy. If many of our people are to grow out of shifting, listless, dependent, often violent lives, psychological treatment of vocational disabilities must be greatly extended.

The demand for services has proved considerably larger than we had anticipated. At the time one staffing grant was written in 1967 it was expected the number of admissions to the in-patient unit would run approximately 200 per year. The figure for the three-month period April 1 to June 30, 1969 is 134, which would give an annual total of 536. Part of this is due to the opening of an alcohol unit. However, non-alcoholic admissions have also increased as the community-oriented program becomes known.

I cannot emphasize strongly enough that successful work, especially in the poverty areas, requires skills of many disciplines and personnel, coordinated efforts often among several private and public agencies, and not infrequently for many months or even years. Splendid results can be achieved, but they do not come easy. The work takes lots of manpower, money, courage and time.

I doubt that the states can take up the whole burden in the near future. Certainly, if they are forced to, the expansion of the work will be further delayed. As it is, most administrative and secretarial costs, rents, and many others must be borne by the states, hospitals, the universities, or privately. Again, this limits sharply expansion of the programs. Third party payments and fees are meager still, particularly from the poor and those whose lives have been most seriously disorganized and are in most need of help. In one of our centers patient fees run less than 2% of costs and third party payments have not yet lifted this above 5%.

We have among us today psychological and social problems of epidemic proportions. We have in sight the means to offer many of those afflicted and many who would otherwise become afflicted healthy lives and fruitful developments. We have the beginnings of knowledge and personnel to do it. This piece of legislation is a serious step in that direction.

Dr. HAVENS. I work for the Department of Mental Health in the Commonwealth of Massachusetts, but my area of responsibility lies in the city of Boston, which includes, as you well know, many areas of poor people, ethnic groups that have severe difficulties and it is to some of those issues that I want to speak briefly now.

I don't think I need to emphasize, having heard much of this testimony this morning and heard about the testimony on Monday, I don't think I need to emphasize that the cities contain certain problems that have to be taken very seriously. There is no exception, to my knowledge, to the statement that the cities have more in the way of psychosis, hospitalization needs, more alcoholism, more addiction, more severe problems per capita than any other part of the country.

Not only that, but the cities often in their more dismal areas have great difficulty attracting people to work in them. The problems involve many agencies and groups and usually require tenacious and determined approaches. On top of that, we have had difficulties in the cities that stem from the fact that many city groups are unable to get matching funds to secure the Federal assistance they need for their programs.

This initiates a vicious cycle in which the poor stay poorer or get poorer and those across the country with resources and able to match funds get richer.

I want to say something now about the work of the community health centers in Boston. We have four and we hope to have five by 1970. I think it is important to emphasize that this work has steadily expanded. I don't think anything is more astonishing in this whole field than the way demand for our services has steadily increased.

The police have called on us more and more for help not only with runaway kids, not only with addiction problems, but with many everyday police patrol problems that they don't feel they are handling as well as they want to. The schools are calling upon us in ever-increasing numbers to help with kids whom the guidance resources and teaching classroom resources are just not sufficient to meet.

The visiting nurses associations, which do so much good work in the cities and go out and into homes that many other professions are unwilling to go into, are using us now to help with very severe problems of many kinds that touch on psychological and social difficulties with which we are able to deal.

The vocational rehabilitation people have sensed increasingly that job difficulties are not simply related to placement and finding jobs for people, not simply related to training or retraining, but so often to psychological difficulties, jealousies of associates, tardiness, many problems that call for psychological help, certainly for the identification of psychological problems.

I am struck how many volunteer charitable organizations have turned to us for guidance in spending their funds. They have come to feel that giving money away or intervening actively in disorganized families is not wise unless they have expert psychological and social advice about how best to intervene. Too often they feel now that they may be increasing dependency or making problems worse unless they can really grasp the nature of the type of problem they are dealing with.

I mention these examples and I won't take more of your time by mentioning others, only to indicate to you that this work is opening up demands on our services, is increasing, which makes this piece of legislation, with special provisions about enlarging the centers, of utmost importance if we are to respond to this very wide community demand.

A word about the financing. In my State of Massachusetts the State has done yeoman service in providing funds to mental health in trying to secure the Federal money, and our universities, hospitals, and other groups have also done yeoman service in trying to scrape their money together to secure Federal money, and they have in many instances been successful.

It is obvious, however, that the State is very hard pressed, as is the Federal Government, to secure enough funds to continue these programs in the way that the community is increasingly calling upon us to do.

Third-party payments for these services is very small return. In one of our centers we were getting less than 2 percent of costs from fees and we probably can't expect in the immediate future that to go much over 5 percent, even with the third-party costs.

Of course, the problem that is presented by the absence of other than professional and staff stipends, because at least half of our costs come from rent and administrative and other expenses, makes the expansion in response to community need of very great difficulty for us at the present time.

Let me make in closing one comment about a subject that Senator Hughes has been asking about a good deal this morning, in the very inspiring and highly intelligent discussion of the alcoholism issues.

One of the big issues we face in Massachusetts is whether the alcoholism programs should be under mental health, under public health, or where they should be. In the legislature in Massachusetts today there are several bills proposing different solutions to this problem.

It seems to me, without being certain, that probably the legislature will go in the direction of putting the alcoholism and addiction programs under mental health. Whether this is wise or not, I don't think anybody can be sure. But when we have said that the programs will be under mental health, I think we have only begun to consider the issues because we can have them under mental health and have them separate from the centers or we can have them in the centers.

We have many possibilities for experimentation. I share Senator Hughes concern with the fact that on the whole the medical profession has not come forward with enthusiasm or determination to deal with alcoholism or addiction problems. And I share the feeling of one of the earlier speakers about the importance of us finding inspired leadership for these programs wherever it may be, public health, mental health, inside or outside the medical profession.

I think, however, that we would be best advised to preserve some connection with the community health center programs in our alcoholism and addiction efforts, because these community mental health programs have become very sophisticated in the sense that they have accumulated half-way houses (we have several in Boston), rehabilitation programs; they have accumulated clinic and group therapy and drug experience, all of which have a place in the treatment of at least some alcoholics and addicted people.

My own hope is we can keep the administrative arrangements for the alcoholism programs flexible so we can experiment with what would be the best method, so we can make use of the available resources we have accumulated in the community mental health centers, so these can be extended to the alcoholic and addicted patients, but keep them separate enough so they don't become second-rate citizens as in some of the medical programs.

Thank you, Senator.

SENATOR HUGHES. Thank you very much, Dr. Havens, for a very enlightening statement here in addition to your printed statement. You analyzed my position correctly. I have great concern about turning the treatment and care of 5 to 10 million Americans plus the compounding emotional problems of their families over to a group of professional men and women who have displayed absolutely no interest in doing anything about the problems except in isolated instances.

I have met here and heard a group of psychiatrists this morning who have the same concern I have, so you hearten me. How do we bring the respectability to this disease to make it acceptable to your colleagues around this country? If you can enlighten me on that, I could perhaps take some courage.

DR. HAVENS. One thing that can be said about the psychiatric profession is that we have been able to make some very unrespectable things respectable. I remember barely 15 years ago that I came into this work and at that time schizophrenic patients were regarded with fright. Today it is almost a popular "bag" in medicine to be a schizophrenic patient and that is only in 15 years.

I don't think in the long run the alcoholic patient is going to present as much in the way of difficulties as has been true in so many patient groups. So I am basically optimistic about this. At the same time I share your feeling we have to maintain the utmost vigilance that this group once again doesn't become relegated as second-class citizens.

Senator HUGHES. Again I would like to ask you a couple of personal questions that are not aimed at you, but are aimed at establishing a record. Did you personally have any training in the field of alcoholism during educational process?

Dr. HAVENS. I have had experiences with some friends of mine and I rate that very high in terms of my learning. In my own technical psychiatric experience I think I have learned enough about the human mind and learned enough about myself to be able to share many of the kinds of problems that bring on alcoholism.

As for specific lecturing and laboratory teaching, in this regard, as previous witnesses have testified, medical colleges for the most part simply have not done the job.

Today we are a little bit better than we were. At Harvard Medical where I teach we have some opportunities for students to become conversant with this work partly due to the fact that the general hospitals that make up Harvard University complex of hospitals have some alcoholism clinics as part of them. And there the students do learn something about this work.

When I took my American Board examination to be certified in my specialty, I made it my business to do some reading in this field and I visited some of the clinics and hospitals that are primarily interested in this problem in Massachusetts.

The basic point you are seeking to emphasize is that the training and emphasis in medical school on this problem has not been sufficient and I agree with that completely.

Senator HUGHES. That is the thing I think we need to recognize. I think simply by recognizing it, most of your professional colleagues ahead of you have testified in fact rather than receiving training, they inherited prejudices.

Dr. HAVENS. Let me add one point to that Senator. I think one thing that may make you an even better friend of the community mental health center movement is this fact. I learned most of psychiatry at Massachusetts Mental Health Center, the old Boston Psychopathic Hospital. When this building was put up in 1912 and when the statutes pertaining to its organization were put through, old people and alcoholic patients were specifically excluded from required admissions to that hospital. In other words, they didn't have to take these people if they didn't want them.

As a result of the community mental health program, that hospital is now responsible for one of the geographical areas of Boston. That hospital is now required to take everybody that comes to it, including alcoholic patients, and over the last 2 years it is taking them in and doing a good job with those patients, the kind of job that made the hospital famous.

In short, this whole hospital and many others have begun to take up some of their responsibility toward this patient group.

Senator HUGHES. As a man who has spent 15 years trying to get people admitted to hospitals and people to treat them, and in some

cases not succeeding, I somehow take heart from your statement. The discrimination is still prevalent. I have tried in the last 2 weeks to gain admission of people for treatment unsuccessfully in this city. It goes on every day we live.

I realize recorded history talks about the possessed and drunk as being those people to avoid and apparently we have learned that Scripture lesson well.

Now is the time we should overcome it and with help of men such as yourself, we can. The disease, of course, is known among those who suffer from it as a disease, so it is well that in the northeast part of the country it is becoming acceptable.

I think your contribution here generally in support of this piece of legislation and the tremendous needs that we have are very beneficial to the committee. I know the chairman would want me to express in his behalf his appreciation for your being here to testify today in support of this legislation. I certainly do individually want to express that and to share the hope with you that we can face these problems for what they are.

This country can afford to do what needs to be done in these areas. The truth of the matter is that it cannot afford not to do these things. Too long have we been looking backward rather than forward.

With your assistance and the assistance of people like you, who are willing to break these barriers, we can make people into a whole human being as well as walk on the moon and we can set the priorities of our people on the value and dignity of the individual human being.

We can all assist one another in making people whole personalities again, not only physically, but mentally and to gain the strength they need from a social structure that will help give it.

Thank you.

The hearing record will be kept open for a few weeks for the benefit of those who could not be here to testify and are submitting statements. I also order printed at this point any other pertinent material submitted for the record.

(The material referred to follows:)

PREPARED STATEMENT OF TOM RAMSOUR, PRESIDENT, MENTAL HEALTH ASSOCIATION,
TYLER, TEX.

We earnestly support and urge passage of S. 2523 (Community Mental Health Centers Amendments of 1969) because we believe it is essential to achieve what was our goal and that of the 85th Congress in making possible needed services for the mentally ill of our country. The program must be continued until communities that already have centers can operate effectively and others (rural and inner-city poverty areas) lacking the necessary local financial support at the present time, can be brought into the program.

The Community Mental Health Center approach has already proved of great value as we see a steady decline in the population of state and county mental hospitals and a substantial reduction in new admissions to those hospitals. Have you ever visited one of our mental hospitals? If so, then you know what this can do to the human spirit regardless of the quality of facilities or services. These centers provide for only a fourth of the population at present and need to be expanded.

Certainly we realize the strain on finances that the foreign and domestic problems of our country make, but our greatest resource is people. Their health and well being is essential to the strength and vitality of this nation. Please give

those with emotional difficulties the opportunity to get help close to home when it is needed by voting for this bill, the Community Mental Health Center Amendments of 1969.

Our membership of around 2500 in the Tyler-Smith County Mental Health Association are but a few of the thousands of people in this area who are concerned about the plight of our mentally ill and the retarded persons among our citizens. We speak for them in pleading for your support.

PREPARED STATEMENT OF BERWYN F. MATTISON, M.D., EXECUTIVE DIRECTOR, AMERICAN PUBLIC HEALTH ASSOCIATION, INC., NEW YORK, N.Y.

On behalf of the American Public Health Association, the largest public health association in the United States, I am pleased to have this opportunity to submit our recommendations on your bill, S. 2523, the Community Mental Health Centers Amendments of 1969. We urge enactment of S. 2523.

The development of community based services for the mentally ill has been stimulated by Federal funds for the construction and staffing of community mental health centers. This trend has enhanced the quality of mental health services by overcoming their traditional isolation. Incorporation into the main stream of medical, hospital and related health services in the community will bring to mentally ill patients the benefit of the full range of modern health services. The American Public Health Association urges that the Federal, State, and local agencies responsible for planning new community mental health facilities and services adopt policies that will encourage the maximum use of general hospitals, local health departments and other established community services in extending care to mentally ill patients.

The Congress has clearly indicated through Public Law 89-749, and its amendments, that comprehensive health planning is an important tool to assist in the national goal of improved health services for all Americans. This legislation established the concept of Federal-State-local partnership for health and strengthened the States' role in the planning for certain formula and project grants.

The American Public Health Association urges that Congress should continue to support the charge it gave to the States under Section 314(a). It should make every effort to assure that the State health planning agency be given a clear and unequivocal role in the planning coordination of each new and revised Federal health program that Congress enacts. In particular, Congress should apply this principle to S. 2523 that is currently pending before your Committee.

In other respects the American Public Health Association endorses the legislation as introduced. We are especially pleased that recognition is given to the differences in economic status among areas within States through the increase in Federal share for mental health centers in urban and rural poverty areas. The increased authorization for appropriations is warranted and should be of assistance in extending mental health services to all areas of the United States. Only 75 million of our population now resides in locations served by community mental health centers.

Again, let me express our support for this legislation and ask that this letter be made a part of the printed record of hearings.

U.S. SENATE,
Committee on the Judiciary,
Washington, D.C., August 7, 1969.

HON. RALPH YARBOROUGH,
Chairman, Health Subcommittee, Labor and Public Welfare Committee,
U.S. Senate, Washington D.C.

DEAR MR. CHAIRMAN: Dr. James K. O'Toole and Mrs. R. D. Schoregge have sent me the enclosed letters regarding S. 2523.

I would deeply appreciate your consideration in including these letters in the permanent record of your hearings on this bill.

With kind regards, I am

Sincerely,

QUENTIN N. BURDICK.

Enclosures.

MEMORIAL MENTAL HEALTH AND RETARDATION CENTER,

Bismarck, N. Dak., July 31, 1969.

Senator QUENTIN BURDICK,
Senate Office Building, Washington, D.C.

DEAR SENATOR BURDICK: I wish to express my thanks and appreciation for your support on Senate Bill 2523 pertaining to the amending, extending, and approving certain Public Health Laws relating to mental health. I am serving as director of the Memorial Mental Health and Retardation Center in Bismarck, North Dakota and constantly will find ourselves in financial difficulties because of the lack of money for mental health in our state and our nation.

Even though the local mill levy has been passed by eight of the ten counties in our catchment area, this would be seventy-five cents per person to support a staff of well trained individuals who are asked to care for 104,000 people. Approximately one new person a day come to our Center requesting some type of social, psychological, psychiatric, or rehabilitative service. Our agency, even though it has been under Federal assistance, had to beg, borrow, and fantasy theft to keep the doors open.

As you know we are a community organization with specialists in a number of related fields trying to pull together the fragmentation of services that one community offers. We are constantly handicapped by personality conflicts within communities and personal interests of individuals in their own particular fields but we do not feel that this is not an insurmountable problem. We strive for continuity of services for individuals who may seek our help and attempt to serve the citizens in our area, without regard to age, economic status, religious or racial differences, who have emotional problems from the most serious psychiatric disabilities to those who have just questions, worries, or concerns. We attempt to give assistance and consultation to other agencies who work with people. This includes the schools, physicians, public health nurses, welfare agencies, rehabilitation agencies, employment agencies, public health service—Bureau of Indian Affairs Hospital, and the court and correctional officers. Unfortunately, because of our limited staff and funds we must spread ourselves very thin.

We would appreciate any help that you can give us from the Federal Government to carry out the responsibilities that have been previously assigned to us. Hopefully you can help bring the Federal matching of all caretaking organizations on a similar base. As you are aware there are many service organizations already receiving 50 to 80 percent Federal matching.

Sincerely,

JAMES K. O'TOOLE, M.D.,
Clinical Director.

NORTH DAKOTA MENTAL HEALTH ASSOCIATION,
Bismarck, N. Dak., July 31, 1969.

Senator QUENTIN BURDICK,
Senate Office Building,
Washington, D.C.

DEAR SENATOR: Permit me to thank you so very much for your interest and concern for Senate Bill 2523 (Community Mental Health Centers Renewal and Extension Act).

It has been my privilege to serve as a member of the Board of Directors for the Memorial Mental Health and Retardation Center in Bismarck. I am heartened by the fact that we have a facility such as this in our community.

We are very proud of our mental health program in North Dakota, our five centers are functioning very effectively.

Our enabling legislators on the State level are extremely good.

It is my belief that the three levels of government (state, local and federal) funding of these centers is the proper way. The amendment you introduced to extend the federal participation to ten years is a very helpful and important aspect. The federal participation insures the discipline a board such as ours needs. I am afraid that when the federal share is completely removed, our centers will cease to be comprehensive in nature. This has been the truly great part of our center program.

I'm really proud to have you for my Senator. Your sponsorship of this Bill makes me even more proud of you. Thanks so much.

Sincerely,

Mrs. R. D. SCHOREGGE.

Enclosures.

U.S. SENATE,
COMMITTEE ON FOREIGN RELATIONS,
Washington, D.C., July 25, 1969.

HON. RALPH YARBOROUGH,
*Chairman, Committee on Labor and Public Welfare,
U.S. Senate, Washington, D.C.*

DEAR MR. CHAIRMAN: I have received the enclosed letter from the Tennessee Mental Health Association and, as you will note, my constituent, Mr. Sanford F. Brandt, has requested that I inform you and members of your Committee of the position of the Association with respect to the bill S. 2523.

I would appreciate very much your making Mr. Brandt's letter a part of the Committee file and I am sure you will give full consideration to the points emphasized by Mr. Brandt.

Sincerely yours,

ALBERT GORE.

Enclosure.

TENNESSEE MENTAL HEALTH ASSOCIATION,
Nashville, Tenn., July 23, 1969.

HON. ALBERT GORE,
*U.S. Senate,
Washington, D.C.*

DEAR SENATOR GORE: I understand the Committee on Labor and Public Welfare will hold hearings July 28 on S. 2523, the proposed community mental health amendments of 1969.

The Tennessee Mental Health Association endorses S. 2523 in its entirety, and we will appreciate your informing Chairman Yarborough and members of the Committee of our position.

Enactment of S. 2523 or comparable legislation extending and enlarging on the existing community mental health legislation would be very much in the interest of Tennessee. For purposes of carrying out the original act of 1965, Tennessee has been divided into 21 "catchment areas," each capable of supporting (in terms of population, geography, etc.) a comprehensive community mental health center. We now have centers in operation, under construction, or approved for construction in 6 of the 21 areas. However, in view of the time it takes to develop local sponsorship, raise state and local matching funds, recruit adequate staff, and so forth, I doubt if it will be possible to organize more than two or three additional centers, at the very most, before the existing authorization for Federal grants expires in 1970.

This is not to say that Tennessee does not need, or does not want, or will not support more centers. It simply means that there hasn't been time in the relatively few years of the program's existence to carry out in every one of the 21 catchment areas the basic educational work that must precede the organization of a comprehensive community mental health center. The Tennessee Mental Health Association and its local chapters across the state are working at it, and the Tennessee Department of Mental Health is working at it. But it takes time, and we need the added time that S. 2523 would give us.

In addition to supporting the bill in general, I would like to comment on two sections in particular that appeal to us. First, one section of S. 2523 would authorize higher-than-average grants in poverty areas. We are highly in favor of this. I do not know how "poverty area" will be defined, but of the 6 approved centers in Tennessee, only one appears to be clearly in a poverty area. A higher level of Federal funding in poverty areas, both urban and rural, would definitely help us.

Second, another section of the bill would authorize appropriations for "developing necessary resources and involving local citizens in the development of mental health programs." As we all realize, there are some parts of our state where it is hard to round up enough money simply to explore the possibilities of establishing a community center. The seed money authorized in this section would pay off very well in Tennessee.

If you would like additional information on the comprehensive community mental health program in Tennessee and our need for the proposed amendments, please call on us. We are well aware that you have consistently supported both authorizations and appropriations for this program in the past, and we are looking forward to your continued support. Meanwhile, we shall appreciate it if you will forward our views to the Committee on Labor and Public Welfare.

Sincerely,

SANFORD F. BRANDT.

U.S. SENATE,
COMMITTEE ON PUBLIC WORKS,
Washington, D.C., July 29, 1969.

HON. RALPH YARBOROUGH,
Chairman, Committee on Labor and Public Welfare,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: I enclose a copy of a letter from the President of the Tennessee Mental Health Association, endorsing Senate Bill 2523 and making comments on particular sections of it that are of particular interest to my state. I will appreciate whatever attention you may be able to give this matter.

Sincerely,

HOWARD H. BAKER, Jr.

Enclosure.

TENNESSEE MENTAL HEALTH ASSOCIATION,
Nashville, Tenn., July 23, 1969.

HON. HOWARD H. BAKER,
U.S. Senate,
Washington, D.C.

DEAR SENATOR BAKER: I understand the Committee on Labor and Public Welfare will hold hearings July 28 on S. 2523, the proposed community mental health amendments of 1969.

The Tennessee Mental Health Association endorses S. 2523 in its entirety, and we will appreciate your informing Chairman Yarbrough and members of the Committee of our position.

Enactment of S. 2523 of comparable legislation extending and enlarging on the existing community mental health legislation would be very much in the interest of Tennessee. For purposes of carrying out the original act of 1965, Tennessee has been divided into 21 "catchment areas," each capable of supporting (in terms of population, geography, etc.) a comprehensive community mental health center. We now have centers in operation, under construction, or approved for construction in 6 of the 21 areas. However, in view of the time it takes to develop local sponsorship, raise state and local matching funds, recruit adequate staff, and so forth, I doubt if it will be possible to organize more than two or three additional centers, at the very most, before the existing authorization for Federal grants expires in 1970.

This is not to say that Tennessee does not need, or does not want, or will not support more centers. It simply means that there hasn't been time in the relatively few years of the program's existence to carry out in every one of the 21 catchment areas the basic educational work that must precede the organization of a comprehensive community mental health center. The Tennessee Mental Health Association and its local chapters across the state are working at it, and the Tennessee Department of Mental Health is working at it. But it takes time, and we need the added time that S. 2523 would give us.

In addition to supporting the bill in general, I would like to comment on two sections in particular that appeal to us. First, one section of S. 2523 would authorize higher-than-average grants in poverty areas. We are highly in favor of this. I do not know how "poverty area" will be defined, but of the 6 approved centers in Tennessee, only one appears to be clearly in a poverty area. A higher level of Federal funding in poverty areas, both urban and rural, would definitely help us.

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If you would like additional information on the comprehensive community mental health program in Tennessee and our need for the proposed amendments, please call on us. Meanwhile, we shall appreciate your forwarding our views to the Committee on Labor and Public Welfare, and we look forward to your supporting S. 2523 when it is reported out.

Sincerely,

SANDFORD F. BRANDT.

AMERICAN PSYCHOLOGICAL ASSOCIATION,
Washington, D.C., July 23, 1969.

HON. RALPH W. YARBOROUGH,
U.S. Senate,
Washington, D.C.

MY DEAR SENATOR YARBOROUGH: I have read with interest your remarks made in the Senate on July 1, 1969, in connection with your introduction of S. 2523, the Community Mental Health Centers Amendments of 1969. I wholeheartedly agree with your statement that "Few measures can be of higher priority than that which seeks to strengthen the mental health of all our citizens."

The bill itself, which not only will extend the life of the Community Mental Health Centers legislation but also will increase funding beyond the present level and institute other desirable changes in the law, has the support of the American Psychological Association. Psychologists have played a significant role in both planning and subsequent operations of the Centers programs. They are now committed to the continued success of these Centers.

We at the APA are delighted that you are now chairing the Committee on Labor and Public Welfare and its Health Subcommittee. In particular, we commend you on the establishment of two vital new subcommittees—the Special Subcommittee on Planning and Evaluation of Social Programs and the Subcommittee on Alcoholism and Narcotics.

Sincerely yours,

KENNETH B. LITTLE, *Executive Officer.*

AMERICAN NURSES' ASSOCIATION, INC.,
New York, N.Y., August 1, 1969.

HON. RALPH YARBOROUGH,
Chairman, Committee on Labor and Public Welfare,
U.S. Senate, Washington, D.C.

DEAR SENATOR YARBOROUGH: The American Nurses' Association, the professional organization of registered nurses, wishes to record its support of your bill S. 2523, which proposes to amend, extend and improve the public health laws relating to mental health.

The American Nurses' Association supported enactment of Public Law 88-164 which provided assistance for construction of mental health centers, Public Law 89-105, which authorized financial assistance to help the centers meet the cost of professional and technical personnel and Public Law 90-31 which further extended, expanded and improved laws relative to mental health.

We supported the legislation because we were aware that the treatment of the mentally ill in state hospitals was handicapped because of the size, location and staffing patterns of these institutions. Too frequently care has been custodial rather than therapeutic largely due to the lack of professional personnel. This resulted in frequent, long, or permanent hospitalizations. Additionally, the isolated location of most state hospitals deprived patients of close, supportive contacts with family, friends, and community life. This situation also made recruitment of qualified personnel more difficult.

The establishment of community health centers is a relatively new approach to the prevention and treatment of the mentally ill. Many communities already have available diagnostic and treatment facilities, in-patient and out-patient psychiatric services, and provisions for emergency care and rehabilitation. In most instances these are not coordinated to the extent that continuing supervision of patients is provided from the onset of symptoms through to complete rehabilitation. One important function of the community mental health center was to stimulate coordinating of the various efforts to improve services to patients and families.

The availability of services in localities where people live can result in early recognition of illness and intervention at a time when treatment is likely to be more successful and lasting. For patients who may still require hospitalization away from their homes, the community mental health center is a resource for providing follow-up care and rehabilitative services. The hospital stay would,

therefore, be shorter enabling the individual more quickly to resume his proper role in society.

In addition to providing direct services to patients and families, the mental health center also has an educational function in the community. Because of lack of knowledge and understanding of the pathological process by members of the family and community, the mentally ill were all too frequently rejected. The support and understanding of relatives is vital to full recovery. Because hospitals for the mentally ill are generally in isolated areas, an effective sustained plan for interpreting mental illness and the patient's needs to his family is frequently impossible.

Closer collaboration is necessary between mental health personnel and other health workers in public and private community agencies, and with practicing physicians, nurses and social workers. Although their major function may not be directly related to mental health and mental illness, they too have a responsibility in prevention, in follow-up care, and in rehabilitation. The staff of the community mental health center becomes a resource of helping these allied professional groups broaden their understanding and knowledge of mental health and, therefore, provide more effective service. The centers provide clinical facilities where doctors, nurses, psychologists and social workers can gain first hand experience in working with psychiatric patients and their families. In addition, consultant service is made available to those coping with the behavior problems of the child and adolescent.

The success of programs to combat mental illness depends in large measure on the availability of well-qualified professional manpower. We have stated repeatedly that buildings alone cannot constitute a program. They provide only facilities for treatment. The provision of treatment and the quality of care is dependent on personnel. We, therefore, urge your Committee to approve the extension of the provision for meeting the costs for staffing mental health centers.

Your bill S. 2523 will continue the assistance to states to help them deal effectively with the problem of mental illness and further relieve them of the tremendous financial burden they carried so long. Establishment of the mental health centers is providing a means, not only for helping patients in their own communities, but also for developing new types of programs that are less costly than the traditional confinement in a long term institution.

We urge the favorable consideration of S. 2523 and request that this communication be made a part of your Committee's record of hearings.

Sincerely yours,

[Mrs.] JUDITH G. WHITAKER, *Executive Director.*

SOUTHEAST ARKANSAS MENTAL HEALTH CENTER,
Pine Bluff, Ark., July 31, 1969.

Hon. RALPH YARBOROUGH,
U.S. Senate,
Washington, D.C.

DEAR SIR: As the Administrator of the Southeast Arkansas Mental Health Center, Pine Bluff, Arkansas, I have been particularly interested in the progress of your proposed legislation concerning appropriations and funding for Community Mental Health Centers.

We have a comprehensive Community Mental Health Center that has struggled until we have gained complete community support. It has been financed with community money and some federal staffing assistance. We serve primarily a rural delta area of Southeast Arkansas where the population is about 42% black, low socio-economic community. As you probably know, we are without state financial support. We have a tremendous patient load with limited funds. Please let me know what we can do to help you get support for your legislation. I would be happy to appear before Senate hearings if that will help.

Please be assured that our Board of Directors backs your legislation one hundred percent.

Sincerely,

CLARENCE W. PERKINS, *Administrator.*

CALIFORNIA ASSOCIATION FOR MENTAL HEALTH,
Sacramento, Calif., July 29, 1969.

Hon. RALPH YARBOROUGH,
*U.S. Senator, Senate Office Building,
 Washington, D.C.*

DEAR SENATOR YARBOROUGH: On behalf of the Board of Directors and the membership of the California Association for Mental Health, I wish to commend you for the introduction of Senate Bill 2523, the "Community Mental Health Centers Amendments of 1969."

Our organization has been deeply concerned about the future of community mental health centers, not only in our state, but across the nation. It is our considered judgment that community mental health centers are most important to the totality of services available to the mentally ill. We believe this legislation is entitled to the highest priority and are sincerely appreciative of your understanding and willingness to take action in this regard.

Sincerely,

Mrs. JOSEPH V. COSTELLO, Jr., *President.*

DEPARTMENT OF MENTAL HEALTH,
Frankfort, Ky., July 31, 1969.

Senator RALPH YARBOROUGH,
*Senate Office Building,
 Washington, D.C.*

DEAR SENATOR YARBOROUGH: Personally, and on behalf of the millions of Americans who need and will benefit from the community mental health movement, I congratulate you and express gratitude for your sponsorship of S. 2523: "The Community Mental Health Centers Amendments of 1969."

Those of us who have worked directly with community mental health centers have been greatly concerned, and have talked about the future of the centers, particularly in impoverished areas. We have been more than apprehensive about the ability of these centers to continue if they become primarily dependent upon local support in regions where more than a third of the families are on some form of "Relief," and where at least another third need financial assistance for a standard of living that would promote physical and mental health sufficient for normal educational progress.

More than fifty percent of the children of Kentucky Appalachia are seriously retarded educationally, but only a small fraction of this results from lack of native ability. Extensive research with laboratory animals has demonstrated that organic brain damage results from dietary deficiency and environmental impoverishment in early life. I see ample reason to believe that like disaster results from malnourishment and environmental impoverishment of children. Fortunately, the brain damage to animals from impoverished environment is reversible, even up to mid-life. I believe that like results can be attained with people in the impoverished areas of America. Mental health centers, together with health improvement programs offer our best hope for insuring that the children of impoverishment will have "equal opportunity." For this hope we thank you and your associates in the Congress of the United States.

I am asking other psychologists who are associated with the Kentucky Department of Mental Health to write to their Congressmen in support of S. 2523.

Sincerely,

MILTON B. JENKINS, Ph. D.,
Chief Psychologist, Division of Regional Services.

U.S. SENATE, COMMITTEE ON PUBLIC WORKS,
Washington, D.C., August 8, 1969.

Hon. RALPH YARBOROUGH,
*Chairman, Committee on Labor and Public Welfare,
 U.S. Senate, Washington, D.C.*

DEAR MR. CHAIRMAN: Enclosed is a copy of a letter from Judge John W. Hereford, President of the West Virginia Association for Mental Health, relative to S. 2523, and a copy of the Association's report on this measure. It was my thought this material would be of interest.

With best wishes, I am

Truly,

JENNINGS RANDOLPH.

THE WEST VIRGINIA ASSOCIATION FOR MENTAL HEALTH, INC.,
Charleston, W. Va., July 31, 1969.

Senator JENNINGS RANDOLPH,
*Senate Office Building,
 Washington, D.C.*

DEAR SENATOR RANDOLPH: I am pleased to learn SB 2523 has reached the stage where hearings are being conducted.

As you know, the West Virginia Association for Mental Health feels very strongly that there is a definite need for the extension and expansion of the Community Mental Health Centers Act of 1963. SB 2523 will be of great benefit in continuing the progress already started in the development of close-at-home centers for the treatment of mental illness.

The West Virginia Association for Mental Health has examined SB 2523 and related the highlights of the bill to the effect it might have on the continued development of comprehensive mental health centers in our State. A copy of that report is enclosed.

Thank you for your continued interest in the comprehensive mental health centers program.

Sincerely,

Judge JOHN W. HEREFORD, *President.*

THE WEST VIRGINIA ASSOCIATION FOR MENTAL HEALTH, INC., CHARLESTON, W. VA.

COMMUNITY MENTAL HEALTH CENTER AMENDMENTS OF 1969

Senator Ralph Yarborough of Texas, with eleven other senators, including Senator Jennings Randolph of West Virginia, has introduced Senate Bill 2523, known as the "Community Mental Health Center Amendments of 1969".

This bill renews and extends the community mental health centers act of 1963.

The West Virginia Association for Mental Health, with the cooperation of the West Virginia Department of Mental Health, Community Services Division, has reviewed SB 2523 and determined the benefits West Virginia would receive if the bill were adopted by Congress and signed into law.

WEST VIRGINIA PROGRESS UNDER GRANT COMMUNITY MENTAL HEALTH CENTERS ACT

Under the original Comprehensive Community Mental Health Centers Act, West Virginia has established two centers providing services in 14 areas. The first, known as the Appalachian Mental Health Center is located at Elkins. The second, known as the Southwestern Comprehensive Mental Health Center, is located at Huntington.

The initial staffing grant at AMAHC reduces to 33.75% in the fourth year of operation as of September 1, 1969. Federal participation reduces to 7½% as of September 1, 1970. During the past year, additional state funds were made available to assist local and federal sources of revenue at AMAHC. Despite greatly expanded state assistance and a fund drive now under way, expenditures have exceeded income to the extent that the Center now has a deficit of \$82,151.

The SCMHC began its second year of operation July 1, 1969. Federal matching funds for the initial phase of operation is at the 63.75% level. A growth grant is scheduled to begin September 1, 1969, at the 75% matching level. This grant will augment existing services for more adequate coverages for all services in the four county area.

There has been considerable success in employing initial staff and a more full scale operation for this region is anticipated with the completion of the SCMHC facility in early September. Although the Center has not developed a significant deficit to date, the anticipated reduction of federal support poses a threat to the continual growth and operation of the program.

Other progress under the current act includes three construction applications now pending. These applications are:

Eastern Panhandle Mental Health Center to be constructed at Martinsburg, serving Jefferson, Morgan and Berkeley Counties.

Northern Panhandle Mental Health Center to be constructed at Wheeling, serving Marshall, Ohio and Wetzel Counties.

Southern West Virginia Mental Health Center to be constructed at Princeton, serving Mercer, McDowell and Wyoming Counties.

The West Virginia state plan for comprehensive mental health services envisions the development of a total of 13 mental health centers as soon as possible.

EFFECT ON PROPOSED AMENDMENTS ON WEST VIRGINIA COMPREHENSIVE MENTAL
HEALTH CENTER DEVELOPMENT

The information below reviews highlights of the amendments as proposed in SB 2523 and their effect on the development of centers in West Virginia.

1. Staffing grants would cover all personnel instead of being limited to "professional and technical" staff as provided in the expiring law.

Under present law, only professional and technical personnel may be supported by federal staffing grants. To date, both comprehensive centers in West Virginia have been able to qualify all personnel for federal matching funds. Future centers that do not consider administrative personnel as giving direct client services would have to bear that cost alone. This is an added burden that a rural and economically deprived area cannot assume.

2. Construction grants would include cost of acquiring land, a cost not now included under the expiring law.

The choice for location of a mental health center has been limited in West Virginia to land either readily available to local planning groups or land easily purchased by the state of West Virginia through the Department of Mental Health. When the latter decision has been made, it has been necessary for the Department to become the construction applicant rather than the local center board. A procedure for leasing the land back to the center board has been required in the construction application. Federal funds for purchase of land as a part of construction costs would expedite and enhance construction plans and would allow for more selective locations.

3. The term for continuation of staffing grants is to be increased to ten years instead of 4.25 years as provided in the expiring law.

This provision would apply to staffing grants already made under the present law as well as future grants made under the new law.

Staffing grants in rural and urban poverty areas would be authorized at 90% the first two years and 75% for the next eight.

These two provisions, if adopted by Congress, would increase stability of existing programs in West Virginia and encourage development of new programs on a more realistic level.

Under this amendment, it appears that the Appalachian Mental Health Center would qualify for up to 75% matching for an additional six years from 1970 to 1976. It is anticipated that under the amendments, most of West Virginia would qualify for grants to rural or urban poverty areas.

4. In rural and urban poverty areas, the Federal share for center construction could go as high as 90%.

In West Virginia, the construction of new mental health facilities is administered by the Bureau of Hospital Facilities of the Department of Health in close collaboration with the Department of Mental Health. The Mental Health Centers Act of 1963 requires a state plan for construction and authorized a federal matching level in West Virginia of 61%. In addition, the Appalachian Regional Development Act makes another 19% federal matching money available, on a maximum federal share from the two sources of 80%. The 90% level would be an added incentive and in some instances, could make the difference between success or failure of planning efforts.

5. The Federal share for planning to initiate the development of programs and community mental health centers in rural and urban poverty areas authorized at 100% (not to exceed \$50,000) per catchment area for one year.

Although limited state funds within the past year have been set aside in planning and developing new centers, funds available do not provide program development and technical assistance for all the regions of the state. If Federal funds become available, monies now used for planning would release local and state funds for expenditures needed for direct services.

SPECIFIC INSTANCE OF NEED

(Current Status of Region VI, Catchment Area 2—Grant, Hampshire, Hardy, Mineral, Pendleton Counties)

Center development has moved very slowly in this catchment area. The West Virginia State Plan for Comprehensive Mental Health Centers envisions the future development of a center program located either in Keyser or Romney.

To date, mental health services have been provided to recipients of the Catchment area on a minimal basis from the Appalachian Mental Health Center, which

has established out-patient services in Petersburg and Franklin. Currently a fund raising drive is underway to provide additional services to several of these counties and to establish new offices of trained mental health professionals at Keyser. Residents in Hampshire County would receive mental health services only from the Hampshire County Mental Health Service.

A comprehensive center is also under development in Cumberland, Maryland which may serve some residents in West Virginia, but no specific plans have been made.

Initial Catchment Area Two meetings regarding center planning development have been held, but an official citizens' planning group has not been selected.

The advantages cited for the total state in the development of comprehensive centers if the 1969 amendments are adopted would be especially true for this region. The area would probably qualify as a rural poverty area. The amendments would provide for immediate initial planning personnel, and a higher rate of participation by the federal government in staff and construction costs than the present act would.

It should be noted that the Appalachian Mental Health Center was originally planned to serve only eight counties, but has extended services to Hardy and Mineral counties. The basic philosophy of the Community Mental Health legislation and of the West Virginia State Plan for Comprehensive Mental Health Centers is to provide services near the patient's home, readily accessible, and available when needed on a continuous basis.

The proposed amendments would speed this goal toward achievement for those counties served in the Keyser-Romney area, removing reliance on services from other regions and placing mental health services within the community.

(Whereupon, at 1 p.m., the hearing adjourned, subject to the call of the Chair.)



has established only one mental health center in the State. There is a need for more mental health centers in the State. The Department of Mental Health is planning to establish a new office of Mental Health in the State. The Department of Mental Health is planning to establish a new office of Mental Health in the State. The Department of Mental Health is planning to establish a new office of Mental Health in the State.

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