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ST. ELIZABETHS HOSPITAL

(PART 2)

DOCUMENTS

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HEARINGS

BEFORE THE

COMMITTEE ON

THE DISTRICT OF COLUMBIA HOUSE OF REPRESENTATIVES

NINETY-FOURTH CONGRESS

SECOND SESSION

ON

DRAFT OF LEGISLATION TO ESTABLISH AN INDEPENDENT CORPORATION WITH EXCLUSIVE AUTHORITY OVER ST. ELIZABETHS HOSPITAL

SEPTEMBER 14 AND 15, 1976

Serial No. 94-1

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ST. ELIZABETHS HOSPITAL

TUESDAY, SEPTEMBER 14, 1976

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE DISTRICT OF COLUMBIA,
Washington, D.C.

The committee met, pursuant to notice, at 9:35 a.m., in room 1310, Longworth House Office Building, Hon. Charles C. Diggs, Jr. (chairman of the committee), presiding.

Present: Representative Diggs, Delegate Fauntroy, Representatives Mann, Mazzoli, Harris, and Whalen.

Also present: Ruby G. Martin, general counsel; James T. Clark, legislative counsel; Wilbur Hughes, staff assistant and Carol Thompson, minority legislative assistant.

The CHAIRMAN. The committee will come to order.

Today the full Committee on the District of Columbia begins 2 days of hearings on a draft bill that would transfer authority for operating St. Elizabeths Hospital from the Department of Health, Education, and Welfare to a private corporation, and I emphasize that it is a draft proposal.

[The proposal and summary thereof referred to follow:]

[Revised Discussion Draft No. 2, July 16, 1976]

[H.R. ———, 94th Cong., 2d sess.]

A BILL To establish an independent corporation with exclusive authority over Saint Elizabeths Hospital

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

SHORT TITLE

SECTION 1. This Act may be cited as the "Saint Elizabeths Hospital Corporation Act".

SAINT ELIZABETHS HOSPITAL CORPORATION

SEC. 2. (a) (1) There is created an independent corporation to be known as the Saint Elizabeths Hospital Corporation (hereafter in this Act referred to as the "Corporation"). Sole management of the affairs of the Corporation is vested in a board of directors (hereafter in this Act referred to as the Board") which shall have exclusive authority over Saint Elizabeths Hospital.

(2) Section 101 of the Government Corporation Control Act (31 U.S.C. 846) is amended by inserting "Saint Elizabeths Hospital Corporation;" immediately after "Tennessee Valley Authority;"

(b) (1) The Board shall consist of five members appointed as follows:

(A) Three members shall be appointed, after consultation with the committees of the Congress having legislative jurisdiction with respect to Saint Elizabeths Hospital, by the Secretary of Health, Education, and Welfare—

(i) at least one of whom shall be a psychiatrist, and

(ii) at least one of whom shall be experienced in administering mental health institutions.

(B) Two members shall be nominated, after consultation with organizations in the District of Columbia interested in mental health issues, by the Mayor of the District of Columbia and confirmed by a vote of two-thirds of the members of the Council of the District of Columbia.

A vacancy on the Board shall be filled in the manner in which the original appointment was made.

(2) The Board shall select one of its members as Chairman.

(3) (A) Except as provided in subparagraphs (B) and (C), members of the Board shall be appointed for terms of five years. Any member of the Board shall be eligible for reappointment.

(B) Any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed only for the remainder of such term.

(C) The members first appointed to the Board shall be appointed for terms as follows:

(i) Of the members appointed by the Secretary of Health, Education, and Welfare—

(I) one shall be appointed for a term of one year,

(II) one shall be appointed for a term of three years, and

(III) one shall be appointed for a term of five years,

as designated by the Secretary at the time of appointment.

(ii) Of the members nominated by the Mayor of the District of Columbia and confirmed by the Council of the District of Columbia—

(I) one shall be appointed for a term of two years, and

(II) one shall be appointed for a term of four years,

as designated by the Mayor at the time of nomination.

(4) Effective October 1, 1976, members of the Board shall each be entitled to receive basic pay at the annual rate in effect for level V of the Executive Schedule. Members of the Board appointed prior to such date shall receive such compensation as the Secretary of Health, Education, and Welfare may prescribe for each day during which they are engaged in the actual performance of duties vested in the Board, except that such compensation may not exceed the daily equivalent of the annual rate of basic pay in effect for level V of the Executive Schedule.

(5) Three members of the Board shall constitute a quorum for purposes of exercising the functions of the Board.

(6) A vacancy on the Board shall not affect the authority of the Board to exercise its functions.

TRANSFER OF FUNCTIONS AND PROPERTY

SEC. 3. (a) Upon a certification by the Board to the Secretary of Health, Education, and Welfare and to the Congress that the Board is ready to assume its responsibilities under this Act, all functions of the Secretary of Health, Education, and Welfare with respect to supervising the administration of Saint Elizabeths Hospital shall vest in the Board, including the Secretary's functions under—

(1) sections 4839, 4851, 4852, and 4858 of the Revised Statutes (24 U.S.C. 165, 211, 211a, and 170, respectively);

(2) the Act of June 23, 1874, (42 U.S.C. 212);

(3) the Act of June 30, 1906 (24 U.S.C. 177);

(4) the Act of June 12, 1917 (24 U.S.C. 196);

(5) the Act of October 6, 1917 (24 U.S.C. 200);

(6) the Act of March 6, 1920 (24 U.S.C. 168 and 176);

(7) the Act of June 5, 1920 (24 U.S.C. 166);

(8) the Act of July 18, 1940 (24 U.S.C. 196b);

(9) the joint resolution of May 9, 1941 (24 U.S.C. 180);

(10) the Act of November 7, 1941 (24 U.S.C. 181-184); and

(11) the Act of August 4, 1974 (24 U.S.C. 169a, 185, and 195a).

(b) Upon the certification described in subsection (a) of this section, all right, title, and interest of the United States in the real property, including buildings and improvements, known as Saint Elizabeths Hospital shall vest in the Corporation. Not later than sixty days after such certification, the Board and the Secretary of Health, Education, and Welfare shall enter into an agreement containing a description of all property transferred by the preceding sentence. Such agreement shall also provide for the transfer to the Corporation of all personal prop-

erty then being used in connection with the operation of Saint Elizabeths Hospital. If the Board and the Secretary are unable to agree on any matter required to be set in such agreement, the matter shall be decided by the Director of the Office of Management and Budget.

(c) (1) All orders, determinations, rules, regulations, permits, contracts, certificates, licenses, and privileges—

(A) which have been issued, made, granted, or allowed to become effective in the exercise of any function transferred by this Act, and

(B) which are in effect on the effective date of the transfer of such function,

shall continue in effect according to their terms until modified, terminated, superseded, set aside, or repealed by the Board, by any court of competent jurisdiction, or by operation of law.

(2) (A) Except as provided in subparagraph (B), this Act shall not affect any proceedings pending before the Secretary of Health, Education, and Welfare which involves any function transferred to the Board by this Act.

(B) To the extent that such proceedings involve a function transferred by this Act, such proceedings shall, upon the transfer of such function, be continued before the Board. In any proceeding so continued, orders shall be issued, appeals shall be taken, and payments shall be made, as if this Act had been enacted; and orders issued prior to such transfer in any proceeding so continued shall continue in effect according to their terms until modified, terminated, superseded, or repealed by the Board, by a court of competent jurisdiction, or by operation of law.

(3) (A) Except as provided in subparagraph (B), the provisions of this Act shall not affect any suit or other proceeding commenced by or against the Secretary of Health, Education, and Welfare which involves any function transferred to the Board by this Act.

(B) To the extent that such suit or other proceeding involves a function transferred to the Board by this Act, such suit or proceeding shall, upon the transfer of such function, be continued by or against the Board. In any litigation pending on the effective date of this Act, the court may, at any time, on its own motion or that of any party, enter such order as the court determines necessary to give effect to the provisions of this paragraph.

(4) With respect to any function transferred by this Act, reference in any other Federal law to the Secretary of Health, Education, and Welfare shall be deemed, after the effective date of such transfer, to be a reference to the Board.

(5) Orders and actions of the Board in the exercise of functions transferred by this Act shall be subject to judicial review to the same extent and in the same manner as if such orders and actions had been made or taken by the Secretary of Health, Education, and Welfare. Any statutory requirement relating to notice, hearings, action upon the record, or administrative review that apply to any function transferred by this Act shall apply to the exercise of such function by the Board.

(6) In the exercise of the functions transferred by this Act, the Board shall have the same authority as that vested in the Secretary of Health, Education, and Welfare immediately preceding such transfer, and the Board's actions in exercising such functions shall have the same force and effect as when exercised by the Secretary of Health, Education, and Welfare.

(d) Nothing in this Act shall affect the applicability of the provisions of part III of title 5 of the United States Code to the employees of Saint Elizabeths Hospital who are such employees on the date of the certification described in subsection (a). Section 422(3) of the Act of December 24, 1973 (Public Law 93-198) shall not apply to the employees of Saint Elizabeths Hospital.

RESPONSIBILITIES OF THE BOARD

SEC. 4. (a) In carrying out its functions under this Act, the Board shall—

(1) take such action as may be necessary to insure that quality mental health treatment is provided by Saint Elizabeths Hospital and to achieve full and unconditional accreditation for Saint Elizabeths Hospital;

(2) strive for integration of services for the mentally ill in the District of Columbia so that resources are not wasted and so that truly comprehensive treatment programs are achieved;

(3) to the maximum extent feasible, place responsibility for setting priorities for mental health programs operated by Saint Elizabeths Hospital in community groups;

(4) maintain close ties with the National Institute of Mental Health and with the mental health programs of the District of Columbia;

(5) provide for the deinstitutionalization of patients consistent with the need for responsible supervision of patients placed in foster homes and other rehabilitation facilities;

(6) provide for the establishment of a separate organizational entity meeting the requirements of section 201 of the Community Mental Health Centers Act (42 U.S.C. 2689) to operate the community mental health center serving that portion of the District of Columbia designated as "area D"; and

(7) to the maximum extent possible, provide separate facilities and staff for the treatment of alleged and convicted criminal offenders.

(b) In carrying out its functions under this Act, the Board may—

(1) allow the National Institute of Mental Health, or other appropriate entities, to use facilities at Saint Elizabeths Hospital for research and related programs;

(2) holding hearings on matters of concern to the public regarding mental health services in the District of Columbia; and

(3) sell or lease, without regard to the provisions of title II of the Federal Property and Administrative Services Act of 1949, any land or buildings determined to be unnecessary for the operation and expansion of Saint Elizabeths Hospital, except that no sale or lease may be entered into until after the Board has received the land use plan required to be prepared by the National Capital Planning Commission pursuant to section 5(b).

The proceeds from any sale or leasing under paragraph (3) shall be placed in a special fund in the Treasury and shall be available only for appropriation for Saint Elizabeths Hospital (beginning with fiscal year 1978), such appropriation being in addition to any other appropriation authorized for Saint Elizabeths Hospital.

(c) The superintendent of Saint Elizabeths Hospital shall be appointed by the Board in accordance with the standards established by the National Institute of Mental Health for mental health administrators and shall be responsible to the Board for implementing the policies established by the Board in carrying out its functions under this Act.

COMPREHENSIVE PLAN FOR THE OPERATION OF SAINT ELIZABETHS HOSPITAL

SEC. 5. (a) Not later than the end of the two-year period beginning on the date of enactment of this Act, the Board shall, on the basis of a thorough review of the operations of Saint Elizabeths Hospital and the needs of the residents of the District of Columbia for quality mental health programs, prepare and transmit to the Congress, the Secretary of Health, Education, and Welfare, the Council of the District of Columbia, and the Mayor of the District of Columbia, a comprehensive plan for the operation of Saint Elizabeths Hospital which shall include a detailed statement of—

(1) the specific goals of the Board with respect to Saint Elizabeths Hospital, especially its goals with respect to the establishment in the District of Columbia of a comprehensive, community-based mental health system;

(2) the specific steps the Board plans to take to achieve those goals;

(3) the Board's priorities in meeting those goals;

(4) the Board's assessment of the time necessary to achieve those goals;

(5) the Board's assessment of the availability of resources, especially financial resources, necessary to achieve those goals; and

(6) such recommendations for legislative or administrative action as the Board believes will facilitate achievement of those goals, including recommendations for future increases in control over Saint Elizabeths Hospital by the government of the District of Columbia through increased representation on the Board or by other means.

(b) In order to facilitate the thorough review by the Board of the operations of Saint Elizabeths Hospital required by subsection (a), the National Capital Planning Commission shall transmit to the Board, not later than the end of the one-year period beginning on the date of enactment of this Act, a comprehensive land use plan for the land area transferred to the Board by section 3. In preparing such plan, the Commission shall take into account—

(1) the needs of the Board for additional financial resources to operate Saint Elizabeths Hospital;

- (2) the needs of Saint Elizabeths Hospital for such land area for its operation and any foreseeable expansion or for other programs related to mental health research or treatment;
- (3) the needs of the community near Saint Elizabeths Hospital, including the need for orderly development of the area around Saint Elizabeths Hospital;
- (4) the comprehensive plan for the National Capital prepared by the Commission; and
- (5) such other factors as the Commission deems appropriate.

CONSULTATION BETWEEN THE BOARD AND THE DISTRICT OF COLUMBIA MENTAL HEALTH ADMINISTRATION

SEC. 6. Each official of the government of the District of Columbia having responsibility for the administration of any mental health program in the District of Columbia shall consult with the Board on a regular basis in order to insure that such programs are coordinated with the mental health programs at Saint Elizabeths Hospital.

REPORTS BY THE BOARD

SEC. 7. Not later than one month after the end of the first fiscal year which begins after the date of enactment of this Act, and every six months thereafter, the Board shall transmit to the Congress, the Secretary of Health, Education, and Welfare, the Council of the District of Columbia, and the Mayor of the District of Columbia, a report—

- (1) describing, in detail, the activities of the Board during the preceding six-month period, including its progress in meeting the goals described in the statement submitted pursuant to section 5;
- (2) describing, in detail the operations of Saint Elizabeths Hospital during such period, including information on—
- (A) the number of patients treated at Saint Elizabeths Hospital,
 - (B) the programs of teaching, training, or research being conducted at Saint Elizabeths Hospital,
 - (C) the steps taken by the Board to insure that only the acutely and chronically mentally ill are in long-term residence at Saint Elizabeths Hospital and that other patients are treated, to the maximum extent feasible, on an outpatient basis.
 - (D) the treatment provided at Saint Elizabeths Hospital for the criminally insane.
 - (E) the steps taken to improve the physical facilities at Saint Elizabeths Hospital, either through renovation or new construction.
 - (F) the nature and extent of coordination between Saint Elizabeths Hospital and mental health programs of the District of Columbia, especially community mental health programs.
 - (G) the staff of Saint Elizabeths Hospital, and
 - (H) the steps taken by the Board to insure that Saint Elizabeths Hospital is meeting the needs of the mentally ill in the District of Columbia; and
- (3) containing such other information as the Board deems appropriate with respect to Saint Elizabeths Hospital or as chairman of the Committee on the District of Columbia of the House of Representatives, the chairman of the Committee on Labor and Public Welfare of the Senate, the Secretary of Health, Education, and Welfare, the Chairman of the Council of the District of Columbia, or the Mayor of the District of Columbia may request be included in such report.

PRESERVATION OF HISTORIC BUILDINGS AT SAINT ELIZABETHS HOSPITAL

SEC. 8. The Secretary of the Interior shall make available to the Board, out of amounts appointed under section 6 of the Act entitled "An Act to provide for the preservation of historic American sites, buildings, objects and antiquities of national significance, and for other purposes", approved August 21, 1935 (16 U.S.C. 466), such sums as may be necessary for the renovation, restoration, and maintenance of the Centre Building, the West Lodge, and the East Lodge at Saint Elizabeths Hospital.

APPROPRIATIONS FOR SAINT ELIZABETHS HOSPITAL

SEC. 9. (a) There are authorized to be appropriated to the Board \$— for the fiscal year 1978, \$— for the fiscal year 1979, and \$— for the fiscal year 1980, to be used for operating expenses of Saint Elizabeths Hospital, including expenditures for capital improvements, which are not met by reimbursements for patient care or from other sources.

(b) It is the sense of the Congress that the government of the District of Columbia should, in addition to payments made to Saint Elizabeths Hospital direct reimbursement for patient care and other services, make increased financial contributions to Saint Elizabeths Hospital in recognition of its primary function as an institution serving the needs of the residents of the District of Columbia.

FACT SHEET ON ST. ELIZABETHS HOSPITAL CORPORATION ACT

The purpose of this bill is to create an independent corporation to be known as the St. Elizabeths Hospital Corporation. This corporation will have exclusive authority over the Hospital. The five-member board will be appointed in the following manner: 3 members will be appointed by the Secretary of HEW after consultation with appropriate committees of Congress with legislative jurisdiction with respect to the Hospital. Of the three, at least one must be a psychiatrist and one a mental health administrator. The remaining two members will be nominated by the Mayor in consultation with local mental health organizations and confirmed by a two-thirds vote of the City Council. Upon a certification by the Board to the Secretary of HEW that the Board is ready to assume its responsibilities, supervision of the administration of the Hospital shall be transferred by the Secretary of HEW to the Board. Notwithstanding this transfer, the rights of St. Elizabeths employees as Federal employees shall not be affected by the transfer.

The bill further requires the Board to seek full and unconditional accreditation for the Hospital, to integrate the services of the Hospital with the services for the mentally ill in the District of Columbia, to allow for priorities to be set by community groups to the maximum extent feasible; to maintain this with NIMH and other mental health programs; to deinstitutionalize those patients who would benefit from alternative settings; to operate the Area "D" community mental health center; and to segregate treatment facilities for alleged and convicted criminal offenders.

The Board may allow NIMH or other appropriate entities to use the Hospital for research, to hold hearings on matters of public concern regarding local mental health services, and to sell or lease any land or buildings determined to be unnecessary for the operation of the Hospital consistent with a land use plan to be prepared by the NCP. The proceeds of these sales shall be placed in a special fund to be used only for appropriation for St. Elizabeths, such funds being in addition to other funds appropriated for the Hospital. The Board is required to appoint a superintendent to implement the Board's policies.

The Board is required to submit to Congress and other officials within two years, a comprehensive plan for the Hospital, including its goals and priorities for the Hospital, and legislative or administrative recommendations for improvements. The Board should consult with the District Mental Health Administration to ensure coordination of mental health programs at the Hospital. The Board must also submit biannual reports or activities to Congressional and District offices. The bill further provides for the preservation of historic buildings at the Hospital and an increasing contribution by the District to the operating funds for the Hospital.

STATEMENT OF CHAIRMAN DIGGS

The CHAIRMAN. This proposal would transfer authority, conceptually, for operating St. Elizabeths Hospital from the Department of Health, Education, and Welfare, at the Federal level, to a private corporation. Today we will hear testimony from witnesses of the District government, the Department of Health, Education, and Welfare, and others concerning their perceptions of the proposed corporations.

Tomorrow any witnesses that were not scheduled today will be accommodated at that point. Additionally, we will hear from representatives of the hospital administration and other concerned groups on their perceptions of the bill.

There may be some modifications of our hearing today because at least two people that I know, myself and the distinguished Delegate, the Congressman from the District, will be attending the funeral for Dr. Mordecai Johnson, which is at 1 o'clock over on the Howard University campus.

OVERSIGHT HEARINGS

On the 28th and 29th of April, last year, this committee held legislative and oversight hearings at St. Elizabeths Hospital. Those hearings marked the end of a 12-year hiatus in the exercise of congressional oversight over the hospital. There had not been any exercise of oversight responsibilities until we came out there. At that time and just as now, the transfer of the hospital from the Department of HEW to the District government has been a crucial issue in the improvement of the delivery of services to the patients of the hospital. It was clear from the testimony presented at that time that no consensus exists to transfer the facility to the District government absent certain safeguards to insure that adequate funding and staffing and organizational structuring would be available to improvisations and to upgrade the quality of services delivered at this facility.

ACCREDITATION

The committee is aware that serious problems face this institution as it attempts to regain its former status as the institution that it was before. The recent loss of accreditation from the Joint Committee on Accreditation of Hospitals looms as a major obstacle to the delivery of quality care for the residents.

The hospital's ability to attract and retain qualified professionals is in jeopardy and the eligibility of the facility to receive Federal funds such as medicare and medicaid will also be affected by the loss of accreditation.

I emphasize that for those whose eyebrows may be raised in connection with this committee's function with the hospital. Every time the committee gets involved in anything around here, people without thinking lose sight of the Federal interest. The Federal interest in this facility is clear as we always establish before we become involved in anything of a local character.

This facility, St. Elizabeths, is in the unenviable position of possibly losing Federal funds if this accreditation problem continues, just as District of Columbia General Hospital is subject to the same kind of situation unless that matter is adjudicated with—in some acceptable fashion.

In addition the recent decision in the case of *Dixon v. Weinberger*, which mandates the placement of patients in less restrictive rehabilitative settings, will also bear heavy on the future operations of the hospital.

There are numerous indications that a significant increase in the level of funding received by the hospital must be matched with new

and innovative programs in order for the hospital to meet the challenge of the coming decades.

LEGISLATIVE ALTERNATIVES

In view of these concerns, the committee has carried on a continuing dialog with interested parties regarding the future of the hospital. In particular, I would like to acknowledge the valuable contributions of my distinguished colleague, Mr. Mazzoli, whose comments on this bill will certainly be useful as we continue our consideration of this question, in addition to the gentleman from the District, Mr. Fauntroy.

As we begin to consider legislative alternatives, a number of options presented themselves. We have been informed that the administration has prepared a bill to be introduced in the near future that would transfer authority over the facility to the District after a specified time period.

While we are generally in support of the concept of local control over programs delivering services to local residents, we are not unaware of the present fiscal and management situation within the District government which in our view would preclude any precipitous transfer of additional responsibilities without appropriate safeguards, primarily those concerning funding.

We are especially reluctant to transfer the facility to the District under those circumstances. The Department that would handle this if the table of organization is followed conceptually is the Department of Human Resources. That has the largest budget and the most expensive responsibilities of any District agency and it has its share of problems these days.

Whether or not they are in the position to absorb this kind of a facility at this particular time, until several of their other problems are adjudicated, is a matter of concern of the committee.

ST. ELIZABETHS HOSPITAL CORPORATION ACT

As an alternative to direct transfer of the hospital, this proposal or draft bill has been designed to generate dialog while creating an independent corporation to be known as the St. Elizabeths Hospital Corporation.

This is not necessarily a new concept but it is a concept which is growing in currency in various places. It has some local precedent. The Economic Development Corporation, for example, at least conceptually is consistent with this kind of operation and provides for an independent kind of mechanism.

This corporation would be known as the St. Elizabeths Hospital Corporation and would have exclusive authority over the hospital. It would be managed by a board composed of five people, three of whom would be appointed by the Secretary of Health, Education, and Welfare after consultation with appropriate committees in Congress with legislative jurisdiction.

Of the three, at least one must be a psychiatrist and one a mental health administrator. The remaining two members will be nominated by the mayor in consultation with the local health organizations and confirmed by a two-thirds vote of the Council of the District of Columbia.

The bill further states that the rights of St. Elizabeths employees as Federal employees will not be affected by the transfer.

The Board is required to seek and obtain full and unconditional accreditation for the hospital and to integrate the services of the hospital with the services for the mentally ill in the District of Columbia. The Board is directed to allow the National Institute of Mental Health or other appropriate entities to use the hospital for research and related programs and to sell or lease any land or buildings determined to be unnecessary for the operation and expansion of the hospital consistent with the land use plan that is to be prepared by the National Capital Planning Commission.

The bill also mandates that the Board submit both a comprehensive plan for the hospital and a semiannual report to the Congress and the District concerning its goals and concerning its priorities for the future operations of the hospital.

As a result of these hearings, we think the committee will be in a better position to consider the visibility of the draft legislation. It is our hope that the legislation that results from these hearings will correct present problems without causing others.

Be assured that throughout our deliberations our only goal will be the improvement of the delivery of services to the patients at St. Elizabeths Hospital. We certainly welcome the comments and recommendations that we expect to be forthcoming.

Before we call our first witness, I would like to yield to the gentleman from the District for any comments he would care to make at this point.

STATEMENT OF DELEGATE FAUNTROY

Mr. FAUNTROY. Thank you, Mr. Chairman. I am very pleased that the committee and staff under your leadership are devoting a great deal of effort and resources to the examination of the level of care which this city provides those who suffer retardation and mental illness.

I am convinced that neither the Federal nor the local governments are as concerned as our committee has been about the state of mental health care in this city. Neither Forest Haven nor St. Elizabeths Hospital is a credit to those responsible for their administration.

One is run by the city and the other by the Federal Government. As I have said often in the past, St. Elizabeths Hospital in my view does not have the resources it needs to become a first rate modern mental health facility. We are all aware, as you have indicated, that St. Elizabeths Hospital still has problems with its accreditation, problems such as the fact that patients' need for treatment and care could be provided in more appropriate places.

Patients with chronic mental illnesses certainly need more facilities for treatment. Substantial overcrowding remains a problem. Deterioration of the present buildings, insufficient staff to provide an acceptable level of treatment and care for many patients and the lack of a separate facility for the hospitalization and treatment of children and teenage patients remains a problem.

This bill provides us an alternative means by which some of these problems may be resolved provided that adequate funding is pro-

vided to insure that such an independent corporation created by this bill would be able to achieve the goal set out by the legislation.

So, Mr. Chairman, in light of the various alternatives that have been proposed in the past concerning transfer, I welcome this suggestion and I am hopeful that an independent corporation will be the mechanism for the solution of these problems.

I am anxiously awaiting a thorough discussion of this and perhaps other alternatives that may well bring relief to what has been a very difficult situation for us all.

Thank you.

The CHAIRMAN. I thank the gentleman for his contribution.

At this point, there will be inserted into the record a letter from Congressman Harris, and other recommendations and comments regarding the proposed legislation.

[The documents referred to follow:]

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., August 27, 1976.

HON. CHARLES C. DIGGS, JR.,
*Chairman, House District Committee,
U.S. House of Representatives, Washington, D.C.*

DEAR MR. CHAIRMAN: Dr. William T. Doran has submitted the attached comments on the draft bill concerning Saint Elizabeth's Hospital.

I think you will find his comments of interest and respectfully request that they be entered into the record when hearings are held.

Thank you.

Sincerely,

HERBERT E. HARRIS II,
Member of Congress.

Alexandria, Va., August 11, 1976.

HON. HERBERT E. HARRIS II,
*Longworth House Office Building,
Washington, D.C.*

DEAR MR. HARRIS: I am pleased to comment on the second draft of Chairman Diggs' proposed bill about developing a corporation to take over St. Elizabeth's Hospital. The Corporation paralleling that of TVA is good. However, unless the Corporation is able to find and appoint a Superintendent of wide experience, great forcefulness and broad capacity, who has managed a large mental institution (a person such as the younger Dr. Menninger of the Menninger Clinic and Topeka, Kansas State Mental Hospital) St. Elizabeth's capacity to become accredited by the Commission on Medical Education, will not develop.

In my opinion, the District of Columbia has no one, either in the Division of Human Resources or elsewhere at the present time, with the experience or capacity to lead the excellent top psychiatrists and other professional and administrative personnel now working at St. Elizabeth's. Neither has the District the funds or the ability to secure funds from OMB to meet the requirements for accreditation, including staffing and sprinkler systems for fire protection, etc. An example on staffing is the need to secure the services of an inhalation therapist; St. Elizabeth's can offer only a Civil Service grade two steps below the private sector pay and therefore is unable to secure such a therapist.

In the proposed bill now and in the prior drafts, as well as in other proposed legislation, there is no mention that St. Elizabeth's employees (professional and blue collar workers) would retain the privilege of protection of the Federal Tort Act, under either a Corporation or the D.C. government. Employees of TVA and of D.C. government do not have Federal Tort Act coverage. Civil Service Commission employees under the Tort Act are defended by the Dept. of Justice and any settlement against them, as in malpractice and other suits, are covered by the Federal government. Without such protection employees would have to take out malpractice insurance of \$250,000 or more, which they cannot afford to do with present-day exorbitant private insurance premiums and frozen Civil Service salaries. Employees would have no choice but to resign.

Finally, the last provision of the proposed draft calls for D.C. Govt. or the proposed Corporation to reimburse the Federal Govt. for any cost for treating Federal patients. The D.C. Govt. has no money to do this so in all probability the bill would be defeated unless OMB would agree to remove this proposal and give D.C. or the corporation sufficient monies to cover care of such patients.

Very truly yours,

WILLIAM T. DORAN, M.D.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
NATIONAL INSTITUTE OF MENTAL HEALTH,
Washington, D.C., August 30, 1976.

HOUSE DISTRICT COMMITTEE,
Longworth House Office Building,
Washington, D.C.

GENTLEMEN: Two of the three items which you requested (Recommendations and Comments from the JCAH regarding the Childrens and Adolescents Division and the Medical and Surgical Department) are enclosed. The third item (Recommendations and Comments on the Alcoholic Program) could not be reproduced by xeroxing because of the poor quality of the source document. However, the report on the Alcoholic Program is available for review in Dr. Fitz' Office, A Building, Room 207, Saint Elizabeths Hospital.

Sincerely,

BEATRICE B. PRUITT,
Secretary, Office of Quality Assurance.

JOINT COMMISSION ON ACCREDITATION OF HOSPITALS,
CHICAGO, ILL.

Mr. EARL W. SHELLY,
Administrator, St. Elizabeths Hospital,
Washington, D.C.

DEAR MR. SHELLY: On the basis of the latest Joint Commission survey, your hospital has been awarded one-year accreditation. This decision has been made by the Board of Commissioners upon review of the recommendations from the surveyors who visited your hospital.

The Joint Commission considers accreditation maintenance as an ongoing educational activity, to be carried on throughout the one-year period for which your hospital is accredited. The Commission commends the work that you have done thus far toward achieving accreditation, but recognizes that one-year accreditation indicates that some specific areas deserve special attention. For that reason, the Joint Commission has prepared the enclosed list of recommendations and comments based on what it believes to be the areas in need of improvement. These recommendations might be considered your educational objectives in regard to accreditation, and should be put into effect before the next visit by Joint Commission surveyors.

Copies of this letter with the recommendations are being mailed to the President of the Medical Staff and Chairman of the Governing Body of your hospital, with whom this information must be shared. Since these recommendations are considered confidential on the part of the Joint Commission, their further release is a matter for your mutual consideration and decision.

We believe that you, your hospital staff and medical staff have the sincere desire to deliver the best care and service possible. It is with this belief in mind that we encourage you to continue your efforts to improve the quality of patient care rendered in your hospital. Should you have any questions concerning the accreditation status of your hospital or the enclosed list of recommendations, please feel free to communicate with us at your convenience. Our staff will be pleased to help you in any possible way.

Sincerely,

JOHN D. POTERFIELD, M.D.
Director.

ST. ELIZABETHS HOSPITAL, WASHINGTON, D.C.

RECOMMENDATIONS AND COMMENTS

Medical staff

1. The periodic reappraisal of each medical staff member must include evidence of consideration of the member's physical and mental capabilities.

2. The medical staff should delineate in its bylaws, rules and regulations the qualifications, status, clinical duties and responsibilities of specified professional personnel whose patient care activities require that their appointment and authority for specified services be processed through the usual medical staff channels. Specific reference is made to surgical assistants.

3. When podiatrists are granted clinical privileges the medical staff by laws, rules and regulations must contain specific references governing podiatric services.

4. The minutes of the monthly departmental meetings should document the actual discussion of patients evaluated and treated, including any conclusions or resultant recommendations.

5. Surgical case review (tissue committee function) should include procedures in which on specimen was removed.

Anesthesia services

1. In the interest of safety, it is desirable that all anesthesia gas machines be equipped with a gas evacuator system.

2. The anesthesia department/service should have written guidelines defining its role in the hospital infection control program.

Emergency services

1. Documentation of cardiopulmonary resuscitative training is required for the physicians who work in the emergency service.

2. The emergency service should have written guidelines defining its role in the hospital infection control program.

Environmental services

1. Hazardous areas must be protected by at least 1-hour fire-resistive construction or an approved automatic fire extinguishing system. Specific reference is made to locker rooms and bulk storage.

2. The emergency service should have written guidelines defining its role in

3. As previously recommended, the written preventive maintenance program must include techniques for cleaning and periodic testing of all equipment. Specific reference is made to equipment in physical medicine services, dietetic services and anesthesia services.

4. Water obtained from a source other than public water supply must be approved as safe by the appropriate authority.

5. Periodic and frequent tests should be made of all electrical appliances, instruments, installations and all biomedical devices to ensure proper grounding, compliance with current leakage and other device safety requirements, with records maintained of these activities.

Medical record services

1. There must be a physician preanesthesia note in the medical record of all patients which specifically includes information relative to the choice of anesthesia for the procedure anticipated.

Pharmaceutical services

1. There must be a written drug recall procedure that can be readily implemented.

Physical medicine services

1. The written guidelines of the physical medicine service should relate to coordination of care between physical medicine treatments and the rehabilitation aspects of nursing.

MAJOR FACTOR AFFECTING THE ACCREDITATION RATING:

The general administrative policies and procedures of the JCAH state that if an accreditation program recommends one year accreditation or non-accreditation for one category of service, no other category of service shall receive more than one year accreditation.

Refer to: "Accreditation manual for hospitals."

Decision of the accreditation committee of the board of commissioners: One year.

SURVEYOR, CHILDRENS AND ADOLESCENTS DIVISION, CHESTER R. DIETZ, M.D.

RECOMMENDATIONS AND COMMENTS

At the time of this survey substantial compliance with the standards in the *Accreditation Manual for Psychiatric Facilities Serving Children and Adolescents* was noted in the following areas in that services are actually organized or the necessary arrangements or plans for the provision of such services are adequate to meet the needs of the PATI.

Patients rights—With the following exceptions:

1. Every effort should be made to make certain that patients are kept informed of their rights, including the right to legal counsel and all other requirements of due process when necessary, e.g., there should be a regular program to ensure that all patients are informed.

2. There should be written policies regarding the procedures for receiving and responding to patient communications. (Referrals, Relations with the community, Volunteer program, and Daily routines.)

Physical care—With the following exceptions:

1. Patient's heights should be recorded at intervals.

2. There should be adequate first aid supplies in the schoolrooms in P-1.

Vocational programs

Partial-day service—With the following exceptions:

1. Documented records of unit meetings should reflect attendance.

2. In addition to other contacts, conferences should be held at least monthly with at least one member of the patient's family and a member of the professional staff responsible for the patient.

At the time of this survey partial or non-compliance with the standards was noted in the following areas, and the following recommendations and comments are presented:

Governing body and management—See Psychiatric Hospital Division Report.

Goals, policies and procedures

1. The written plan for clinical services should specify the age groups served.

2. The written plan for clinical services should specify the basic therapeutic programs offered.

3. The written plan for clinical services should specify the methods for providing or arranging for partial-day and outpatient services when they are needed by patients.

4. The written plan for clinical services should specify ways in which the facility provides or makes arrangements for other medical, dental, special assessment and therapeutic services.

5. The written plan for clinical services should delineate the arrangements for the provision of pediatric neurological services.

6. Intake or admission policies and procedures should be adequate to meet the needs of both the patients and the facility.

7. The decision to accept a child or adolescent for inpatient treatment should be based upon the determination that the child or adolescent requires treatment of a comprehensive nature and is likely to benefit by the program and alternative for less intensive treatment are not suitable.

8. The decision to accept a child or adolescent for partial-day treatment should be based on the determination that the child or adolescent is likely to benefit by the program and more intensive treatment is not required and less intensive treatment is not suitable.

9. The decision to accept a child or adolescent for outpatient treatment should be based upon the determination that the child or adolescent is likely to benefit by the services provided by the outpatient service and other forms of therapeutic intervention either are not required or are being provided elsewhere.

10. The criteria for and the procedures followed in the use of various treatment modalities should be stated in writing, along with any procedures for ensuring their appropriate use and counteracting unwanted side effects and possible complications.

11. There should be written policies and procedures specific to the use of electroconvulsive therapy or other forms of convulsive therapy which are in accordance with the standards in the *Accreditation Manual for Psychiatric Facilities Serving Children and Adolescents*.

12. There should be written policies which prohibit the performance of lobotomies or other surgical procedures for intervention or alteration of a mental, emotional or behavioral disorder on children and adolescents.

Staff composition and organization—Also see Psychiatric Hospital Division Report.

1. The staffing patterns of the facility should be adequate for the provision of high quality care and appropriate in relationship to the characteristics of the patient population; the hours and days the facility operates; the chronological and developmental ages of patients; assessments, therapeutic and follow-up programs; and the nature of disorders of the patients.

2. There should be a sufficient number of qualified child psychiatrists.

3. The participation of the qualified child psychiatrists should be such that they are able to assume professional responsibility for supervising and reviewing the needs of all the patients and the services being provided.

4. There should be a sufficient number of qualified social workers.

5. The staff should be organized to provide effective governance of its affairs and to ensure proper acceptance and discharge of its delegated responsibility for the quality of assessment, treatment and care of the patients.

6. The qualified professional clinical staff members should have responsibility for determining which staff members shall be assigned specific treatment responsibilities.

7. There should be a written staff organization plan which clearly delineate responsibility for functions listed in Staff Composition and Organization Section of the Accreditation Manual for Psychiatric Facilities Serving Children and Adolescents.

8. Each physician providing coverage for the childrens and adolescents psychiatric services should be trained or experienced in caring for children and adolescents with mental or emotional disorders.

Personnel policies and records—See Psychiatric Hospital Division Report.

1. Personnel policies and practices should be designed, established and maintained to ensure that there is an adequate number of personnel to support quality patient care, e.g., there should be policies and procedures to ensure that there are adequate numbers of personnel qualified or trained in the care and treatment of children.

Staff development

1. There should be records indicating participation in appropriate programs of staff development for the administrative, clinical and support personnel.

2. The staff development programs should be under the supervision and direction of a qualified person or committee, who may delegate any part of the program to other appropriately qualified individuals.

3. There should be a formally designated mechanism to evaluate the effectiveness of professional education and inservice training programs.

Research and human rights review

1. The research and human rights review committee should include at least one qualified child psychiatrist.

2. Each project involving the use of human subjects should be reviewed by the committee at least every three months.

Assessment and treatment planning

1. There should be a complete assessment for each patient accepted for treatment.

2. There should be records indicating adequate input from the responsible child psychiatrist, and other clinical professional staff members responsible for the assessment.

3. There should be evidence that a qualified child psychiatrist has participated in the supervision of preparation and/or initial and periodic review of the treatment plan for all patients.

4. The assessment of each patient should include clinical consideration of educational and social needs.

5. Assessment records should include written statements regarding the nature and type of evaluations and/or examinations carried out.

6. The treatment plan should include clinical consideration of each of the fundamental needs in its formulation.

7. The individual treatment plan should indicate the anticipated time required to reach each of the objectives; designate the expected locations and frequency

of treatment procedures; designate specific staff responsibilities for the conduct of such services and activities; designate the means for measuring the progress or outcome; and specify the criteria for the termination of treatment.

8. The treatment plan should be reviewed and updated at least every three months during continued treatment.

9. The assessment of the patient's physical health should include speech, hearing and language assessment; and review of immunization status and completion according to the U.S. Public Health Service Advisory Committee on Immunization Practices and Committee on Control of Infectious Diseases of the American Academy of Pediatrics.

10. A staffing conference, involving a range of disciplines including the professional staff responsible for the patient and the other clinical staff who participate in the patient's care and treatment, should be held for each patient, within one week after admission, and the results of the staffing conference should be summarized and made a part of the patient's record.

12. Treatment planning for inpatients should include planning of clinical services and programs necessary to promote the patient's progressive transition to day-care or outpatient treatment and return to the family.

13. The initial appraisal of each outpatient should include clinical consideration of each of the fundamental needs of the patient, particularly educational.

14. A staffing conference involving a range of disciplines, the professional clinical staff responsible for the patient, and other clinical staff who participate in the patient's initial assessment and/or treatment program should be held for each outpatient whose period of assessment and/or treatment extends beyond six sessions.

15. The findings of the initial appraisal, all assessment procedures and any initial treatment responses should be reviewed at the staffing conference.

16. Treatment appointments for outpatients receiving medication should be scheduled frequently enough, and with appropriate medical supervision to meet the clinical needs of the patients.

Clinical patient records

1. Records should contain documentation of the implementation of the plans for follow-up.

2. Progress notes by the clinical staff should document the implementation of the treatment plan.

3. All entries should be signed and dated.

4. Records of discharged patients should be completed within 15 days.

5. There should be written policies regarding the permanent storage, disposal and/or destruction of the clinical records of patients which is compatible with the protection of the patient's rights against disclosure of confidential information later in life.

Clinical care evaluation

1. There should be regular staff meetings and/or service unit meetings to review and monitor the management of the individual child or adolescent patient.

2. The clinical case meetings should be held frequently enough to ensure that each individual patient has a case review one month after initiation of active treatment and subsequently at least every six months during the course of active treatment.

3. Supervisory and consultative responsibility should be reflected and documented in individual case review meetings; and minutes of staff conferences.

4. There should be at least one clinical care evaluation study in process at all times.

5. Clinical care evaluation studies should consist of selection of a particular pattern of care for study; formulation of an appropriate design; specification of information to be collected, an appropriate sampling procedure if indicated and the duration of the study; collection of data from clinical records; analysis of data with conclusions and recommendations; production of a study report; transmission of study report to clinical staff, administration and others concerned; and implementation and follow-up.

6. Staff responsible for clinical care evaluation studies should keep records documenting at least monthly meetings.

7. Written reports of all studies should be made to the chief administrative officer, the leaders of service units and/or departments, and to other appropriate clinical staff.

8. There should be a plan for utilization review studies which cover the appropriateness of admission to services; the provision of certain patterns of services; and duration of services.

9. Meetings including utilization reviews, which may be combined with other quality control reviews, should be held at least monthly and records should be kept.

Safety

1. There should be written evidence of a current valid report of inspection for each separate building in which patients are housed or receive treatment which shows compliance with NFPA Life Safety Code 1973.

2. The written report should clearly indicate that each separate building was considered in terms of the appropriate section of the NFPA Code.

3. There should be written procedures for personnel to follow in the event of a breakdown in mechanical systems, or a lack or inadequacy of any utilities.

4. There should be policies regarding the usage, maintenance, supervision and safety precautions for patients and staff using any special activity areas such as swimming pools, gymnasiums, etc.

5. All staff should have knowledge of the safety program.

6. All potentially dangerous or toxic substances should be stored in a locked cabinet or enclosure.

7. All refrigerators and freezer should be capable of being opened from the inside.

8. There should be free and unobstructed egress from all parts of the children's and adolescents' dormitories.

9. Every structure housing children and adolescents should have battery powered emergency lights in all exit corridors and stairwells.

Environment

1. Ventilation, air treatment and humidity control systems should be adequate for comfort.

2. There should be evidence of routine cleaning and maintenance.

3. There should be indoor and outdoor recreation areas and equipment appropriate to the age group served.

4. Repairs to broken items should be carried out promptly; torn screens.

5. Clinical areas should be designed and located to help staff carry out treatment goals and make staff members appropriately and easily available to patients at P-1.

6. All sleeping areas should provide adequate space and privacy at P-1.

7. There should be no more than eight patients sleeping in one room at P-1.

8. There should be adequate provision for individual privacy in all multi-patient sleeping rooms.

9. Patients should be encouraged to participate in decorating their rooms and in arranging furniture and their own possessions.

10. Facilities should be available, in or near the living area, to allow patient participation in baking, preparing meals on special occasions, etc.

Living group

1. The composition of each living group should be purposefully and therapeutically planned, and periodically evaluated. Consideration should be given to the mixing of patients in relation to their ages, development levels, sex and clinical conditions.

Recreational and social activities

1. Appropriate programs of recreational and social activities should be provided for all patients for daytime, evenings, and weekends.

2. Community resources should be enlisted to provide opportunities for patients to participate in normal community activities, as they are able.

Educational progress

1. Educational programs should be provided or arranged to meet the needs of all patients being served.

2. There should be regularly scheduled conferences and communications and collaboration between other members of the clinical staff and those involved in the patient's education.

3. The educational director and staff should meet state and/or local certification requirements for education and/or special education.

Staff interaction

1. All staff who participate in the care and treatment of the patient should have sufficient knowledge of the goals and objectives, both short- and long-term of the patient's individual treatment plan.

Outpatient service

1. Waiting areas should be adequate and comfortable.

2. The design, location and furnishings in the waiting areas should reflect a consideration of the characteristics of the patients and families, the length of anticipated waiting time, their needs for privacy and/or support from staff, and the goals of the outpatient services.

All recommendations and comments should receive immediate attention in order that accreditation may be attained.

For a fuller understanding of these recommendations, reference should be made to: Accreditation Manual for Psychiatric Facilities Serving Children and Adolescents.

Rating by board of commissioners: Non-accreditation.

MAYO CLINIC,
Rochester, Minn., September 7, 1976.

Hon. CHARLES C. DIGGS, Jr.,
U.S. House of Representatives,
Longworth House Office Building,
Washington, D.C.

DEAR CONGRESSMAN DIGGS: I am very sorry my present clinical responsibilities preclude my acceptance of your invitation to testify on the proposed draft of the bill to transfer authority over St. Elizabeths Hospital from the Department of Health, Education and Welfare to an independent corporation.

At the time the Advisory Committee, which I was privileged to chair, submitted its Report to the Secretary of Health, Education and Welfare, over six years ago, we made those recommendations fully aware of "the complex problems inherent in the delivery of mental health care to the District of Columbia—all other things being equal." (p. 8) And our Report continued, saying that the prerequisite for the ultimate resolution of this perennial and thorny problem "... will never be met until the Hospital (becomes) an important element in the entire health-care system of the District. . ." and "... is integrated with all of the other related organizational elements and given the fiscal support it needs to effect the changes herein recommended." (p. 8)

The Report went on to detail seven "performance criteria against which our recommendations should be measured." (p. 9) The Committee was mindful of the fact the implementation of its recommendations required a one-step-at-a-time-approach if "the administrative transfer of St. Elizabeths Hospital per se will (not) be, as it has been in the past, a paper change without substance." (p. 9)

Our first Recommendation specifically took note that the independent Mental Health Authority it proposed "... be incorporated at some later time into a similar overall independent District of Columbia Health Authority." Obviously this was to be a first-step in an integrated, coordinated system of service. At that time you will recall the District was as yet deprived of home rule; it was in a most anomalous political position not prepared to undertake the full responsibility of a burdensome mental health problem added to the dire straits of its general health, welfare, delinquency and educational problems.

Since then I am informed the status of Home Rule for the District has been established. The relevant details of this legislation, however, are unknown to me. I have learned recently of the disaccreditation of the hospital and of the decision enacted to discharge 50 percent of the patients. Again, I do not know what community facilities have been made available for these persons. I do know the disaster and the scandal created in other jurisdictions by the wholesale emptying of mental hospitals by administrative fiat. I understand that the General Accounting Office has under preparation a study of the pros and cons of deinstitutionalization.

All of this is to say that whereas times have changed, the deplorable situation which we found at St. Elizabeths in substance is virtually unchanged. I understand that there have been legislative enactments and regulatory directives and administrative proposals which, in my judgment, make our Advisory Committee

recommendations of six years ago totally inapplicable to the current needs of the District as well as St. Elizabeths.

It is my opinion that it would be a serious mistake for your Committee to do anything less than address the mental health problem in the context of the many other District problems that pose contingent and relevant factors. The mere creation of an independent Mental Health Authority puts yet another band-aid on a long-gaping wound.

Sincerely yours,

HOWARD P. ROME, M.D.

[Western Union mailgram]

WASHINGTON, D.C., August 9, 1976.

WILBUR HUGHES,
House District of Columbia Committee,
Longworth House Office Building, Washington, D.C.

This is a copy of the message sent to George T. Coldewey, Associate Director, Joint Commission Accreditation of Hospital, 875 Michigan Ave., Chicago, Ill. 60611.

This is to inform you that Saint Elizabeth's Hospital does not object to the release of JCAH Survey Report on the rendering of verbal testimony by representatives of the JCAH before the House District of Columbia Committee on September 14 and 15, 1976.

HAROLD THOMAS, *Special assistant.*

Our first witness this morning is Mr. George Coldewey, Associate Director, Joint Commission on Accreditation of Hospitals. He is being accompanied by Dr. Walter Wolman, director of the psychiatric facilities programs and Dr. Myrine McAninch, associate program director for psychiatric accreditation programs.

Mr. Coldewey, you have submitted to the committee a prepared statement. You may proceed.

STATEMENT OF GEORGE COLDEWEY, ASSOCIATE DIRECTOR, JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, ACCOMPANIED BY DR. WALTER WOLMAN, DIRECTOR, PSYCHIATRIC FACILITIES PROGRAMS AND DR. MYRINE McANINCH, ASSOCIATE PROGRAM DIRECTOR FOR PSYCHIATRIC ACCREDITATION PROGRAMS

Mr. COLDEWEY. Thank you, Mr. Chairman. My name is George T. Coldewey and I am an associate director of the joint commission on accreditation of hospitals.

I appear today on behalf of the JCAH director. We are most pleased to accept the committee's invitation to appear today, and will attempt to provide whatever assistance we can in your consideration of the problems related to St. Elizabeths Hospital.

Recognizing the severe constraints upon the time of the members of this committee, we have attempted to assemble the material we have to present in such a way as to hold the time required to do so to an absolute minimum, with the expectation that it will generate questions to us on the part of the committee members to which we will be pleased to respond.

JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

I will present a brief general overview of the joint commission and its role in the contemporary health care scene. Drs. Wolman and Mc-

Aninch will, in turn, present a discussion of the psychiatric facility survey process and describe the procedures by which JCAH arrives at a decision as to whether or not to accredit a surveyed facility.

The joint commission on accreditation of hospitals was founded in 1951 as the outgrowth of the hospital standardization program conducted until that date by the American College of Surgeons. JCAH is a private, voluntary organization, chartered in the State of Illinois as a not-for-profit corporation under section 501(3) of the U.S. Internal Revenue Code.

Its governing authority is a 20-member board of commissioners, the members of which are appointed by the commission's four member organizations, which are the American College of Physicians, the American College of Surgeons, the American Hospital Association and the American Medical Association. The joint commission's corporate by laws recite its purpose and objectives, which are as follows:

(a) To establish standards for the operation of hospitals and other health-related facilities and services.

(b) To conduct survey and accreditation programs which will encourage members of the health professions, hospitals and other health-related facilities and services voluntarily to:

(1) Promote high quality of care in all aspects in order to give patients the optimum benefits that medical science has to offer.

(2) Apply certain basic principles of physical plant safety and maintenance, and of organization and administration of function for efficient care of the patient;

(3) Maintain the essential services in the facilities through coordinated effort of the organized staffs and the governing bodies of the facilities.

(c) To recognize compliance with standards by issuance of certificates of accreditation.

(d) To conduct programs of education and research and publish the results thereof, which will further the other purposes of the corporation, and to accept grants, gifts, bequests and devices in support of the purposes of the corporation.

(e) To assume such other responsibilities and to conduct such other activities as are compatible with the operation of such standard-setting, survey and accreditation programs.

ACCREDITATION PROGRAM

The joint commission is probably best known for its largest and most visible program, the hospital accreditation program. Since the late 1960's, however, JCAH has been responsive to the rapid growth in the numbers of facilities and programs for specialized patient care by establishing additional accreditation programs.

As early as 1966, for example, JCAH had begun surveying long-term care facilities, and in 1971, this activity was formalized through the establishment of our accreditation council for long term care facilities. Similarly, heightened public awareness of, and interest in, mental health, coupled with our lack of expertise at the time in thoroughly evaluating facilities for psychiatric treatment strongly suggested the need for establishment of a separate accreditation program for these institutions and services.

Thus, the accreditation council for psychiatric facilities was created in 1970, in cooperation with six national organizations with that interest. The number organizations represented upon the council has grown since its establishment to 10, and they are, the American Academy of Child Psychiatry; the American Association on Mental Deficiency; the American Association of Psychiatric Services for Children; the

American Hospital Association; the American Psychiatric Association; the Association of Mental Health Administrators; the National Association of Private Psychiatric Hospitals; the National Association of State Mental Health Program Directors; the National Coalition for Alcoholism Program Accreditation; and the National Council of Community Mental Health Centers.

The council develops standards for the accreditation of psychiatric facilities and programs which are subject to ratification by the JCAH board of commissioners.

These standards are developed in consultation with a wide panel of outside professional and technical experts in the field of psychiatric care. It is particularly important to note here that the process of standards development is dynamic, rather than static.

The accreditation standards for psychiatric facilities, like all JCAH accreditation standards, are under continual scrutiny and evaluation, with a view to revising them as necessary to keep them current with the state of the art and insure that they will prescribe an optimal achievable level of performance for facilities surveyed by the program.

Utilizing the standards, the program performs onsite visits of psychiatric facilities to determine that substantial standards compliance is, in fact, being maintained. In his presentation, Dr. Wolman will describe the professional background of the survey team members, their training and qualifications, and the survey process itself.

The recommendations of the survey team are returned to the program's Chicago headquarters where they are analyzed and evaluated by central office staff in order to assure consistency with program policy and standards.

The entire survey report is next reviewed by the program's professional staff to assure that the recommendation as to accreditation status of the facility is consistent, and is supportable by the detailed survey findings.

The next step in the decision process is consideration of the individual facility by the council's accreditation committee, which meets once a month in order to formulate and express its decisions based on the recommendations made during the preceding steps in the decision process. The council accreditation committee's decisions are, in turn, reviewed by the accreditation committee of the board of commissioners which either ratifies them or remands them to the council for further consideration.

This process, although tortuous, is designed to provide for every facility surveyed the fullest possible consideration for accreditation. With respect to those facilities for which to contest such decisions either as to fact or as to the standards upon which the decision is made.

Against this backdrop of general information about JCAH and the psychiatric facilities program we would now like to present specific information regarding the subject of the committee's interest, St. Elizabeths Hospital, Washington, D.C., and Drs. Wolman and McAninch will make this presentation on the program's behalf.

Dr. Wolman?

DR. WOLMAN. MR. Chairman, I would like to present briefly an overview of the AC/PF accreditation process. Dr. McAninch will present some specifics of the St. Elizabeth survey and accreditation decision.

ACCREDITATION PROCESS

The accreditation process begins with a request from a facility or program for survey. An application form is sent which upon its return permits AC/PF central office staff to determine whether the facility is eligible for survey and its categories of service. It also permits initiation for scheduling and planning for the survey.

A self-evaluation questionnaire is available which offers the facility a means of self-evaluation and provides it with indications of possible deficiencies.

The surveyor's onsite visit is the heart of the process. It is the basis for the firsthand information available to the central office and accreditation committees for their consideration. The onsite survey provides information about the facility's organization, its policies, its provision of treatment, care, and other services to the patient and its documentation of these processes.

The purpose of that survey is to permit a discussion and educational process to take place, as well as to evaluate compliance with the standards. In this connection, the survey team meets with the facility's administrative and medical staffs, as well as with major department heads, in the course of the survey.

Primary, but not exclusive concerns of the onsite visits are the environment, safety, and quality of medical care and patient management. The survey includes a review of a random sample of medical records, a followthrough on patient care, and review and examination of the facility buildings and grounds.

An information interview is conducted immediately prior to the beginning of the survey. This interview permits anyone who believes he has important information about the facility's compliance with accreditation standards to present it to the survey team.

SURVEY FINDINGS AND RECOMMENDATIONS

At the end of the survey, the survey team reports its findings and recommendations to the representatives of the facility's governing body, administration, and staff at a summation conference. This conference actually may be viewed as the first step in the appeal process, since facility representatives are provided the opportunity to correct or rebut the reported findings of the surveyors.

If the recommendation is for nonaccreditation, the facility or program is afforded due process through the appeal mechanism. The facility can request an interview with staff. The results of that interview then are considered by the council accreditation committee.

If the committee still recommends nonaccreditation, the facility can request a hearing before an appeals hearing board which is composed of individuals selected by the board of commissioners and which cannot have on it the individuals who surveyed the facility, or members of the council accreditation committee that recommended the non-accreditation decision. The panel's recommendation is then sent to the board's accreditation committee for ratification.

If the decision is still for nonaccreditation, the facility may appeal directly to the board of commissioners less those members who served

on the accreditation committee that made the previous decision. The decision of the board is final.

I would like to add a word about the qualifications of the surveyors participating in this process. Surveyors are selected on the basis of experience and knowledge in the areas of mental health. They are psychiatrists, administrators of mental health facilities, or other mental health professionals.

They undergo several days of training and orientation with emphasis on the standards and their interpretation. As a part of the training they are sent as observers on surveys along with experienced surveyors. Next they participate as a part of a survey team after which they are considered ready to survey independently.

Mr. McAninch will now present information relevant to our survey of St. Elizabeths Hospital.

Dr. McAninch?

SURVEY OF ST. ELIZABETHS (1975)

Dr. McANINCH. Mr. Chairman, based on accreditation procedures, just outlined, a team of four surveyors conducted an on-site visit of St. Elizabeths Hospital on September 8 through 11, 1975. All of the surveyors were psychiatrists by profession.

The survey team compared the existing conditions of the physical plant and service delivery system(s) with the approved AC/PF standards. As is our practice, corrections made in response to recommendations made in conjunction with our 1974 survey were noted as part of this survey.

The survey team based its judgment as to the level of compliance of St. Elizabeths Hospital largely on a multiplicity of items pertaining to the quality of patient treatment as noted in the fundamental principles section of the Accreditation Manual for Psychiatric Facilities.

This manual contains nine fundamental principles, compliance with which is considered important in order for accreditation to be attained or retained. These are as follows:

Principle I.—The primary functions of any psychiatric facility shall be to diagnose and treat persons with psychiatric disorders, to restore them to an optimal level of functioning and to return them to the community.

Principle II.—The psychiatric facility shall acknowledge the dignity and protect the rights of all of its patients.

Principle III.—The psychiatric facility shall have a competent staff whose members subscribe to ethical and professional standards.

Principle IV.—A psychiatric facility shall not exclude any person from receiving services, or from membership on the governing body or medical staff, or from employment on the basis of race, creed, sex, or national origin.

Principle V.—The psychiatric facility shall integrate its services with other community resources and shall be responsive to community needs.

Principle VI.—The psychiatric facility shall have clearly delineated purposes and goals reflected in its written policies, procedures and organization plans.

Principle VII.—The psychiatric facility shall promote a climate that makes possible the establishment of significant relationships among staff, patients and their families.

Principle VIII.—The activities of the psychiatric facility shall be conducted in accordance with the law and with accepted standards for clinical practice and human dignity.

Principle IX.—The psychiatric facility shall be organized so as to perform its functions and accomplish its goals.

With the exception of principle IV, varying degrees of noncompliance were found with respect to all.

ADVERSE ACCREDITATION RECOMMENDATION

AC/PF central office review of the survey reports and related supportive materials submitted by the survey team resulted in an adverse accreditation recommendation which was concurred in by the AC/PF accreditation committee and then ratified by the accreditation committee of the board on November 11, 1975. Noncompliance in areas affecting patient safety was instrumental in the nonaccreditation decision.

On January 28, 1976, representatives of St. Elizabeths Hospital met in an informal interview with AC/PF central office staff to discuss any questions raised by the letter of recommendations forwarded to St. Elizabeths Hospital on November 28, 1975.

Corrections were noted subsequent to the onsite visit. There were still major areas of noncompliance, particularly those affecting patient safety and treatment. The accreditation committee of the board reaffirmed its nonaccreditation decision on April 16, 1976.

APPEAL PANEL

On May 5, 1976, St. Elizabeths Hospital formally requested that an appeals hearing panel meet to review the nonaccreditation decision.

The appeals hearing panel was conducted on June 11, 1976. Members of this panel were knowledgeable about the standards and accreditation process and were persons who had had no prior review of these materials or association with the accreditation decisions pertaining to St. Elizabeths Hospital.

The quality of treatment planning and its implementation and the environmental and safety deficiencies affecting the general quality of patient treatment were of major consideration in the appeals hearing panel's recommendation. The panel ratified the decision of the accreditation committee, and subsequently the panel's ratification was itself ratified by the executive committee of the board August 14, 1976.

Mr. Chairman, this concludes the prepared segment of our presentation. As was indicated earlier, however, we would be pleased to respond to the committee's questions.

The CHAIRMAN. Thank you very much.

I yield to the gentleman from the District, Mr. Fauntroy.

REASONS FOR NONACCREDITATION

Mr. FAUNTROY. Thank you, Mr. Chairman. I have several questions for any member of the panel. In the first instance in your judgment, are the primary deficiencies at St. Elizabeths Hospital those most directly responsible for nonaccreditation, do they relate to budget, or some other factors?

In other words, would additional funds solve the institution's accreditation problems?

Dr. MCANINCH. The major problems were in areas having to do with environmental, patient safety, patient treatment, particularly as it pertains to documentation of the kinds of treatment rendered, the

quality of the staff and in terms of the governing body and management as it pertains to policies and procedures in the entire organizational function.

Accordingly, many of these items are in fact affected by budget. But budget in and of itself would not have resolved the problems of St. Elizabeths Hospital.

Mr. FAUNTROY. I believe that the District of Columbia General Hospital, a District facility, is similar to St. Elizabeths in that it, too, is not accredited by your association. Are the problems of these two institutions, those leading to nonaccreditation, similar? Are they related? How much does the lack of funds contribute to the problems of both institutions?

Mr. COLDEWEY. I am fearful that we did not come prepared to discuss any of the details of the District of Columbia General. We have the impression that they are at the present time nonaccredited. I think it is reasonable to say that it is probable that part of the reason for that, at least, is a financing problem.

That has been our experience with many similar institutions.

Mr. FAUNTROY. On that point, are there many mental institutions of the size and budget of St. Elizabeths Hospital that are not accredited by your institution?

Dr. McANINCH. Well, there are a variety of State hospitals who receive nonaccreditation that are similar in size such as Pilgrim State Hospital in New York, St. Lawrence in New York.

There are several others that we might mention. Again budget as it pertains to the remodeling of many of the older buildings is a major item. But beyond that, it also has to do with the deployment of staff and the provision of quality care and an evaluation system, a system to determine the nature of the care and treatment that is rendered that we are also very concerned about.

Mr. FAUNTROY. We are concerned with whether or not an institution has to be of a certain size in order to be accredited. We expect to hear testimony later that St. Elizabeths is too large and should be scaled down and deinstitutionalized. I wondered if you would care to comment on that concern?

Dr. WOLMAN. There is no limitation as far as our eligibility requirements for accreditation survey is concerned. In regard to whether they are eligible for survey, it does not pertain to how small or how large they are.

Mr. FAUNTROY. I wonder if you would care to expand on your identification of the policymaking structure and management as being a problem?

Dr. McANINCH. Well—

Mr. FAUNTROY. This is related to an alternative suggestion that an independent corporation might be a way of more effectively addressing these problems. I just wondered how this draft legislation might have, if any, effect on your ability to judge the institution.

Dr. McANINCH. I could say that in review of it, there seems to be no inconsistencies in the draft legislation and the standards contained within the green manual. In terms of the problems that St. Elizabeths is presently experiencing in terms of the governing body, there are a number of recommendations that we have made during our 1975, 1974,

and 1975 surveys that do directly pertain to the organization of its governing body and the ability to provide adequate physical resources so that there would be appropriate care of psychiatric treatment rendered at St. Elizabeths.

We are also very concerned in terms of our standards pertaining to their written goals and policies and procedures and an organizational plan whereby there is a delivery system evident.

This has been a problem with the present structure.

HOSPITAL SIZE

Mr. FAUNTROY. On the basis of your information and experience, would you say that large State-owned and operated mental hospitals are a thing of the past?

Dr. WOLMAN. I think at one time about 15 years ago, about the time that the Joint Commission on Mental Illness and Health made its report to the Congress, there was the great hope that the large institutions for the mentally ill could be if not eliminated at least reduced considerably.

It is on that premise that there has been an attempt for the patients to be released to small units in the communities. Unfortunately, this has not always worked out. The quality of care and the treatment in those small units has not been as it should be and there has been a great deal of concern about the environment of some of these small homes.

As a consequence, there is still a great need for larger institutions with the recognition that it would be fine if they could be reduced. But they are still with us and probably will be for a long time.

Mr. FAUNTROY. I assume that your organization is divided into geographical areas of some type. I wondered what the States encompassed in this region are and if there are any institutions comparable in size and budget to St. Elizabeths in this region that are not accredited?

Mr. COLDEWAY. In response to the first part of your question, sir, we do not operate on a regional basis. We are national in scope without geographical breakdown. So far as similar nonaccredited hospitals, Dr. McAninch earlier cited two that came to mind, so to speak.

I would say further that of the currently 7,100 hospitals currently registered in the United States, the joint commission accredits roughly 5,000, leaving one with the conclusion that we do not accredit about 2,100. To generalize about those that are not accredited, however, would be very difficult.

My impression is that they range in size from very small to very large, that they are reasonably distributed geographically across the entire United States, that their ownership characteristics and other characteristics for that matter vary such as to make a characterization almost impossible.

Mr. FAUNTROY. Thank you.

Mr. Chairman, I will yield at this time. Both Mr. Diggs and I have a funeral to attend.

Mr. HARRIS. Thank you, Mr. Fauntroy.

[At this point Mr. Harris assumed the chair.]

Mr. HARRIS. Mr. Whalen?

Mr. WHALEN. I presume that the findings of your survey have been transmitted to the committee staff?

Is that correct?

Does the committee have copies of this so we can go into this in more detail at our own pace?

Mr. COLDEWEY. We have indicated to the staff that whatever information is required we will be more than happy to furnish.

HOSPITAL DEFICIENCIES

Mr. WHALEN. Perhaps we could get into some of the specific deficiencies to which you have alluded in your comments. You refer to inadequate environment. Could you be a little more specific as to what this failure is?

Dr. McANINCH. Mr. Whalen, this has to do with a variety of situations. Let me give you a few examples. Sleeping facilities should provide appropriate privacy for each patient. This is given in particular reference to Nichols, East Side, Haden, O'Malley, Richardson, and Hoffman buildings. In other words, in terms of environment, one of our major concerns is the protection of human dignity, privacy being one such situation.

The fact that the person is able to have his own personal articles and opportunity to decorate his own room, things of that nature.

Similarly, there were recommendations made about clothing provided by the facility should be appropriate and should not be dehumanizing. There should be areas available—

Mr. WHALEN. May I interrupt here?

With respect to the second deficiency, it would seem to me that this could be done without any radical changes or perhaps even any significant increase in funding. How about the first? Is it possible to correct that deficiency in the existing facilities to which you referred?

Dr. McANINCH. Yes. Personally—I have to indicate that I was not at St. Elizabeths at the time of the survey. But from my past experience with other similar State hospitals, I would assume that this could go down with another one of our recommendations, having to do with every resident having ample closet and drawer space in which to keep his private property.

Frequently, what we are seeing is very large wards, dormitory style. If appropriate drawer space is used as dividers, frequently this will meet both kinds of standards that AC/PF is concerned about.

There are a variety of recommendations along that line having to do with places where the patients can be alone when it is not clinically contraindicated, that they should have proper and adequate lighting, daylight, the furniture should be comfortable and in good condition.

These are many of the kinds of things that came up in terms of environment.

Mr. WHALEN. In your commission's surveys throughout the country, have you noted recently constructed facilities which are better able to accommodate these recommendations than the old kind?

Dr. McANINCH. Well, I think there is a general move across the United States to close out, particularly the buildings that were built in the 1800's and are still being used by many of the psychiatric patients and move toward new construction at this point in time.

Obviously, they would be more in keeping with the life safety code as it applies to the 1973 code and they would also be more in keeping with environmental standards.

Mr. WHALEN. You refer to noncompliance of patient safety criteria. Is this due primarily to the facilities that exist?

Can they be upgraded?

Dr. McANINCH. A good number of them have been upgraded. I think part of it, in terms of St. Elizabeths Hospital, is also the confusion as to the fire marshall, who is really legally responsible for that particular set of buildings, things of this type, that have never really been clear cut, plus the problems that are existing within the buildings.

Both of these have compounded the problems in terms of patient safety.

PERSONNEL

Mr. WHALEN. You mentioned patient treatment. What are some of the examples of failures there? Lack of staff? Lack of qualified personnel or a combination of the two?

Dr. McANINCH. It would be a combination of the two and it would also be noted in terms of patient records. In other words, we are concerned that there are identifiable admission criteria whereby patients are selected for treatment and that it is deemed appropriate for them to be provided this treatment within St. Elizabeths Hospital. Second, there should be an adequate diagnostic assessment and we can clearly find indications of this in the medical record.

Next we would be concerned that there are indications in their records that there has been implementation of such.

Mr. WHALEN. In other words, you are talking about recordkeeping. I think you referred to documentation earlier and it seems to me this is more of a management problem than a strictly medical problem.

Is that correct?

Dr. McANINCH. I think it goes together because we are concerned that there is multiple discipline input into this entire treatment planning situation and that we can find situations—indications that the treatment per se has been rendered and is appropriate.

Going along with that, there should be an evaluation system involving utilization review of patient care evaluation studies to guarantee the quality of this care.

Part of it is documentation, part of it is staff and part of it is having written goals to indicate the nature of the treatments to be rendered.

Mr. WHALEN. From the commission's experience, is this situation fairly widespread throughout the country?

Let me explain the question by stating, from my own limited observation, it seems to me that in our public facilities, mental and psychiatric, we are suffering from an acute shortage of doctors, qualified physicians and psychiatrists.

Dr. McANINCH. I am thinking of how I would like to really respond to that best. It seems to me that the problem of documentation is fairly widespread in terms of the level of sophistication of many hospitals. However, I do believe that we are not putting the emphasis entirely on the physicians as carrying the complete burden of psychiatric care and treatment.

We are looking at a multiple discipline team approach. I think many State hospitals have been quite successful in finding this kind of a combination.

EFFECTS OF NONCERTIFICATION

Mr. WHALEN. Just one final question: What are the practical effects of decertification? The institution would continue to operate. But what are the effects on the patient in terms of medicare, medicaid, and so forth? Would this ultimately cause the closing down of the institution?

Dr. WOLMAN. I think the chairman with his opening remarks hit upon a very crucial point with respect to the effects and that is the nonavailability of medicaid and medicare funds which has considerable consequences.

More than that, there is an effect upon the training of professional people, professionals who come for their training to various institutions of this type. They are reluctant to come to one that is not accredited.

I think that is obvious. I think there is a third aspect. If an institution or the people that govern it have any self-respect, self-esteem, or professional pride about taking care of the mentally ill, I believe that in itself has a devastating effect.

I think the professional pride in not just the professionals but everybody concerned with the institution is an important aspect of it.

Mr. WHALEN. Thank you, Mr. Chairman.

Mr. HARRIS. Thank you, Mr. Whalen.

I have one very quick question. I noted with regard to your statement on the second to the last page, you state that:

The AC/PA central office review of the survey reports and related supportive materials submitted by the survey team resulted in an adverse accreditation recommendation which was concurred in by the AC/PF Accreditation Committee and then ratified by the Accreditation Committee of the board on November 11, 1975.

That is concurred in:

Noncompliance in areas affecting patient safety was instrumental in the nonaccreditation decision.

PATIENT SAFETY

You also say that upon review there were still major areas of non-compliance particularly those affecting patient safety and treatment.

As to the final decision of failure to accredit, would you say that the major problem was safety?

Dr. MCANINCH. Within all of our manuals, Mr. Harris, patient safety can be a sole factor determining nonaccreditation. It is the only such factor that can stand on its own.

That is why there is that indication in our testimony of today. Obviously there were other problems dealing with patient treatment that were also indicated that were a part of the total decision of nonaccreditation.

Mr. HARRIS. In any review, I presume, with respect to accreditation, you are going to find with regard to your nine principles different degrees of noncompliance. The corners of the steps are dirty and that kind of thing all goes into the report.

Perhaps some of these other things might have been corrected but that with regard to safety, this problem was clear and specific enough that this required a nonaccreditation. Is that an incorrect interpretation of what you said?

Dr. McANINCH. That would be a correct interpretation.

Mr. HARRIS. As I look at St. Elizabeths and talk about safety, as a layman, I would hate to have a job at St. Elizabeths when I look at the age of the buildings and that sort of thing.

Isn't the correction of the safety problem at St. Elizabeths a very expensive undertaking?

Dr. McANINCH. I think it undoubtedly would be. I think beyond the correction we are also concerned with having an offset plan during any such correction. This was not available to us at the time of the onsite visit.

In other words, a form of preventive maintenance, a plan to carry out to insure patient safety during any such renovation. It is sort of a three-pronged thing that we are interested in.

Mr. HARRIS. That answer is very responsive. The situation not only proved to be unsafe but you were not sure there was any plan to make it safe, nor a plan to improve safety during moving toward making it safe.

Dr. McANINCH. That is right.

Mr. HARRIS. Thank you very much.

I appreciate your testimony. Counsel?

DEPARTMENT OF HUMAN RESOURCES

Ms. MARTIN. On page 10 you state that the psychiatric facility shall be organized so as to perform its functions and its goals. I assume that at least one of you is familiar with the organization of the Department of Human Resources. The draft legislation which this hearing is about and in his opening statement the chairman said the committee was reluctant to transfer St. Elizabeths to the District government because of the organization of DHR.

Based on your experience with DHR in connection with your review of District of Columbia General Hospital, what would be your reaction to the chairman's opening remarks about his concerns about the organization of DHR as it was impacted upon St. Elizabeths?

Mr. COLDEWEY. A quick poll reveals that we do not have any experience with the Department of Human Resources.

Ms. MARTIN. I thought it was your organization that also rendered District of Columbia General Hospital nonaccredited?

Dr. WOLMAN. Yes. We did not come prepared to discuss District of Columbia General.

Ms. MARTIN. I wondered if you could respond to that in writing.

Mr. COLDEWEY. Yes.

EFFECT OF NONACCREDITATION

Ms. MARTIN. What does the final decision mean? What happens next? Is the door closed forever or is the ball in somebody's court?

Dr. McANINCH. I believe we have just received contact from them that they will continue their appeal through the appeal process and

present their situation to the board of commissioners at its next meeting which I believe is going to be in November of this year.

At that time if the board of commissioners of the joint commission of accreditation of hospitals does arrive at nonaccreditation, then it is finalized at that particular point in time.

That does not mean, however, that St. Elizabeths, 6 months subsequent to that decision, could not reapply for a resurvey. In essence, this would amount to giving them approximately 1½ years from the time of the original survey in September 1975 to correct as many of the recommendations that we have made to them as possible.

So it would be closed for a period of time. It is up to them, if they so choose, to reopen it.

Ms. MARTIN. Thank you.

Mr. HARRIS. I don't want any misinterpretation of your last statement. You mean the case would be closed and not St. Elizabeths?

Dr. McANINCH. I mean the case would be closed.

Mr. HARRIS. I thank you very much for your testimony. We appreciate the time that you have taken.

Next we have Dr. David Reynolds, deputy commissioner, Erie County Department of Mental Health, the State of New York. Dr. Reynolds, we are appreciative of your coming before us today. We appreciate having a copy of your statement.

You may proceed either way, if you would like. You can file the whole statement for the record now or you can go ahead and do your whole statement.

Which would you prefer to do?

Dr. REYNOLDS. I think the statement is reasonably brief, Mr. Chairman. Perhaps I could go through it and read it for the record.

Mr. HARRIS. Fine, you may proceed.

STATEMENT OF DAVID S. REYNOLDS, PH. D., DEPUTY COMMISSIONER, ERIE COUNTY DEPARTMENT OF MENTAL HEALTH, BUFFALO, N.Y.

Mr. REYNOLDS. Thank you.

Mr. Chairman, and members of the committee, I appreciate the opportunity to express my views today on revised discussion draft No. 2 of the St. Elizabeths Hospital Corporation Act and the prior issues related to mental health services in the District of Columbia and at St. Elizabeths Hospital. I am currently deputy commissioner for mental health, retardation and alcoholism services in Erie County, N.J., a metropolitan area of approximately 1.1 million people.

I was in the District of Columbia area in the middle to late 1960's when hopes were running high for the emerging programs of community mental health. For the past 8 years I have been part of a parallel experience in Erie County, N.Y.—an experience involving the development of a full range of community services for the mentally disabled under the auspices of local government.

It is my hope that our experiences in Erie County can assist you in focusing and resolving the critical issues that emerged in the oversight hearings of this committee in April 1975, and which the draft legislation now under discussion obviously attempts to address.

REVIEW OF ISSUES

Last year's hearings opened with questions in two relatively circumscribed areas—the quality of services being rendered by St. Elizabeths Hospital and whether the hospital should be transferred from the Federal Government to the government of the District of Columbia.

From a reading of the record of these hearings, the picture that was uncovered was remarkably similar to the pattern of conflict involving mental health services that has occurred across the country in the last decade—a conflict initiated by dramatic efforts to establish local community programs in place of major institutional programs.

A conflict that was intensified by the assumption built into the original Federal legislation on community mental health centers could eventually be eliminated.

The validity of comparing the issues before this committee and related struggles elsewhere in the country was suggested by Rev. Joseph O'Brien in his testimony for the committee of one thousand. He clearly drew the analogy of the District's relationship to the Federal Government as similar to that of other municipalities to the States in which they are located.

The picture that emerged before this committee was of initial enthusiasm and excitement over the prospect of replacing long-term hospital treatment with short-term programs. That enthusiasm was ignited by the promise of Federal seed money and fanned by professional and public views that short-term replacements for large institutions were not only desirable but possible. As with all great hopes, reality gradually intruded. The problems of the chronic patient defied quick solutions. Local governments found it difficult to replace shrinking funds. The new programs found themselves unable to fully deliver on their original promise and turned to dealing with the less troublesome client in order to survive.

COMMUNITY SERVICES

Older, established institutions, like St. Elizabeths Hospital, were initially in support of community services for professional reasons. Gradually, however, they began to sense the threat to their own survival—a threat that was clearly evident in the shift of Federal funds away from staff development programs and by the eruption in professional organizations and literature of an emphasis on community service.

Threatened on the one side with professional obsolescence and extinction and pressured on the other by right-to-treatment issues and accreditation bodies, they moved in the only direction open—the establishment of community programs of their own.

This stage was clearly identified to the committee in the testimony concerning the gradual breakdown of discussions regarding discharge planning and community facility developments between St. Elizabeths Hospital and local agencies.

While such movements of the hospital programs into the community were precipitated by pressures within the hospital itself, it was abetted by the general inability of local agencies to respond to the needs of the chronic patient.

They were facing survival issues of their own—usually identified as money problems.

As the hospital stretched itself into the community, the litany of problems recited to this committee developed. Constant organizational changes resulted in unequal distributions of staff resources throughout the hospital. Frequent changes of emphasis in program areas led to a loss of purpose and morale problems for a staff that had once been part of a well defined structure.

Collisions with community groups because of inadequately staffed and managed community programs only intensified the morale problems. The final blow frequently came, as it did for St. Elizabeths with the loss or threatened loss of accreditation. It is understandable, then, why the committee heard the accreditation issue connected as frequently with a loss of prestige as with a loss of resources.

DISTRICT'S UNIQUE SYSTEM

While this general summary serves to link the mental health issues in the District to those around the country, there are two aspects that make it unique. One is that the "State hospital" serving District residents is controlled by the Federal Government.

As a result, the procedures usually available to local government for resolving issues with the next higher level of government are absent. The other difference, while not totally unique, is the apparent lack of an organized and decentralized public service system under a seasoned, representative local government. Such a deficiency, whether real or only assumed by its constituents, results in a lack of an acceptable forum for defining meaningful local issues.

It is not surprising that in the testimony before the committee last year there was little vigorous opposition to the eventual transfer of St. Elizabeths Hospital to the District of Columbia. Nor is it surprising that there was no sustained support for such a transfer now.

Neither the hospital nor the local programs were seen as sufficiently stable to accommodate each other. In their parallel efforts to survive, the implications of such an accommodation had been approached mainly in fiscal management terms. That is probably not the area in which the real issues will be addressed.

PUBLIC SERVICE MANAGEMENT

Effective resource allocation and management is certainly important in any program operated with public funds. But there is a fundamental error in the assumption that better managers and the application of good business techniques will resolve the issues in the public service sector.

Private industry achieves its role in the marketplace through competition and the application of a precise technology against a profit demand by its investors. The need to show a profit means that managers are always seeking greater efficiency.

Service institutions such as programs for the mentally disabled, however, must be responsive to a different set of conditions. Their role is not achieved through competition in the marketplace. Their results are not judged in terms of a profit margin. Instead, they are assigned a

job because of public need and are supported by the economic surplus of our society.

The conditions that define and control a successful business—profit—will not influence public services. Public services are intended to reflect the values of a developed society and their success must be determined by their performance in relation to specific tasks based on those values.

It is within this framework that the problems related to mental disability services for District of Columbia residents must be resolved. The question is how to manage public service institutions for performance. The answers will not come easily since there are few proven models despite the fact that more than half of the personal income of the United States is spent on public service institutions.

PUBLIC MENTAL HEALTH SERVICES

There are, however, a few examples around the country of apparently successful public mental health institutions. Among these I would include the programs of Orange County, Calif., River Region, Ky., and Erie County, N.Y.

The approaches taken in these widely separated areas have some common marks that would be helpful in approaching the tasks ahead for the District of Columbia. These common marks are basically similar answers to the key questions which must be asked if public mental health services are to perform satisfactorily.

These same questions must be asked and answered with regard to District of Columbia programs.

PURPOSE

The first major question is what is our business or purpose now and what should it be? The answer, from the record, is that the business now is to run two separate mental health operations by two separate levels of government for the same population.

The purpose should be to provide cost-effective quality programs which minimize disruptions to people's lives caused by mental disability. That statement of purpose implies that you cannot maintain two competing or even separate operations. It means that all the resources available to do the job must be part of a single organized plan that permits ease of patient movement from one part of the program to another. It also implies that the plan should be geared to assisting the client without severing him from the community, if possible.

PRIORITY SETTING

The next issue is a statement of objectives and priorities against that basic purpose. If the programs in the District of Columbia are to be cost effective then the first priority must be service to the chronic patient and those at greatest risk of hospitalization. The most severe costs of any mental health service system, both in human and fiscal terms, are connected with the operation of large institutions. Unless services to this group of clients are clearly defined as a priority, the system will be out of control and unmanageable.

The second priority must be to maintain a full range of services so that the client's needs can be met regardless of the level of difficulty.

It would make little sense to concentrate on either hospital-based services or community-based services since both must be in balance if the patient is to be served in accordance with what his needs are at a given point in time.

A third priority must be to make services accessible. This means the elimination of geographic, ethnic, language, and bureaucratic barriers. Services must be located so that people can get to them. Once they are identified as needing assistance, they should be able to access any element of the total spectrum of services in accordance with their need. If that is to happen, all agencies providing a public mental health service must see themselves as part of a larger system in which they perform a specific function.

Finally, services must be responsive to community need. As a public service, mental health programs must be linked closely to need as defined by the community itself if they are to have the support necessary to gain public acceptance and public dollars.

They cannot be thrust on a neighborhood or community by professional planners or special interest groups.

Each of the above priority statements can be reduced to measurable time limited objectives.

RESOURCE INVENTORY

A third area of questions to be addressed involves an inventory of resources necessary to doing the job. Such an inventory would include those resources currently in existence, such as St. Elizabeths Hospital, and all District programs. It would also include a list of necessary management tools such as common policies and procedures, common program design and budgeting arrangements and a common management and personnel information system for monitoring results against objectives.

Finally, the organizational structure must be defined. Experiences elsewhere in the country would suggest that in order to be sustained over time, public mental health services must be organized under a mental health authority at the local government level.

Only with such an arrangement does the local community feel their needs are being met and that they have access to the decisionmakers. Only under such an arrangement can mental health services begin to reflect the unique values of a particular community. In order to enhance the community's sense of ownership of their public institutions such as mental health, citizens must also have an ongoing share in their control.

This requires a decentralized arrangement in which the authority to make policy decisions is truly shared among elected officials, professional bureaucrats and citizen representatives of geographic neighborhoods or particular client groups. Control sharing has been demonstrated to work for mental health programs in relation to policy decisions about service levels, service effectiveness and general administrative standards.

LEGISLATIVE RECOMMENDATIONS

From the remarks above, I would conclude that the issues with regard to St. Elizabeths Hospital and District of Columbia mental

health programs are not remarkably unique to this community. I would also conclude that there are some guidelines for future action based on experiences elsewhere, many of which have been suggested in the testimony of others before this committee.

Based on these conclusions, I would urge that the committee review the draft St. Elizabeths Hospital Corporation Act as landmark legislation intended to move the scattered pieces of mental health services for the District of Columbia residents into a single system under the planning and operational control of local government.

Such a system could solidify the position and purpose of St. Elizabeths Hospital as a strong component of a major service effort and bring all services into a linked arrangement against real community need. The outcome could well be a national model for public mental health service.

In reviewing the draft legislation I would particularly urge that the committee attend to those sections which are likely to confuse or compromise the expected results.

Specifically, I would recommend that:

First, the board of the corporation should include the addition of the senior mental health authority in the District of Columbia as an ex-officio member. The establishment of a corporation sufficiently addresses the problem of a clearly defined authority for St. Elizabeths Hospital. However, contentious issues with regard to planning and service design could be reduced by the up front involvement of local government.

Second, section 4(a), paragraph 3, should be reworded to emphasize policy sharing with community groups through the locally established mental health authority. The present wording could lead to unnecessary conflict between well intended community groups simply because the channels of accountability were unclear.

Third, section 4(a), paragraph 4, should be spelled out in greater detail so as to guide the corporation toward common policies, a common program/budgeting procedure, and a common management information system with the District of Columbia. These are critical linking tools if the separate services are ever to view themselves as part of a common effort.

Fourth, section 4(a), paragraph 5, should be amended to require effective deinstitutionalization as a priority in accordance with a plan developed jointly with the District of Columbia. It should further specify that mechanisms and policies be established for joint discharge and aftercare planning by St. Elizabeths Hospital staff and the appropriate District of Columbia mental health staff for all District of Columbia residents to be released. Such amendments would link both community and hospital programs to a common interest in the priority area for any public mental health system.

Fifth, section 4(a), paragraph 7, should be amended to provide for the establishment of a separate organizational entity for the area D community mental health center by the District of Columbia in accordance with a plan developed by the corporation and the District of Columbia.

Sixth, section 4(b), paragraph 2, should either be deleted or amended to show that all such hearings must be held jointly with the

appropriate administrative body of the District of Columbia government.

Since I would assume this committee always retains the power to hold such hearings, the addition of a public forum somewhere between local and Federal Government could unnecessarily divert attention from the intended locus of decisionmaking regarding District of Columbia mental health services.

Seventh, section 9(b) should be amended to reflect a sense of Congress that District of Columbia Mental Health Services and those operations of St. Elizabeths Hospital which serve District of Columbia residents, as part of a comprehensive plan for services to the District, be identified in a single annual program/budget document. The current language tends to conflict with earlier requirements for a financial plan by prematurely determining the outcome of such a plan. I would assume the ultimate intent is to be a joining of resources and services without determining then in advance of a plan the weighting of the burden.

Mr. Chairman, I appreciate the committee's indulgence and hope that these remarks from outside the immediate family of the District of Columbia community will be helpful to you and the committee in your deliberations.

BOARD

Mr. HARRIS. Thank you, Dr. Reynolds, for an excellent paper. I notice on page 9 that you suggest there in your first recommendation that the board should include the addition of a senior health official as an ex officio member.

Whom do you mean by senior health authority?

Dr. REYNOLDS. I would assume that the District of Columbia can define their senior mental health authority. I don't propose to be an expert on that end of it.

Mr. HARRIS. The legislation calls for two members of the board to be appointed by the Mayor. I would assume he would know.

Dr. REYNOLDS. I am talking about not an individual but I am talking about the individual responsible for making the management decisions within the bureaucracy of the District of Columbia. This would be the senior mental health professional or administrator.

Mr. HARRIS. This would not have to be a major change. The Mayor would have discretion to choose among several people. You use the term ex officio which simply means that that person would serve on the board as a full-fledged member of the board.

COORDINATION OF MENTAL HEALTH SERVICES

Mr. HARRIS. As you point out, very cogently, there is a need for coordination of the total mental health services in the District of Columbia. The question came to my mind should the legislation create a mechanism that more clearly operates to achieve that coordination. Do you feel there is any additional mechanism needed?

Dr. REYNOLDS. In addition to the legislation?

Mr. HARRIS. Yes.

Dr. REYNOLDS. Mr. Chairman, I believe that the legislation as proposed would have to be amended to provide such a mechanism. It

runs the risk now of simply setting up another bureaucratic structure which does not link effectively to the local government base.

I think that beyond that, there are a number of things that have to be done that probably are not necessarily legislative issues but are management issues and development issues.

COMMUNITY CENTERS

Mr. HARRIS. Might I ask you, if you would, to explain the relationship between the community mental health centers and the community hospitals in Erie County?

What is that relationship?

Dr. REYNOLDS. We have only one program that would be considered a community mental health center under the Federal model. The programs that have been developed there in the past 8 years were developed at variance with the community mental health center models for a number of years.

The models simply do not fit the needs of a community as we currently see those needs. We are organized with 1.1 million people into six areas. We refer to them as management territories.

They are approximately involving 200,000 people. Each of these areas have a mental health corporation which are all the community people, organized and incorporated for the purpose of providing, coordinating, planning the mental health services for their specific area or district.

The representation on the board reflects the composition of the community at large. Each corporation has a contract with our office which is a central management group. We do not run any district services from the local government base.

Everything is contracted to local community boards. So in the case of Erie County, each of the six areas has a mental health services corporation. These corporations are backed up by some centralized services in the areas of forensic, psychiatry, mental health, children, each of these having separate corporate bodies, transitional services for individuals coming out of our institutions, a centralized crisis service, all of this is tied together with a council of executives.

This is the executives of each of the major clusters for the service dimensions of the system which provide the major decisions with regard to policy over the entire system.

I have the material that lays out the system in more detail.

Mr. HARRIS. Actually, as you explained it, it seems to me that the corporation principle that is in this legislation is very consistent with the type of arrangement that seems to have been successful.

Dr. REYNOLDS. Except that it is not linked into the grassroots, the core of the community to the extent that these programs are. We have hospitals that are not part of the corporate structure.

For example, we have State hospitals. The ties are through formal shared agreements with community groups and not for—through a corporate structure for the hospital itself. But I believe this is a unique situation to the extent that you do not have an umbrella State agency here and the hospital would tend to drift without such a structure on top of it.

Mr. HARRIS. The District of Columbia presently has four community mental health centers for a population of 750,000 people. Do you think this is enough? Do you feel like there needs to be more?

Dr. REYNOLDS. I have no idea; the testimony before the committee does not provide the kind of detail that would be necessary to give some sense of what the extent of those programs is.

A community mental health center could be anything from a small operation to 200,000 people. Obviously with a population between 750,000 and 800,000, four would be sufficient from a planning base.

But the question is the extent to which those programs were developed and the effectiveness with which they are operated.

Mr. HARRIS. Thank you very much. Congressman Mann?

Mr. MANN. No questions, Mr. Chairman. Thank you very much.

Mr. HARRIS. Ms. Martin?

SEPARATE MENTAL HEALTH AUTHORITY

Ms. MARTIN. We may have some questions in writing for you. Is it your testimony that the District Government should have a separate department of mental health?

Dr. REYNOLDS. I did not include remarks to that point in my comments. I believe that local governments should have a separately defined mental health authority. I would think that the District of Columbia should have such a separately defined mental health authority if there is going to be any equitable competition for the small resource pool that is available.

There is a major effort across the country to develop human service programs the effectiveness of which have been mostly shown to occur at the operational level. At the administrative level from State down to local government there have been serious problems in trying to combine mental health, health and related services under human services.

Mr. HARRIS. Thank you again. The committee is very much indebted to you for your testimony. Our next witness is Mrs. Polly Shackleton, the chairperson of the Committee on Human Resources and Aging, the District of Columbia Council.

STATEMENT OF POLLY SHACKLETON, CHAIRPERSON, COMMITTEE ON HUMAN RESOURCES AND AGING, DISTRICT OF COLUMBIA COUNCIL; ACCOMPANIED BY LEE PARTRIDGE, COMMITTEE STAFF DIRECTOR

Mrs. SHACKLETON. Thank you.

Mr. HARRIS. Mrs. Shackleton, it is a pleasure and an honor to welcome you to the committee. Knowing as we do your tremendous contribution you have made to the community and the excellence of your service as a public official, we are pleased to have your testimony.

You may proceed.

Mrs. SHACKLETON. Thank you very much, Mr. Harris. I appreciate those kind words. I am accompanied by Mrs. Lee Partridge, the staff director of the Council's Committee on Human Resources and Aging.

Mr. Chairman, members of the committee, I appreciate your inviting me to testify this morning on the draft bill to establish an independent Federal corporation to operate St. Elizabeths Hospital. The Council's Committee on Human Resources and Aging, which I chair, has general oversight responsibility for the city's mental health programs, and I am therefore concerned about the impact any changes in the organization of St. Elizabeths Hospital may have on mental health services in this city.

DRAFT LEGISLATION

I believe this draft bill is a major improvement over the several previous bills that would merely have transferred the hospital from the Federal to the District Government. This bill creates a corporation with a five-member board of directors.

Three members of the board are to be selected by the Secretary of Health, Education, and Welfare, and two members by the Mayor of the District of Columbia with the advice and consent of the District of Columbia City Council. Such a board preserves the Federal involvement in the hospital, but admits much more local voice in the hospital's operation.

When I testified before this committee in May 1975 on this same issue, I mentioned that the Rome committee report recommended an independent mental health authority be established and that this authority operate St. Elizabeths Hospital and all other public mental health services and facilities in the District.

St. Elizabeths is not merely the equivalent of a State mental hospital for the District. It has always had a broader mandate, and I believe the corporate approach this bill contemplates, with the Federal-District mix, is therefore a more appropriate organizational structure.

ST. ELIZABETHS PRESENT STATUS

The transfer of the responsibility for operating St. Elizabeths to the new corporation will free the hospital from the many layers of bureaucratic supervision it now endures.

I checked recently on the organizational structure under which St. Elizabeths now works. I learned that St. Elizabeths is a part of the National Institute for Mental Health, which in turn is part of the Alcohol, Drug Abuse and Mental Health Administration, which is under the Public Health Service, which is part of the Department of Health, Education, and Welfare.

Thus, approval of any action St. Elizabeths superintendent wishes to take could require concurrence from the Director of NIMH, Administrator of ADAMHA, Director of the Public Health Service, Secretary of HEW, and finally the President of the United States. No acute care hospital should be forced to operate under such a cumbersome system.

The hospital's present status as part of HEW also, I am sure, has contributed to its funding and staff shortage problems over the past decade. When our committee studied the problems of District of Columbia General Hospital, we learned that District of Columbia General's staff had often requested funds that were cut out of the budget as it worked its way through the executive branch.

Budget protocol then precluded the District of Columbia General administration from making their true needs known to the Council, the Congress and the community.

I am certain a similar situation has prevailed for St. Elizabeths, especially with regard to their capital budget. The result for both hospitals has finally been lack of accreditation by the Joint Commission on the Accreditation of Hospitals. A quality hospital requires sound financial support, and the best way to secure that, is a well-informed governing board free to argue for the funds to meet the hospital's needs.

LEGISLATIVE RECOMMENDATIONS

Two sections of this draft bill do, I think, require some further study. Section 5 of the bill requires the Board to develop, within 2 years of the enactment of this bill, a comprehensive plan for the operation of the hospital. Section 5(b) requires the National Capital Planning Commission to transmit, within 1 year of the enactment of this bill, a comprehensive land-use plan for St. Elizabeths property which takes into account the needs of St. Elizabeths Hospital for such land area for its operation and any foreseeable expansion or for other programs related to mental health research or treatment.

I don't think the National Capital Planning Commission can properly plan for the use of the site until the Board has determined the hospital's future needs, and I don't think the Commission should usurp the Board's planning functions. Therefore, I would suggest that section 5(b) be amended to require the NCPC plan to be filed within 1 year of the Board's filing of its comprehensive plan.

Section 9 of the bill covers the funding for the hospital. I have two problems with this section as it presently stands. Subsection (b) is, of course, only a sense of the Congress statement and does not actually require that the District of Columbia Government make contributions to St. Elizabeths in addition to payment for patient care. Nevertheless, I do not believe it is appropriate for the District to have to pay for more than the care of patients who are a public responsibility. I would urge this section to be dropped.

Section 9(a) will set the appropriations for the hospital for the next 3 fiscal years. As now written, the section provides no incentive to the corporation to maximize its revenue collections from sources other than the government.

Public hospitals are traditionally weak in this area. They receive government appropriations for their entire budget and are disinclined to worry about collecting from those who have insurance or income sufficient to pay for their care.

Generally, such revenues collected become part of the general government income, and do not return to the hospitals. Thus, there is no incentive for collecting on the part of the hospital, and no readily visible measure of the hospital's efforts to capture such funds.

As I stated in my testimony over a year ago, before transfer of the hospital is effected, its budget must be at a level sufficient to insure good care for all inpatients and meet the deficiencies in the physical facility cited by the joint commission.

The corporation board, however, should be expected to maximize collections from those with the ability to pay.

I suspect there are, for example, persons at St. Elizabeths who were committed by the courts many years ago and their families are still contributing to their care at the same rate set by that old court order. Those situations should, at a minimum, be examined to decide whether the corporation should seek authority for higher payments.

If the corporation is required to make these efforts, they will need staff with experience in financial management, and that should be taken into account in determining the level of these appropriations.

Mr. Chairman, I appreciate your courtesy in seeking our views on this proposed bill. This draft represents a conscientious attempt by your staff to meet many of the objections to and problems raised by earlier transfer legislation.

I hope you will call upon us at the Council if there are ways we can be helpful to you as you continue your work on this very important legislation.

Mr. HARRIS. Thank you very much, Mrs. Shackleton. As an old local government man, I was interested in your comments that by the time the Council sees the budget, the executive branch has sanitized it to the extent that you don't know what the original requests were and can't properly evaluate how badly the funding has been cut or how poorly the needs have been met.

Is that a fair summary of what you said?

Mrs. SHACKLETON. I would say that it is, Mr. Harris.

Mr. HARRIS. My experience with local government is that this type of department with its clients and constituency have always been able to make its needs known to me. They always actually knew—I always knew how badly the county executive had worked them over.

Somehow, those that were particularly interested in their program also knew it. Doesn't it work that way in the District of Columbia?

Mrs. SHACKLETON. It does and it doesn't. There are various restrictions placed on the personnel of the departments who are really not supposed to deal directly with Council members.

As a matter of fact, systems have been set up whereby if our committee wants information from the Department of Human Resources, for instance, we are supposed to put in writing a request which then goes through the city administrator who then sends it to Mr. Yeldell who then sends it to whoever is supposed to respond and then it comes back through the same route.

Mr. HARRIS. You don't really put up with that, do you? That breaches all kinds of constitutional rights.

Mrs. SHACKLETON. We obviously have people come to us. Certainly in some of these mental health situations, there are community groups which are fighting the battles and do come to us.

But it is a problem. They are very secretive about these things.

Mr. HARRIS. I felt in my experience that I had detected some of that. I don't think that is good for government. The Council is composed of people with a gamut of interests representing the needs of the community.

I really think the Council needs to be able to go to department heads or division heads or what-have-you and get them to tell what they actually think. I don't think that destroys effective administration at all.

I think it is possible that maybe this is one of the basic reforms that you should try to achieve. I don't know whether we can help or not.

Mrs. SHACKLETON. We are working on it. I think as a result of negotiations with the Department that we are getting a little more back and forth dialog with people. But, basically, we don't have the opportunity to really get the whole flavor of what is there, or go out and make visits in the community and visit the sites and do our own investigation.

With limited staff and limited resources, we can't always do it.

REASONS FOR NONACCREDITATION

Mr. HARRIS. Knowing your work in the community and your experience in government, I very much doubt that a whole lot goes on that you are not aware of. Can I ask you straight off as chairperson of the Council's Committee on Human Resources and Aging, to what do you attribute the loss of accreditation of the local hospital, District of Columbia General and St. Elizabeths?

Mrs. SHACKLETON. I think it is a combination of over a period of time of shortchanging, budget freezes, and in the case of District of Columbia General with which I am somewhat more familiar operationally, I think there has been a management problem there that hopefully has been helped by bringing in a new administrator.

But for the past several years there has been no administrator of the hospital. Then there is the fragmented operation of the hospital whereby the personnel department is up town and the hospital does not completely have its own full responsibility in order to get personnel.

It has to go through DRH personnel. It can't go out and recruit its own people. I think that is one of the problems with the District of Columbia General. I assume that probably the same thing goes on at St. Elizabeths. The institution is not given full responsibility and therefore cannot be helpfully accountable for what goes on.

Mr. HARRIS. My experience has been with independent corporations running the local hospital rather than the local government running it directly. It used to be the conventional wisdom: "For God sakes, don't let the government run the hospital because they will make a mess of it."

I went through a period where one of my major efforts was to achieve coordination between the independent hospital board and the objectives of local government in the other areas that were not only ancillary to but directly a part of the mental health care delivery system.

Is there a danger in going the independent or quasi-independent corporation way for St. Elizabeths? Along with that, if there isn't, is that the way we should go with the District of Columbia General?

DISTRICT OF COLUMBIA GENERAL HOSPITAL

Mrs. SHACKLETON. Actually there is legislation before the council introduced by Chairman Tucker to set up the District of Columbia General as an independent hospital with appropriated funds from the District. I think we believe that that is the direction that it should

go to take it out from under this whole bureaucracy and give it its own independence, its own authority and then make it fully accountable.

Mr. HARRIS. Would you be setting it up as a corporation or just as an autonomous agency?

Mrs. SHACKLETON. It would be set up with its own board of directors, a commission, which would be broadly representative of the community and the professionals. It would collect its own funds.

FUNDING

That is one of the problems, as I mentioned in my testimony, that there is no incentive to collect funds that are needed because they just go into the general District funds. For that reason, literally millions of dollars in District funds have been lost because of the lack of procedures to collect them properly.

Mr. HARRIS. When you talk about funds, do you just mean government funds? Are you talking about voluntary contributions also?

Mrs. SHACKLETON. I am talking about third-party payments and collection of medicaid and so forth. I believe that the same would be true with the St. Elizabeths Hospital, that that is the direction I believe it should go.

Mr. HARRIS. I can see your point very clearly. The additional point I would ask about is—we have had experience that when you do set up an independent agency like this, there are a great many contributions that can be made available to it.

There are many people interested in supporting a hospital from a community base, from a foundation base.

Mrs. SHACKLETON. I think that is true.

Mr. HARRIS. Do you think it is feasible to set a date for the transfer of St. Elizabeths Hospital to the District of Columbia government?

Mrs. SHACKLETON. No. I don't think we can set a date until we are certain that there will be support to put the institution into condition to be run by somebody else. I think right now it would be handing us—well, it would be a disaster to hand it to us in its present state with the needs of many millions of dollars, I understand.

Even the funds that were requested by the President to go into the hospital to help improve it have not been appropriated.

I don't think that I would want to set any date. I think it would be purely dependent on if and when certain conditions are met.

INDEPENDENT MENTAL HEALTH DEPARTMENT

Mr. HARRIS. Does the council favor the concept of setting up an independent mental health department?

Mrs. SHACKLETON. Well, the council has not acted on it. I personally do favor something along those lines. I think we have had many requests and discussions from community groups that do favor that. I personally would see that as the way we would like to go.

However, the council has not taken any action on that so I am speaking personally.

Mr. HARRIS. Are there any other questions?

[No response.]

Mr. HARRIS. Mrs. Shackleton, thank you again for coming before us. We appreciate your testimony. I am sure we will be talking more with you as we proceed with this legislation. There are several organizations that have submitted statements for the record of these hearings.

Without objection, we will include them in the record at this point. I would also note that this committee is scheduled to meet tomorrow morning at 9:30 a.m.

[The documents referred to follow:]

REPORT OF THE ADVISORY COMMITTEE TO THE SECRETARY OF HEALTH, EDUCATION,
AND WELFARE ON THE TRANSFER OF ST. ELIZABETHS HOSPITAL FROM DHEW
TO THE DISTRICT OF COLUMBIA GOVERNMENT

COMMITTEE MEMBERS

- Dr. Howard P. Rome, Chairman, Mayo Clinic, Rochester, Minnesota.
Mr. Arnold Barach, President, D.C. Mental Health Association, Washington, D.C.
Dr. Frank S. Bacon, President, D.C. Medical Society, Washington, D.C.
Dr. Walter Barton, Medical Director, American Psychiatric Association, Washington, D.C.
Dr. Francis Chucker, Arlington, Virginia.
Dr. K. Albert Harden, Former Dean, School of Medicine, Howard University, Washington, D.C.
Rev. Dr. John C. Harper, Rector, St. John's Church, Lafayette Square, Washington, D.C.
Dr. Raymond T. Holden, Washington, D.C.
Dr. O. Benwood Hunter, Chevy Chase, Maryland.
Monsignor Harrold Murray, Director, Department of Health Affairs, U.S. Catholic Conference, Washington, D.C.
Mr. John A. Nevius, Attorney, former Member, D.C. Council, Washington, D.C.
Dr. John Nardini, President, Washington Psychiatric Society, Washington, D.C.
Dr. John Parks, Dean, School of Medicine, George Washington University, Washington, D.C.
Dr. Charles Prudhomme, Howard University, Washington, D.C.
Dr. John Rosen, Dean, School of Medicine, Georgetown University, Washington, D.C.
Mrs. Daniel Schorr, Washington, D.C.
Mrs. Polly Shackleton, former Member, D.C. Council, Washington, D.C.
Mr. William Sheffey, President, Concerned Citizens of Capitol Heights, Washington, D.C.
Dr. Paul B. Cornely, Chairman, Dept. of Community Health Practice, College of Medicine, Howard University, Washington, D.C.
Dr. Hayden H. Donahue, Director, State Department of Mental Health, Central State Griffin Memorial Hospital, Norman, Oklahoma.
Dr. Leonard Duhl, Professor of Urban (Social Policy and Public Health), University of California at Berkeley, Berkeley, California.
Dr. Donald Greaves, Professor of Psychiatry, Kansas City Medical Center, Kansas City, Kansas.
Dr. W. Walter Menninger, Menninger Foundation, Topeka, Kansas.
Dr. Alan D. Miller, Commissioner, State Department of Mental Hygiene—New York, Albany, New York.
Dr. Francis A. Tyce, Medical Director, Rochester State Hospital, Rochester, Minnesota.
Dr. Harold Visotsky, Professor of Psychiatry, Northwestern University, Chicago, Illinois.
Dr. Cecil Wittson, President, University Medical Center, Omaha, Nebraska.
Dr. Robert S. Jason, San Diego, California.
- On June 13, 1969, this Committee was asked by Secretary of Health, Education, and Welfare Robert Finch to "advise the Department and the District of Columbia Government on the most effective means of transferring the responsibilities for the operation of St. Elizabeths Hospital from DHEW to the D.C.

Government." The Secretary in recognition of the "great variety of opinions among various organizations and individuals in the greater Washington area" urged the Committee to study the following areas.

1. Ways to insure that quality of medical care will be maintained or improved.
2. Ways to continue the development of a model facility for institutional and community care of the mentally ill at St. Elizabeths.
3. The organizational arrangement for administering St. Elizabeths Hospital within the D.C. governmental structure.
4. The Federal role in transition and the financial arrangement to assure quality of care.
5. Identification of the best method for providing for patients now under care at St. Elizabeths Hospital who do not require continued psychiatric attention.
6. The future involvement of the NIMH in research and training programs at the hospital.
7. Ways to insure that the transfer will be accomplished with full attention to the rights and welfare of both employees and patients at the institution.

It should be noted that we view the task with which we are charged to be primarily but not exclusively concerned with the transfer of St. Elizabeths Hospital to the District Government. We could not comply with the Secretary's admonition to study "the organizational arrangement for administering St. Elizabeths Hospital within the D.C. governmental structure" without increasing the narrow scope of this charge.

Accordingly, after appropriate discussion in October and November 1969 with the authorities concerned, we participated as the Mental Health Committee in the activities of the Mayor's Task Force on Public Health Goals. The final report of that Task Force submitted in January 1970, should be seen as the larger context within which this Report fits as a facet.

We wish to express our gratitude to all the officials of the District Government for their unstinted cooperation in what they agree with us is a mutual endeavor to upgrade the standard of services rendered the citizens of the District. In the course of its deliberations, the Committee had occasion to review the several previous studies which dealt with the question of the optimal administrative location of St. Elizabeths Hospital in the total governmental structure in order to enhance as well as upgrade operations.

In 1963, Secretary of Health, Education and Welfare Anthony Celebrezze appointed a distinguished Committee of Consultants headed by his Special Assistant for Health and Medical Affairs, Mr. Boisfeuillet Jones. In May 1964, the Jones Committee recommended to the Secretary that St. Elizabeths be operated as a National Demonstration Center under the aegis of the National Institute of Mental Health. Although there was a considerable discussion at that time about the faltering reputation of St. Elizabeths, neither the Department of Health, Education and Welfare nor the District of Columbia made a sustained effort to implement all the generally sound recommendations contained in the Jones report.

Over the next five years, the existing unsettled state of affairs was compounded by a number of alternate suggestions as to ways to cope with the problems of the hospital. As late as May 20, 1969, Dr. William Stewart, then the Surgeon General of the U.S. Public Health Service, forwarded to the Department of Health, Education and Welfare the recommendations of a Steering Committee which outlined four rather divergent options for the administrative disposition of St. Elizabeths.

Before presenting its recommendations for specific and clear-cut action, the Committee would like to underscore the significance of persisting distortions which have clouded both professional and public discussions of St. Elizabeths in the past.

The first and most damaging distortion was, and is, that St. Elizabeths has always been the very model of a public mental hospital. Its staff has had this intention but it has been handicapped by encumbrances not within its control. St. Elizabeths did initiate many progressive movements in modern psychiatry in such areas as psychodrama and dance therapy. It was among the pioneers in the development of residency training programs in psychiatry; it was the first mental hospital in the country to be accredited for approved residencies in general surgery and in internal medicine. Over the years, it broke ground in establishing the importance of forensic psychiatry within a hospital framework.

However, unfortunately despite these earnest efforts most of these achievements had little impact upon the day-in and day-out care of thousands of its

psychiatric patients. The 19th century buildings in which they were housed were deteriorating and despite the increasing decrepitude were not replaced. Further, the newer rehabilitative programs designed to enhance the discharge of patients were not supported by those community agencies and fiscal resources upon which the hospital necessarily depends. As a consequence, the hospital continued to operate as an isolated unit and thus it became burdened with chronic patients who received only a minimum of custodial care by the overtaxed staff.

A correlative distortion, perpetuated in several previous studies, portrays St. Elizabeths Hospital as benefiting from a high visibility and a concern on the part of the Congress. The precise level of Congressional concern manifested by its fiscal support in its early days when the hospital was affiliated with the Department of the Interior is irrelevant now, but there is no gainsaying the fact that, as a constituent part of the HEW budget since 1953, the hospital has received very little attention as gauged by the fiscal support to do the job with which it was charged.

A keen appreciation of this lack of visibility and concern led Secretary John Gardner in 1967 to recommend the transfer of St. Elizabeths—then an independent agency in a vast bureaucracy—to the National Institute of Mental Health as an interim procedure. The avowed purpose of this transfer was to establish it as a model National Center for Mental Health Services, Training and Research. When the actual transfer was completed in November 1968, there was an abundance of rhetoric, but subsequent budget requests and appropriation for its operation, new buildings and personnel made these statements somewhat suspect.

Thus, the inescapable conclusion that the submersion of St. Elizabeths in a large federal agency has been an administrative anomaly and requires drastic change. It is not possible by administrative fiat alone to create a "National Demonstration Center." In no way does this help to create for the hospital its own identity which it requires to fulfill its potential as a community resource. In no way does this create for the District the psychiatric facility that it needs as a linch-pin in its network of comprehensive mental health programs. After 117 years of being mislocated and isolated in the federal governmental structure, St. Elizabeths must finally be relocated in the local governmental jurisdiction whose people it now serves.

We are mindful of the objections that have been raised repeatedly to the transfer of St. Elizabeth Hospital. Some of these are realistic and others merely reflect the pessimism that has been part and parcel of every effort to improve the lot of the citizens of the District and especially the lot of its mentally ill citizens. Admittedly, the barriers to social, economic and legislative progress are formidable. These have also been noted and commented upon by previous Advisory Committees. But simply to deplore these indisputable facts has not and will never bring about change and the improvement which is so desperately needed. Nor is it likely that any one plan for a change in the psychiatric in-patient subsystem necessarily will suit or satisfy everyone.

In the light of all these considerations, we advocate the transfer of St. Elizabeths Hospital to local control. This too has been recommended by other Committees as being the best solution to the complex problems inherent in the delivery of mental health care to the District of Columbia—*all other things being equal*. It is obvious that all other things have *not* been equal heretofore, and consequently this prerequisite has never been met. In our judgment, it will never be met until the Hospital as an important element in the entire health-care system of the District is integrated with all of the other related organizational elements and given the fiscal support it needs to effect the changes herein recommended.

This has been the major factor for the stymie of every effort that has been made to improve the care and treatment of patients simply by attempts to change derivative effects of the central administrative problem without attention to the central problem itself.

It follows that unless there can be similar administrative change which will conduce to an effective integration of mental health services with other essential services, that what is to be expected from the administrative transfer of St. Elizabeths Hospital per se will be, as it has been in the past, a paper change without substance.

Throughout the United States the variety of independent events taking place in the health fields are suggesting trends, and performance criteria against which our recommendations should be measured. These are :

1. Increasing health coverage, by third party payors, proposed national health coverage and a variety of prepaid health plans.

2. Incorporation of the private sector, through group practice, into mental health care delivery systems.

3. Territorially oriented health care resources, the availability of network resources close to the consumer, accessibility, speed of response to service needs, non-fragmented humane personalized comprehensive services are essential demands and expectation by all professionals and consumers.

4. Decentralization of large mental health systems—to provide a decision and program base closer to the consumer of services.

5. A well defined system of echelons of service, in a program of a continuum of care, e.g.

(a) Neighborhood health and mental health centers for screening and treatment of acute cases alternatives to in-patient care—special problem programs such as addiction, suicide, and mental retardation.

(b) In-patient treatment centers as a second echelon resource.

(c) Aftercare and rehabilitative resources, nursing homes, shelter care, vocational workshops and half-way houses.

6. Modern mental health programs related to new career ladders of manpower. This requires a close integration with educational programs.

7. Peer review of care systems, and consumer equity in mental health programs. Increasingly program control must be responsive to unique local needs and this final control must be decentralized. This entails the elements: public accountability through cost-accounting, program budgeting and the economics of effective staff and personnel utilization.

Recommendation No. 1

This committee's first and fundamental recommendation consists of three parts:

(a) that an independent Mental Health Authority for the District of Columbia be established at the earliest possible moment which could, hopefully, be incorporated at some later time into a similar overall, independent District of Columbia Health Authority;

(b) that the Secretary of Health, Education and Welfare and the Mayor-Commissioner of the District of Columbia ask the President to seek from the Congress appropriate legislation to establish such a Mental Health Authority; and

(c) that St. Elizabeths Hospital and all other public mental health services and facilities in the District of Columbia be transferred to the Authority through a prompt but orderly transition process.

Comments

1. The Mental Health Authority will consist of representatives from consumers and providers of mental health services both from the public and private sectors in the District of Columbia.

2. The Mental Health Authority will be responsible for the overall provision of public mental health services in the District of Columbia including coordination of services, training, research and planning.

3. The Mental Health Authority will receive and disperse all funds allocated for public mental health services.

Recommendation 2

In addition to the main recommendation we propose the following:

(a) The status of the employees of St. Elizabeths Hospital and all other mental health facilities and services must not be jeopardized or downgraded in any way with regard to salaries, retirement benefits and professional standing as a result of the organizational changes proposed.

Comments

The confusions and uncertainties of the past year or more as to the eventual disposition of the hospital have been very demoralizing to its dedicated staff. Every effort must be made to assure employees that the Mental Health Authority should be committed to making St. Elizabeths one of the finest public mental hospitals in the country.

In order to attain this high status, there has to be adequate funding not only for salaries and operations but also the modernization of facilities. This has been recognized for some time.

(b) To preclude future deterioration of staff morale, that a continuing study of personnel needs and costs should be the responsibility of the Mental Health Authority.

Comments

The high per-capita cost of the Hospital's present program and the comparatively low return in relation to comparable operations of other states has been the source of concern to the Committee. It has not been possible for this Committee to resolve this crucial issue in its present study of the many problems posed by the transfer.

The cost-accounting study that this suggests has to be sufficiently detailed so that a cost-base can be established for assaying the operation of each division of the hospital. These are the essential data needed to justify personnel requests, new facilities, new adjunctive programs, as well as to assure the citizens of the districts and the Congress of the ongoing efficiency of the St. Elizabeths part of the total health program of the District.

(c) The intensive retraining and continuing education program, now under the direction of the National Center for Mental Health Services, Training and Research (NIMH) should continue its efforts.

Comments

Hopefully it will explore the establishment of a liaison relationship for the education and training of allied health personnel with the Federal City College and/or the Washington Technical Institute. The Federal City College has a mandate to offer educational programs at both technical and professional levels, including graduate programs. Such a cooperative effort will augment the community-wide integration process by fostering a relationship of the health educational programs on the para-professional level. Further, it will provide yet another resource to the pool of employment opportunities available to the residents of the District.

Recommendation No. 3

It is recommended that St. Elizabeths Hospital be organized into units that relate to area mental health centers, that active vocational programs and rehabilitation activities be extended and the alternates to in-patient care be fully utilized with placement in the community of all patients who have received maximum hospital benefit. It should be clear, however, that reduction of the patient population at St. Elizabeths should not be an end in itself. Patients should be placed in the community only when this would be a more effective form of care for the individual.

Comments

Community placement is a generic category that includes nursing homes, foster homes, half-way houses, sheltered workshops, vocational rehabilitation facilities, etc. There are different standards for the licensing of the extra-hospital adjunctive health institutions. This Report assumes that when psychiatric patients are admitted to these community resources they will have met whatever standards are required including the assurance there will be no discrimination. There are five ways in which this program could be of potential benefit:

1. It could provide an opportunity for rehabilitation out of the Hospital, for those patients, who at present, merely remain in the hospital, because of a lack of community resources to aid in their out-of-hospital adjustment.

2. The Hospital would be enabled to decrease its in-patient population by an estimated 1500 patients who have been judged by individual survey to be suitable candidates for other placement. This would permit the demolition of eleven 19th century buildings that are fire hazards and have long since been declared obsolete and have recently been vacated by 1099 patients. Moreover, a smaller population would enable the Hospital staff to devote more time and effort to the energetic treatment of those patients whose illness warrants intensive treatment.

3. Assuming that the current per-diem cost per patient in residence is approximately \$31/day, this amounts to approximately \$960/month or \$11,520/year/patient and a sum to over \$17 million dollars per year for an estimated 1500 patients. Surely it is possible with this amount of savings to upgrade the level of remuneration paid to the operators of foster homes who are now paid \$125/month/patient. This would be an incentive for more persons to offer their homes for community placement service. It also would enable the service to be more selective initially as well as provide for more staff supervision and control.

4. Moreover this program would promote closer relations between the Hospital and its neighboring community of Anacostia as well as other sectors of the District.

5. Finally, it would extend the scope and involvement of the staffs of the Area Mental Health Centers by permitting them to function to a greater extent as a more visible community resource.

St. Elizabeths Hospital's function and work-load at present can be best visualized if one examines it in terms of the nature and movement of the psychiatric patient population of the District. The ambulatory services function to provide early treatment. If this is successful it precludes the need for in-patient hospital treatment and will reduce the length of hospital stay of those patients whose illness requires in-patient treatment. The ambulatory services work in close cooperation with the in-patient services so that they function as receiving out-patient services when the patient has received maximum benefit from his hospital care. Typically Area D Community Mental Health Center serves this function but is not budgeted for these out-patient services. It should be.

As of July 21, 1970 there were on the rolls of St. Elizabeths: 3843 in-patients and 2136 out-patients, of which 555 were in foster care programs and 1581 on other convalescent leave status.

If hospital care is judged necessary, the patient is admitted to the appropriate unit as an in-patient to St. Elizabeths and provided with room, board, and a prescribed treatment and services for as long as he is deemed in need of this treatment regimen. This function is the responsibility of the in-patient hospital staff.

When the patient is evaluated by the staff as having received maximum benefit from his hospital stay, he is discharged to the community on a convalescent status. He then becomes an out-patient, eligible for whatever follow-up care is prescribed. There are many auxiliary aids in the form of organized activities available to him at this juncture: foster home placement, nursing home, extended care, vocational rehabilitation, sheltered workshops and the many social services.

The overall philosophy of treatment conducted by the Hospital and its relation to other agencies in the community is a function of the administrators who are the policy makers of the institution.

Up to now, the patient movement among these four general categories of function has been hampered by both discontinuity of care and discontinuity of supervision and administration. The Hospital and its patient population have been split between two disparate systems: 1) the St. Elizabeths—NIMH Administration which has been charged with the operation of the Hospital, and 2) the D.C. Mental Health System which sends patients to and receives patients from the Hospital. Then, too, there are three ambulatory services connected with the D.C. Mental Health System (Area A, B, C Mental Health Centers) and a fourth connected with St. Elizabeths-NIMH Administration (Area D Mental Health Center)—but all four of these services use the Hospital as a backup facility.

The hospital staff cares for all patients when they are in an in-patient residential treatment status. Patients are admitted from all four community mental health centers. The administrative system of St. Elizabeths Hospital operates under the aegis of NIMH and therefore has no official connection with the D.C. Mental Health System. This means that many of their shared activities have been carried out on the basis of agreements which have to be ratified by both parties. As a consequence of this divided authority and responsibility, it has been extremely difficult and at times impossible to coordinate services to formulate system-wide policies, to coordinate parallel functions, to avoid wasteful duplications and to provide effective disposition, and the inevitable result is that patient care suffers.

It follows that there has to be a bilateral effort at synthesis which vests authority and responsibility in one system of administration. This is particularly essential for the coordination of the four Area Community Mental Health Centers. The post-hospital patient disposition program has borne the brunt of this administrative anomaly. A coordinated community placement service has to maintain a centralized control because it has the responsibility for the finding, evaluation and supervision of foster home placement as well as the training of sponsors. It should be involved in cooperative research of the factors that play important roles in determining the success or failure of this important activity. The supervision of the community workers who deal with the patients and their sponsors has to be another responsibility of one standard setting group.

Ultimately these data need to be correlated and made available to the Mental Health Authority as well as the community mental health center if substantive data of benefit to the patient and the system are to accrue.

Recommendation No. 4

It is recommended that a general medical and surgical hospital with an ambulatory health center be constructed on the grounds of St. Elizabeths.

Comments

In part this is to replace the W. W. Eldridge Building which has been used for this purpose solely for the in-patients of St. Elizabeths Hospital. In addition, it will meet medical and surgical needs of the residents of the Anacostia District. Studies summarized in Chapter IV—Report on Hospitals by the Mayor's Task Force on Public Health Goals—Subcommittee on Community Health Resources (p. 127-131) indicate substantial justification for the location of a new general hospital on this site.

Moreover, the location of an all-purpose general hospital with an ambulatory health center on these 320 acres will do much to break through the psychological barrier which has isolated St. Elizabeths from its neighbors in Anacostia.

It is necessary that the planning of the design and functions of this facility be undertaken with the active participation by all appropriate groups concerned.

It is further suggested that the Medical Schools be cooperatively involved in the plans of this activity.

The location of an all-purpose open general hospital with an ambulatory health center on St. Elizabeths grounds would make it possible to involve the private practice sector of the medical profession in the activities of the new hospital. This will be a medical facility open to all patients regardless of their economic circumstances.

Recommendation No. 5

It is recommended in accordance with a long-standing proposal that a part of St. Elizabeths Hospital be converted to a facility for the care of the chronically disabled including the aged.

Comments

This proposal would implement the plan previously recommended by the Director, NIMH. The W. W. Eldridge Building, which was erected in 1931, now serves as a medical and surgical wing of St. Elizabeths. This building could be made suitable for the residential care of long-term chronic medical patients. This proposal also is consonant with the budgetary plans recommended for the reprogramming of the funds which were originally appropriated for the construction of special purpose buildings. These have not been approved.

The Hospital Medical Facilities Survey and Construction (Hill-Burton P.L. 91-296) Program in its recommendations for 1969-1970 recognizes the need for modernization and for construction of additional facilities and beds in the long-term care category. Their plans contemplate the addition of 1764 beds needed in six facilities in the District which include non-profit and proprietary and independent nursing homes and units of general hospitals. The conversion of the Eldridge Building to this use would aid considerably in the implementation of this need medical facilities program.

Recommendation No. 6

It is recommended that a facility entirely separate from St. Elizabeths Hospital be provided for alleged and convicted offenders who have been judged to be psychotic or who are held for observation. It should have its own superintendent and its own staff who are responsible to the Mental Health Administration of the D.C. Department of Human Resources.

Comments

The care and treatment of this offender population is the responsibility of the D.C. Department of Legal Psychiatric Services of the Mental Health Administration.

The removal of this unit from St. Elizabeths jurisdiction would make it possible for the unit system of the Hospital to operate freely without restriction of the movement of patients. The responsibility of St. Elizabeths staff for the operation of this maximum security facility has been an enormous drain on the limited resources of the professional staff of the Hospital. This time and the

resources can be directed to the care and treatment of other patients when the staff is relieved of this responsibility.

Recommendation No. 7

Until the Mental Health Authority is constituted it is recommended that the National Institute of Mental Health continue to operate St. Elizabeths Hospital under the authority of the Secretary of Health, Education, and Welfare in accordance with the mandate of 1967.

The Committee's recommendations, adopted by Committee Members and Consultants without dissent, are the expression of a sincere conviction that when they are fully implemented they will significantly improve the health-care delivery system of the District of Columbia. There are a great many specifics to which this report does not address itself for we were primarily preoccupied with removing the major barriers to the delivery of a non-fragmented coordinated mental health service to *all* of the citizens of the District. In doing so this will materially improve the lot of the present and future patients in St. Elizabeths Hospital and its related facilities. It is their welfare that is the focus of our concern and to that end we directed these efforts.

The Committee is indebted to a great many persons in the organizations concerned with the operations of St. Elizabeths Hospital for their cooperation in making available to us the information which we requested and the assistance we required. It helped us form the opinions which this Report contains.

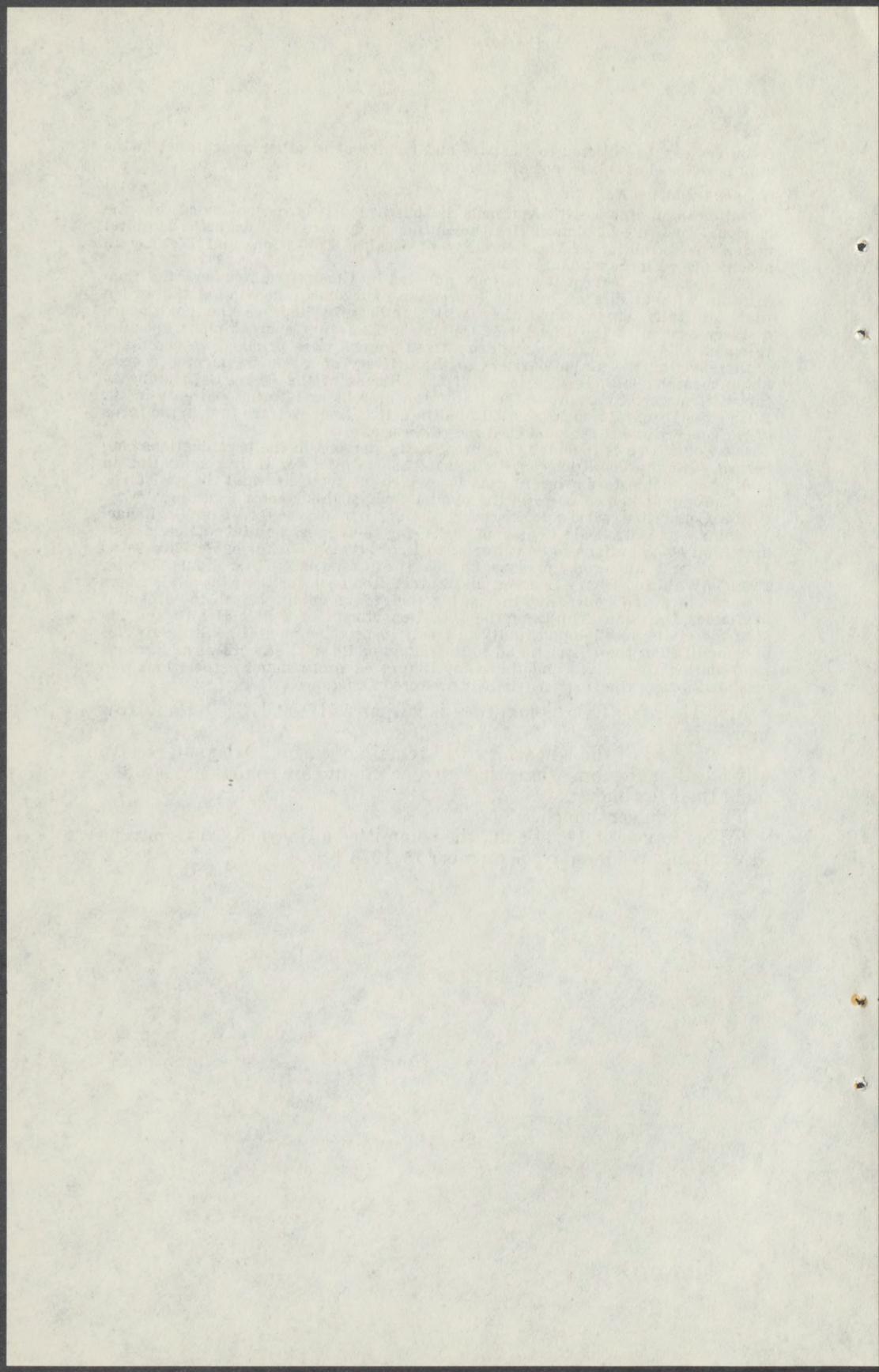
The Committee wishes to sincerely thank Drs. James Cavanaugh, Michael Woodbury and Mr. Dale Sopper of HEW for their most helpful advice, assistance, and contributions to our efforts; to Dr. Sherman Kieffer of St. Elizabeths Hospital and numerous persons on his staff, especially Drs. Louis Jacobs, Francis Waldrop, Henry Lederer, and Luther Robinson for their hospitals offers of assistance and generosity in making their data on St. Elizabeths Hospital available; Dr. John Schultz of the D.C. Department of Public Health and his staff for giving us the opportunity to freely inspect the mental health activities and facilities of the District, and to the many public spirited persons and groups representing themselves and the many interested professional associations and organizations of the District for their proffered assistance.

Mr. HARRIS. This committee is adjourned until 9:30 tomorrow morning.

The record of these hearings will remain open for 10 days to receive any additional submissions that anyone might care to make to supplement their testimony.

Thank you very much.

[Whereupon, at 11:30 a.m., the committee adjourned, to reconvene at 9:30 a.m., Wednesday, September 15, 1976.]



ST. ELIZABETHS HOSPITAL

WEDNESDAY, SEPTEMBER 15, 1976

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE DISTRICT OF COLUMBIA,
Washington, D.C.

The committee met, pursuant to notice, at 9:35 a.m., in room 1310, Longworth House Office Building, Hon. Charles C. Diggs, Jr. (chairman of the committee) presiding.

Present: Representative Diggs, Delegate Fauntroy and Representative McKinney.

Also present: Ruby G. Martin, general counsel; James T. Clark, legislative counsel; Wilbur Hughes, staff assistant; and Carol Thompson, minority legislative assistant.

The CHAIRMAN. The committee will come to order.

Today the Committee on the District of Columbia will conclude its hearings—at this stage at least—on our draft bill to transfer St. Elizabeths Hospital to a private corporation. I emphasize that it is a draft bill.

Yesterday, we heard testimony from a number of witnesses, including representatives of the accrediting body that is responsible for the disaccreditation of the hospital, and also the disaccreditation of District of Columbia General Hospital.

Today, we will hear from representatives of various community groups involved in the mental health issues in the District as well as representatives of HEW and the Department of Human Resources.

As a result of our deliberations and the testimony heard yesterday and today, we will be better able to assess the advisability of our present draft. While we are not presumptuous in believing that this proposal represents the only solution to the problems of St. Elizabeths administration and funding, it is our hope that the matters covered in these hearings will stimulate a rethinking of the issue, not only up here on the Hill but at the local level as well.

We do conceive of this as a problem which has both local and Federal interests. It is clear that a cooperative effort involving interested community groups as well as the Government involved will determine in large measure the effectiveness of any attempt to improve conditions at St. Elizabeths.

Our first witness will be Mr. Joseph P. Yeldell, the Director of the Department of Human Resources of the District of Columbia.

Mr. Yeldell has submitted an advance copy of his testimony to the committee. You may proceed in whatever way that you wish to proceed.

STATEMENT OF JOSEPH P. YELDELL, DIRECTOR, DEPARTMENT OF HUMAN RESOURCES, THE DISTRICT OF COLUMBIA; ACCOMPANIED BY DR. JEFFERSON McALPIN, ADMINISTRATOR, MEDICAL ADMINISTRATION

Mr. YELDELL. Thank you, Mr. Chairman. I am accompanied by Dr. Jefferson McAlpin, the Administrator of the Medical Administration, the Department of Human Resources.

My name is Joseph P. Yeldell and I am Director of the Department of Human Resources of the District of Columbia Government. It is indeed a pleasure to have the opportunity to provide testimony to the committee on the proposed bill draft of July 16, 1976 on St. Elizabeths Hospital.

COMMENTS ON DRAFT LEGISLATION

The bill would establish an independent board with exclusive authority and responsibility for the management of St. Elizabeths Hospital. In our view, the provision would only serve to perpetuate the dualistic and fragmented health system that presently exists.

In effect, the necessity to assure continuity of care along with accessibility to long-term and/or acute inpatient services would not be possible or facilitated if negotiations had to take place on a continuous basis with another autonomous authority.

Additionally, the establishment of the Board as set forth in the proposed bill would not provide the District of Columbia Government with any control over the St. Elizabeths Hospital, despite a patient population consisting of 85 percent District of Columbia residents.

Rather, it appears to force the District of Columbia Government, on a fragmented basis, to conform to the program requirements of St. Elizabeths Hospital which is inconsistent with the community mental health thrust characteristic of the current mental health program.

Although the proposed bill gives the Board responsibility for insuring accreditation of St. Elizabeths Hospital, it does not provide resources nor a time commitment for regaining accreditation.

Further, the proposed bill provides that the Board shall consist of five members, two members appointed by the Mayor and three members by the Secretary of the Department of Health, Education, and Welfare. Such a composition of the Board does not give the District of Columbia fair representation, nor does it give the Mayor of the District of Columbia the same appointment rights as the Secretary of the Department of Health, Education, and Welfare.

This is particularly significant given the fact that, as stated earlier, the preponderance of patients at St. Elizabeths Hospital are residents of the District of Columbia.

The bill also provides that it is the sense of the Congress that the government of the District of Columbia should increase its financial contributions to St. Elizabeths Hospital. Although the bill does not specify then any time frame for this, it is the city's position that increased financial participation should occur only after careful con-

sideration and the development of a viable financial participation formula for the District Government and St. Elizabeths Hospital. This is critical in view of the District's severe financial posture.

RECOMMENDATION OF DISTRICT GOVERNMENT

It is the position of the District of Columbia that the logical way to deal with a dual and fragmented mental health system in the District of Columbia is to transfer St. Elizabeths Hospital to the District of Columbia Government. The outcome of such a transfer would be the establishment of a single authority for comprehensive administrative responsibility to include not only the hospital but the existing District of Columbia's mental health programs.

The gains in transferring St. Elizabeths Hospital to the District of Columbia, Mr. Chairman, are very clear now in terms of programmatic consideration and in terms of establishing a unified mental health system. Furthermore, the city could gain a great deal by moving forward in the laudable activity which the hospital, since 1968, has been attempting to do in moving more patients into the community and out of the hospital setting.

The community mental health centers would gain a great deal by the interchange of personnel and by the kinds of training and supportive program activities which are uniquely available within the St. Elizabeths Hospital structure. We feel that St. Elizabeths Hospital personnel could gain from our experiences in programs which involve monitoring of foster home care activity, outreach activities, and the attempt to keep individuals from having to be hospitalized by using other treatment modalities than the very expensive kind of inpatient services which are offered by St. Elizabeths Hospital.

OPPOSES DRAFT LEGISLATION

In summary, Mr. Chairman, the proposed bill of July 16, 1976, will not obviate the dualistic and fragmented mental health delivery system in the District of Columbia but will allow St. Elizabeths Hospital to remain in an autonomous posture thereby fostering the problems that currently exist.

Clearly, such a situation is not conducive to the development of a unified comprehensive mental health system for the District of Columbia. Therefore, the District of Columbia Government strongly opposes this proposed bill since, in our opinion, it is obvious that it does not provide a solution to the problem of comprehensive mental health care for the District of Columbia residents.

Mr. Chairman, I trust that the information provided to you today will significantly aid you and the committee in considering the outcome of St. Elizabeths Hospital. I will be happy to respond to any questions that the committee may have.

The CHAIRMAN. Thank you, Mr. Yeldell.

There has been some question raised about whether the District Government has the resources to handle this additional institution if it is simply transferred over. How do you respond that that?

Mr. YELDELL. Well, if resources are used in its broadest sense, I would certainly question the capability of the District to assume it from a financial point of view without a very carefully phased in program.

If you are thinking of it in terms of the management capability, I think that it is very likely that the District could, indeed, deal with this as part of a comprehensive mental health program. I would suspect the biggest concern generates about whether or not it should properly be lodged in the Department of Human Resources.

SEPARATE MENTAL HEALTH DEPARTMENT

I would suggest, Mr. Chairman, that that would be a very open question. I think that in relation to the size of St. Elizabeths Hospital and the size of the mental health program per se that I would perhaps lean toward the establishment of a separate mental health department within the District of Columbia Government with a strong director of mental health that could pull together the entire program.

Under those bases, I would say the resources would exist.

The CHAIRMAN. How would this separate department of mental health be figured into the table of organization?

Would it be, as I see it, under the Department of Human Resources? Or, would it be an independent agency or what?

Mr. YELDELL. As I say, it is an open question but I would suspect it would more than likely be a separate department with cabinet rank of a department head. There are many gains in terms of a human resources structure.

The impact of the size of the human resources department has caused people to think in a negative way. I would opt that the bigger pie here is the ability to establish a comprehensive mental health program and on such basis would support a separate department that would have cabinet rank and report directly to the Mayor.

The CHAIRMAN. As you know, the hospital is not accredited at the present time. There is some thought that it might be advantageous to allow the Federal Government to get the hospital in shape for accreditation before any consideration is given to transferring it to the District of Columbia government, if, in the final analysis, that is deemed advisable.

I would like to get your comment on that.

SUPPORTS HEW LEGISLATION

Mr. YELDELL. Mr. Chairman, we strongly support the proposed HEW bill which will be forwarded to the Congress shortly. As to that bill, the District takes a strong position that the hospital should not be transferred until accreditation is gained.

[The proposed bill referred to follows:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE.

HON. CARL ALBERT,
Speaker of the House of Representatives,
Washington, D.C.

DEAR MR. SPEAKER: Enclosed for the consideration of the Congress is a draft bill "To transfer Saint Elizabeths Hospital to the District of Columbia." The transfer would be effective on September 30, 1979, or the 120th day following accreditation of the hospital by the Joint Commission on Accreditation of Hos-

pitals, whichever is later. This provision is to assure that the hospital is improved so as to regain accreditation before its transfer to the District of Columbia and to provide sufficient time for joint planning by the Department of Health, Education, and Welfare and the District.

Since its establishment by Congress in 1855 as the Government Hospital for the Insane, Saint Elizabeths Hospital has been located, organizationally, within the Department of Interior, the Federal Security Agency, and, since 1953, within the Department of Health, Education, and Welfare. Today, Saint Elizabeths Hospital provides care, treatment, and rehabilitation services predominantly to patients who are residents of the District of Columbia. Facilities of the hospital include a forensic psychiatry and security unit for the examination, treatment, and rehabilitation of patients referred by the courts in relation to various types of criminal proceedings. Hospital facilities also include a comprehensive community mental health center. Presently, District of Columbia residents comprise an overwhelming majority of the hospital's inpatient population: of its 2,850 inpatients, 86 percent or 2,444 are from the District, and all of its outpatients are District of Columbia residents. These statistics indicate that Saint Elizabeths Hospital serves primarily as a local facility. Financing of its programs and operations is derived from several sources, including direct appropriations to the Department of Health, Education, and Welfare and reimbursements for patient care, principally from the Government of the District of Columbia.

Over the past ten years, uncertainties over transfer of the hospital have caused reluctance to make long-term investments in improvements of operations and facilities. This has made it impossible for the hospital to keep up with current standards and to maintain quality care for its patients. Thus, the hospital was denied accreditation by the Joint Commission on Accreditation of Hospitals in December 1975.

We, therefore, propose enactment of the enclosed draft bill to transfer the hospital to the District of Columbia. The draft bill is in keeping with the President's 1977 Budget proposal, proposing to (1) set a future date for transfer, contingent upon accreditation, (2) gradually reduce Federal support for the operation of the hospital over an extended period, and (3) authorize \$100,000,000 for construction and/or renovation of mental health facilities connected with Saint Elizabeths Hospital, taking into consideration the needs and resources of the District of Columbia. Moreover, the Congress has been equally committed to correcting the deficiencies at Saint Elizabeths Hospital. To assist in the efforts for reaccreditation, the Congress authorized a redirecting of facility funds last year, and has appropriated a total of \$10.6 million in facility improvement funds during the current fiscal year. Congress has also approved additional manpower in shortage categories identified by the Joint Commission on Accreditation of Hospitals.

Our proposed bill would assure reaccreditation of the Hospital prior to its transfer, and would permit the initiation of a comprehensive program of management improvement at the hospital; further, it would require joint and collaborative planning by the District Government and the Department of Health, Education, and Welfare.

Employees of the hospital at the time of the transfer would be transferred with the hospital, and those with competitive status would retain the protection of that status so long as they occupied the same positions. In addition, all positions at the hospital would continue to be or would be established in the competitive service unless excepted as provided by title 5 of the United States Code or other statutory law. The Department of Health, Education, and Welfare retains the authority under other provisions of law to detail Public Health Service personnel to the hospital if so requested by the District.

The transfer would not alter the hospital's obligation to care for Federal beneficiaries, provision for whom would still be made there on a basis that would reimburse the Hospital for its costs.

With the enactment of the District of Columbia Self-Government and Governmental Reorganization Act, continued Federal operation of Saint Elizabeths Hospital, primarily for the benefit of the District of Columbia, seems wholly inappropriate. The proposed transfer reflects our view that the hospital should be controlled and supported at the local level, serving the people of the District of Columbia as an effective and important part of a single mental health services delivery system. This would be in keeping with the modern practice of comprehensive programs for mental health care, which include: inpatient services, out-

patient services, day care, emergency services, and consultation and education in a unitary, community-based system.

We therefore urge the prompt and favorable consideration of our draft bill.

We are advised by the Office of Management and Budget that enactment of this proposal would be in accord with the program of the President.

Enclosure.

A BILL To transfer Saint Elizabeths Hospital to the District of Columbia

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

DEFINITIONS

Section 1. As used in this Act—

- (1) the term "Secretary" means the Secretary of Health, Education, and Welfare;
- (2) the term "Mayor" means the Mayor of the District of Columbia; and
- (3) the term "Hospital" means Saint Elizabeths Hospital.

TRANSFER OF THE HOSPITAL, AND THE SECRETARY'S FUNCTION RESPECTING IT, TO THE MAYOR

SEC. 2. (a) (1) *Transfer of Function.* The Secretary's function of supervising the administration of the Hospital, including the authority delegated by section 3(2) of Executive Order 11609, 36 F.R. 13737 (July 24, 1971) (pertaining to the establishment of per diem rates for care), is transferred to the Mayor effective on the date specified in paragraph (2). To the extent necessary or appropriate to perform this function, the Mayor, in accordance with the provisions of the District of Columbia Self-Government and Governmental Reorganization Act, 87 Stat. 774 (1973), may exercise, after its transfer, any authority available by law to the Secretary prior to the transfer.

(2) *Date of Transfer of Function.* The transfer of function provided for in paragraph (1) shall occur on—

(A) September 30, 1979, or

(B) the 120th day following accreditation of the Hospital by the Joint Commission on Accreditation of Hospitals,

whichever is later.

(b) *Statutes Affected.* For the purpose of effectuating the transfer of function under subsection (a) (hereinafter in this Act referred to as "the transfer"), the Mayor shall, upon the transfer, succeed to the authority of the Secretary under the laws governing the Hospital, which shall include, but not be limited to—

- (1) sections 4839, 4851, 4852, and 4858 of the Revised Statutes (24 U.S.C. §§ 165, 211, 211a, and 170, respectively);
- (2) the Act of June 23, 1874, 18 Stat. 251 (24 U.S.C. 212);
- (3) the Act of June 30, 1906, 34 Stat. 697, 730 (24 U.S.C. 177);
- (4) the first section of the Act of June 12, 1917, 40 Stat. 105, 179 (24 U.S.C. 196) (as amended by section 4(c) (1) of this Act);
- (5) the Act of March 6, 1920, 41 Stat. 503, 513 (24 U.S.C. 176);
- (6) the Act of June 5, 1920, 41 Stat. 874, 920 (24 U.S.C. 166);
- (7) the Act of July 18, 1940, 54 Stat. 766 (24 U.S.C. 196b) (as amended by section 4(c) (3) of this Act);
- (8) the Joint Resolution of May 9, 1941, 55 Stat. 186 (24 U.S.C. 180);
- (9) the Act of Nov. 7, 1941, 55 Stat. 760 (24 U.S.C. §§ 181, 182, 183, and 184); and
- (10) the Act of August 4, 1947, 61 Stat. 751 (24 U.S.C. §§ 169a, 185, and 195a).

(c) (1) *Transfer of Property.* Effective upon the effective date of the transfer, there are also transferred to the District of Columbia all right, title, and interest of the United States in certain lands in the District of Columbia, together with all buildings and improvements thereon and, except as provided pursuant

to paragraph (3) (E), all personal property used in connection therewith (as determined by the Secretary), known as Saint Elizabeths Hospital.

(2) *Interim Advisory Body.* There shall be established an Interim Advisory Body, consisting of (A) a chairman, who shall be the Secretary's designee, (B) six members designated by the Secretary, and (C) six members designated by the Mayor. The Interim Advisory Body shall make recommendations to the Secretary and the Mayor for developing policies and plans pursuant to the transfer and implementing a program for placement of identified patients of the Hospital who should be housed in alternative care facilities. The Interim Advisory Body shall submit a report on its activities to Congress on January 1, 1977, every six months thereafter, and a final report within thirty-one days after the transfer. The Interim Advisory Body shall cease to exist thirty-one days after the transfer.

(3) *Implementing Agreement.* Prior to the effective date of the transfer, the Secretary and the Mayor shall enter into an agreement containing—

(A) a description of the boundaries of the land transferred by paragraph

(1);

(B) an inventory (in such detail as the Secretary and the Mayor may agree) of the other property transferred by paragraph (1);

(C) a specification of the financial obligations of the Hospital respectively assumed by the Secretary and the Mayor upon the transfer;

(D) the agreement of the Mayor to receive at the Hospital beneficiaries of the Federal Government on a basis that would reimburse the Hospital for its actual costs in connection with such beneficiaries;

(E) the terms and conditions upon which the Secretary may conduct research (not in furtherance of the functions of the Hospital) in the William A. White Building, and an inventory of any property that, after the transfer, the Secretary will continue to hold in such Building, as property of the United States, for use in such research; and

(F) such other terms and conditions, consistent with this Act, as the Secretary and the Mayor deem appropriate.

If the Secretary and the Mayor are unable to agree on any matter required to be set forth in the agreement (other than a matter of amendment to such agreement after the transfer) or on any other matter pursuant to the transfer, the matter shall be decided by the Director of the Office of Management and Budget. For purposes of the portion of the agreement made pursuant to clause (D) of the first sentence of this paragraph, the provisions of section 2 of the Act of August 4, 1947, 61 Stat. 751 (24 U.S.C. 168a) shall continue to apply with respect to the Hospital, except that the District of Columbia (or the official designated by the District) shall be substituted for the Superintendent of the Hospital.

(d) *Transfer of Unexpended Balances.* Effective upon the effective date of the transfer, all unexpended balances of appropriations, allocations, and other available funds of the Hospital, including funds appropriated under section 5(a) of this Act, are transferred to the District of Columbia for use as provided by law in the operation of the Hospital, except to the extent (determined by the Director of the Office of Management and Budget) required to meet obligations already incurred and not assumed by the District.

PROVISION FOR EMPLOYEES OF THE HOSPITAL

SEC. 3. (a)(1) *Transfer of Employees; Competitive Status Retained.* Each person employed by the Hospital on the day before the effective date of the transfer shall be transferred in his position, and shall retain all of the rights, benefits, and privileges pertaining thereto held prior to such transfer so long as he remains continuously employed in that position, wherever located in the Government of the District of Columbia.

(2) *Hospital Positions to be in Competitive Service.* All positions at the Hospital shall be in the competitive service on and after the effective date of the transfer unless exception thereto were or are authorized under 5 U.S.C. § 3302 or other statutory provision. This paragraph does not extend the applicability of title 5 of the United States Code to the District of Columbia government in its operation of the Hospital beyond the requirements of that title which relate to employment in the competitive service.

(b) *Waiver of Licensure.* The Mayor shall prescribe regulations establishing the period or periods during which the licensing and registration requirements

of the laws set forth in title 2 of the District of Columbia Code shall not apply to a retained employee engaged, in the course of his employment with the Hospital after the transfer, in an occupation in which he was engaged, in the course of such employment, prior to the transfer. Such period or periods shall be reasonably sufficient to permit a retained employee to qualify under such laws in such occupation.

APPROPRIATION AUTHORIZATIONS

SEC. 4. (a) *Modification of present appropriations authorization.* Appropriations to the Secretary for fiscal year 1977 and each fiscal year thereafter, until the effective date of the transfer, for the maintenance and operation of the Hospital in providing care to patients of the Hospital eligible for care by reason of their residing in the District of Columbia, shall not exceed 72 percent of the costs for each fiscal year of the maintenance and operation of the Hospital in providing care to those persons.

(b) *Transitional appropriation authorizations.* There are authorized to be appropriated to the Secretary, to enable the Secretary to pay to the District of Columbia part of the cost of the maintenance and operation of the hospital—

(1) for that portion (if any) remaining, after the effective date of the transfer, of a fiscal year which began before that date, and for each of the two succeeding fiscal years, 72 percent of the costs for each of those periods in providing care to a number of patients of the Hospital equal to the number of patients who were provided care during the last fiscal year ending on or before the effective date of the transfer and who were eligible for care by reason of their residing in the District of Columbia, and

(2) for each of the succeeding thirteen fiscal years—

(A) 67 percent, for the first of those fiscal years,

(B) 62 percent, for the second of those fiscal years, and

(C) in like manner for each succeeding fiscal year, the percentage for the preceding fiscal year, decreased by five, of the costs for each fiscal year in providing care to the number of patients of the Hospital specified in clause (1).

(c) *Repeal of appropriation authorizations for Federal beneficiaries—*

(1) The first section of the Act of June 12, 1917, 40 Stat. 105, 179 (24 U.S.C. 196) is amended by striking out “, and the expenses attendant thereon shall be paid from the appropriation for the support of Saint Elizabeths Hospital”.

(2) The sentence beginning with “The Superintendent of Saint Elizabeths Hospital” in the first section of the Act of Oct. 6, 1917, 40 Stat. 345, 373 (24 U.S.C. 200) is struck out.

(3) The Act of July 18, 1940, 54 Stat. 766 (24 U.S.C. 196b) is amended by striking out “, and the expense of transfer shall be paid from the appropriation for the support of the hospital”.

APPROPRIATION AUTHORIZATION FOR CONSTRUCTION OF HOSPITAL FACILITIES; FORGIVENESS OF PRIOR CONSTRUCTION DEBT

SEC. 5. (a) *Renovation of Hospital.* For fiscal year 1977, and for each fiscal year thereafter, there are authorized to be appropriated to the Secretary such sums as may be necessary for (1) the construction of buildings and facilities at the Hospital, including the purchase and fabrication of equipment, and the remodeling of existing buildings at the Hospital (including repair and replacement of equipment), and (2) the acquisition and leasing of land, the acquisition, leasing and construction of buildings and facilities, including the purchase and fabrication of equipment, and the remodeling of existing buildings (including repair and replacement of equipment), to meet the psychiatric needs of those Hospital patients placed in community settings, except that the aggregate of such appropriations may not exceed \$100,000,000.

(b) *Forgiveness of Prior Debt.* Upon the effective date of the transfer, the proviso to the item captioned “Saint Elizabeths Hospital” in the Department of Health, Education, and Welfare Appropriation Act, 1953, 68 Stat. 443, is repealed. Obligations that would accrue, and be payable by the District of Columbia, under such proviso for the fiscal year of the transfer and for fiscal years beginning thereafter, are forgiven. Amounts paid by the District of Columbia in full or partial discharge of any such obligation in the fiscal year of the transfer shall be refunded to the District.

SAVINGS PROVISIONS

SEC. 6. (a) *Continuity of Prior Agency Action.* All orders, determinations, rules, regulations, permits, contracts, certificates, licenses, and privileges—

(1) which have been issued, made, granted, or allowed to become effective in the performance of the function transferred by section 2(a); and

(2) which are in effect upon the effective date of the transfer; shall continue in effect according to their terms until modified, terminated, superseded, set aside, or revoked by the Mayor or other authorized official, or a court of competent jurisdiction, or by operation of law.

(b) *Claims and Pending Proceedings.* No suit, action, or administrative proceeding to which the Secretary is party, nor any claim against the Secretary, respecting the function transferred by section 2(a), shall abate by reason of the transfer. Such suit, action, or administrative proceeding shall be continued as though this Act has not been enacted, but with the District of Columbia substituted for the Secretary. Such claim, if in contract and if filed after the transfer, shall be brought against the District, in lieu of the Secretary, and shall be governed by such procedures as may then apply to claims against the District in like cases. Such claim, if in tort and if arising before the transfer, shall not be brought against the District.

REPEALER

SEC. 7. Effective upon the date of the transfer, any provision contained in a District of Columbia Appropriation Act prescribing the inpatient rate for services rendered by the Hospital for patient care for the fiscal year of the transfer is repealed with respect to services rendered on or after that date.

Mr. YELDELL [continuing]. We strongly support the fact that the hospital, if it is to be turned over to the District of Columbia, should be fully accredited or commitments made to assure accreditation within a given time frame.

PERSONNEL PROTECTION

The CHAIRMAN. There is one particular employee matter that is of considerable concern. As you know, the Federal Tort Act insures employees charged with tort actions that they will be defended by the Department of Justice and that the Federal Government will pay any settlements.

St. Elizabeths employees are covered. The District employees are not. Many professionals are drawn to employment at St. Elizabeths because they see the Federal Tort Act as a benefit. They don't need malpractice insurance, for example. There is concern in that category of employees that if St. Elizabeths were transferred to the District of Columbia government, that this benefit may not go with it.

I wondered if you could give any reassurance about the benefits that you would offer this group of professionals in order to encourage their continued services.

Mr. YELDELL. The District government is self-insured. We have addressed this same problem with the physicians at District of Columbia General Hospital. Separate legislation was passed to cover them then so that malpractice insurance was not required.

I would assume the District of Columbia government would assure the same coverage to those persons in the psychiatric community and therefore to the employees at District of Columbia General Hospital. I might say that a general bill is under consideration at the very moment in the District of Columbia to look at the whole prospect of liability on my District employee.

At the present time, he is covered in only certain areas. I think specifically if you are driving a District vehicle or specifically the legislation that was passed for the doctors at District of Columbia General Hospital. But the City Council in passing the bill for the doctors is considering a broader bill that would allow coverage for all District employees.

ST. ELIZABETHS AND NINMH

The CHAIRMAN. What about the authorization for the NIMH to use the hospital for research and related programs? Would you have any problem with that of St. Elizabeths were transferred to the District of Columbia?

Mr. YELDELL. We have no objection to that, Mr. Chairman. We supported the retention that the hospital should be available for research. We support that.

COMMUNITY MENTAL HEALTH PROGRAMS

The CHAIRMAN. Could you tell the committee what you perceive that your Department has done in the last year to improve community mental health programs, some indication of the capacity and the credentials of the local agency as presently constituted to handle this extra responsibility?

Mr. YELDELL. I would refer that to Dr. McAlpin who has direct responsibility for that area.

Dr. McALPIN. Mr. Chairman, I wish you would repeat your question.

The CHAIRMAN. What has DHR done since 1975 to improve the mental health programs of the community? I guess what we are looking for here or providing here, I should say, is an opportunity to answer those who have some question about the capacity of either DHR or some other designated local agency to handle this extra responsibility.

Dr. McALPIN. Basically, because of budgetary considerations, we have been in a holding pattern in a good deal of the mental health system in the District. Since 1975, I think one significant program has been developed and we will start in operation in the next several weeks.

That is a residential treatment center for children at area B. We have had to do some tightening up in the past 2 or 3 years. We have combined our inpatient units for the mental health center. Basically—I hate to say this but it does come down basically to a budgetary consideration.

I think the matter of getting expertise and so forth, I think that is available and can be made available.

DISTRICT'S RECOMMENDATIONS

The CHAIRMAN. I just have one other question. As you know, the chairperson for the District of Columbia Council committee that has jurisdiction over this general area testified yesterday and testified in favor of the legislative proposal.

I wondered whether we have a divided situation here. I don't know whether the testimony of Mrs. Shackleton reflects the whole City Council or a majority of it or what.

Maybe you can answer that. But do we have a situation here where there is division among the principals in the local government on this matter, that the executive branch is opposed to it but the legislative branch, or at least part of it, is for it?

If that is the situation, what is the problem in reconciling these differences, if there are any?

Mr. YELDELL. I don't know whether Mrs. Shackleton was speaking for herself or for the City Council. I can certainly say that the executive has taken a strong position, almost from the inception of this talk on the transfer of St. Elizabeths Hospital that the proper way to handle the mental health program in the District of Columbia is to have a unified program.

Therefore, it would strongly support the transfer of St. Elizabeths after accreditation and with a reasonable financial plan worked out for the District of Columbia and would strongly oppose the move to establish an independent authority. The situation, if it is that she represents the view of the entire Council, is one that certainly should be addressed within the city between the Mayor and the Council.

I would hope that they could address it and reach some accord. I would also suggest that perhaps the strongest part of the objection to the transfer of the hospital to the District is the assumption that upon transfer, it would become a part of the mental health administration within the Department of Human Resources. I think that there are some strong genuine concerns that the Department is too large as it stands now and the addition of St. Elizabeths with some 4,000-plus employees would aggravate an already complex situation.

I think that if the Council understands that the executive would support the establishment of an independent—a department of mental health which encompassed the St. Elizabeth program along with the other existing mental health programs as a department of cabinet rank reporting directly to the Mayor that it might alleviate some of the concerns about the transfer and I suspect the District could come up with a single position.

The CHAIRMAN. You have not made what we call a whip check among the City Council to find out whether or not Mrs. Shackleton's views are her own, or whether or not they reflect those of a majority? That would be a little surprising to me. She is the chairperson for the committee having jurisdiction, the Committee on Human Resources and the Aging, and I would think that her views would carry extra weight or certainly should be a matter of concern to the executive branch.

I would think that you would have proceeded to find out if her statement represented her own views or those of a majority of her committee. You are acquainted with the legislative process. If someone in that position makes some kind of an expression, the person subject to that jurisdiction just conventionally would check to find out the extent that that view was representative of the whole body or at least of that committee.

Mr. YELDELL. Mr. Chairman, we of course work through our legislative office and we were privy to the testimony of HEW but were not privy to the testimony of Mrs. Shackleton. I have no way of determining at this point whether that represents the entire Council. I would say that Mrs. Shackleton has spoken for the Council before.

She has spoken for herself before and I think the Council has largely supported her view. I would not have any hesitancy to think that her view would not carry extremely large weight within the City Council.

Therefore, if she is suggesting she would support an independent authority, I would suspect the Council would under the conditions that it has now. I think the only unknown ingredient is whether or not the executive has any flexibility as to the placement of St. Elizabeth when it comes into the District.

But in relation to talking to the Council itself or to Mrs. Shackleton in relation to what her testimony would be, I would—I was not privy to that and there was nothing I could find out through our legislative office that would indicate which way her testimony was going and what it represented.

The CHAIRMAN. Mr. Fauntroy?

Mr. FAUNTROY. Thank you, Mr. Chairman and thank you, Mr. Yeldell, for your testimony.

Mr. Yeldell, yesterday we had testimony from the Joint Commission on Accreditation of Hospitals, the same commission which is responsible for the nonaccreditation of District of Columbia General as well as St. Elizabeths Hospital. While that commission took no position on this particular bill, in the course of their response to questions, they identified problems at St. Elizabeths Hospital that are quite similar to those which they identified relating to District of Columbia General Hospital and tended to parallel their reasons for nonaccreditation in both instances.

You have responded to the basic question which we as Members of the Congress or members of this committee are going to have to answer to the Congress about, and that is, why, when we have presently accreditation problems with our District of Columbia General Hospital and Forest Haven, do we feel we want to take on the additional administrative burden of St. Elizabeths Hospital?

HOSPITAL AS INDEPENDENT AUTHORITY

You have responded by suggesting that one of the problems which the accrediting association or commission has identified—namely, lines of authority and closer board management of the affairs of the hospital—you have suggested that you would not be averse to an independent agency being established I take it, not unlike the format suggested here, with a board membership that would be appointed by city government.

Mr. YELDELL. I would not be opposed to a department being structured within the city government. I would be opposed to an independent agency.

The department would be an operating department within the District of Columbia Government reporting directly to the Mayor as a department head.

Mr. FAUNTROY. I see. Has your thinking in that area gone to any of the other functions now under the Department of Human Resources?

Mr. YELDELL. Not necessarily. I think my problem, Congressman, is that I believe very strongly in the concept of human resources. There is much to be gained by a unified delivery system. I think the problems that the Department is dealing with are so manifest and so complex and of such long standing that it is very difficult to deal with them in a rational manner without dealing with the politics of the mounting problems that have pervaded those areas.

To to the extent that it would assist the city in moving programs forward, I would not be opposed to any of them functioning in a way that would give us the best delivery of services. There has been much talk of a separate health department and a separate welfare department.

I think the city needs to weigh that in terms of what it buys the city. If one were to compare the expenditures today with what they would have been in separate departments, they are far less on a unified basis.

I think the other independent result is the measure of service to the client and I think it is vastly improved under the human resources structure. I do not stand ironclad in any area that we stay in a particular posture for a given period of time.

I think we have to be flexible and deal with it on the basis of what is required at the current time that would bring the best results for the dollar spent and the best service to people.

But I think very clearly that the movement of St. Elizabeths Hospital into the District of Columbia Government and further into the Department of Human Resources with all the air that surrounds the Department now is not a very practical matter.

Therefore, I think the bigger battle here is to get a unified mental health system. Certainly, if that means the establishment of a separate department, not only would I not object to it, I would support it because the District should have a single mental health delivery system.

DRAFT LEGISLATION

Mr. FAUNTROY. You suggest that the proposed bill would really perpetuate the dualistic and fragmented mental health delivery system. You say it will allow St. Elizabeths Hospital to remain in an autonomous posture thereby fostering the problems that currently exist.

What problems do you have reference to here?

Mr. YELDELL. Well, I think, from an administrative point of view, the patients are District residents. St. Elizabeths keeps these persons until they are prepared to release them.

They then are picked up by community mental health center. We have no control over the programing that takes place within the hospital itself. I think that that in and of itself fragments the care. Just from an administrative point of view, that is where I see the problem.

DUAL AUTHORITY ON MENTAL HEALTH

Mr. McKINNEY. I think that is basically the problem. I think efforts have been made to develop a good relationship on the part of St. Elizabeths and on the part of the mental health administration. But I think a reality is, not only with mental health but with other systems, too, when you have two separate authorities trying to do the same job and with no ultimate control over those authorities, there is going to be a difference of opinion, there is going to be a lot of territoriality involved.

If nothing else happens out of this committee's deliberations, if they can do something to develop a unified mental health system under one authority, I think that will be the best thing that can happen to the District.

COMMUNITY INVOLVEMENT

Mr. FAUNTROY. I have one final question and that is that one of the problems that currently exists apparently is the inability to move patients into the community and out of the hospital setting. You indicated that since 1968 that has been the objective of the District government. And yet we on the Hill hear that there are at least 100 elderly people at District of Columbia General today who have not yet been moved into the community who should be moved.

The question is, What assurance can you give this committee that the elderly at St. Elizabeths Hospital would be moved into a community setting if that hospital were transferred to the District government?

Mr. YELDELL. My statement was that the hospital itself had embarked upon a laudable program. I think the population at St. Elizabeths was 7,000 maybe 10 or 12 years ago, and now it is down to maybe 3,000.

The situation you address is one that not only faces Washington, D.C., but the entire country and that is the nonavailability of beds for the elderly or chronically ill. The *Dixon v. Weinberger* case addresses the very same problem.

You say there are 100 people at District of Columbia General that should be in less than acute care. I think that that would be true in every hospital in the city. St. Elizabeths Hospital itself by the JCAH standard has some 1,300-plus patients who should not be in the hospital but in the community.

The problem is not solved easily because there are not the beds to place them in. We operate District of Columbia Village, supposedly a 700-bed facility but we are operating on a 500-bed basis because of staffing and budgetary restraints.

We have the Metropolitan Hospital on New Hampshire Avenue, again a 400-plus-bed facility designed for intermediate care but which was never opened because the rate of pay for such care did not warrant private enterprise moving into it.

I think that we have a phenomenon that people are living longer, requiring longer care, and we don't have the wherewithal to develop those beds for such people.

This problem does not just address Washington. It addresses every city in this country. I can't give any assurance that we can place the 1,300 people at St. Elizabeths Hospital because the District does not have the resources at this time to do it.

Perhaps the moneys directed toward accreditation of St. Elizabeths Hospital could also be diverted to building the places required and that efforts be made to open up the Metropolitan Hospital and to encourage new persons to come into the arena to provide these kinds of beds.

One break on the horizon is that under medicaid we are now required to pay reasonable care as compared to a previous posture of paying whatever the tariff would bear from a financial point of view.

I think once we go to reasonable care, the private enterprise sector will come in because there is a shortage of supply and an increased demand. But only when these things start to work together can we actually outplace these persons and put them in the proper level of care.

Mr. FAUNTROY. Thank you.

The CHAIRMAN. Mr. McKinney?

Mr. MCKINNEY. No questions.

The CHAIRMAN. Does counsel have any questions?

TRANSFER PLANS FOR ST. ELIZABETH

Ms. MARTIN. The matter of the possible transfer of St. Elizabeths Hospital to the District government has been kicking around for 4 or 5 years now. I assume that somewhere in the District government in somebody's bottom drawer there is a plan that the District government has drawn up to implement this transfer if it should ever come about.

Could you describe what plans you have made to receive St. Elizabeths Hospital?

Mr. YELDELL. I don't think that there is in existence any such plan per se. St. Elizabeths Hospital staff and District government staff have been meeting for quite some time to work out those areas of responsibility that we could jointly address now and also to look toward the movement of the hospital into the District of Columbia.

There has been talk of a proposed study being financed by HEW to address specifically how to best integrate St. Elizabeths Hospital into the District of Columbia.

There has been a great deal of interchange between the staffs of my department and the staff at St. Elizabeths Hospital and the Mental Health Administration—NIMH on an ongoing basis in relation to addressing these specific problems as they relate now and which would occur should such a transfer actually take place.

I would say it has been kicking around more than that period of time that you mentioned. Every time we go into it with earnest, something else comes up and there is no transfer. The way we are approaching it now is that the director of NIMH has assigned Dr. Gallagher to be his primary liaison and I have assigned someone and they are meeting on a regular basis to discuss the problems associated with a dualistic operational system.

SEPARATE MENTAL HEALTH DEPARTMENT

Ms. MARTIN. In response to questions it was my understanding that you suggested that a separate department of mental health would be the appropriate entity to administer St. Elizabeths Hospital along with the city's mental health programs.

I wondered why the city hasn't moved to establish a separate mental health administration? What are the program advantages of that? Should this committee simply wait until the District government organizes its own mental health administration into what it considers appropriate form before we take any action with respect to St. Elizabeths?

Mr. YELDELL. I don't think the District would move to establish it unless the hospital were transferred. With the size of the hospital, the psychology and the politics of moving that into a department that is already considered too massive would be answered by the movement of the entire mental health program out into a separate department.

I would strongly support that. Though I feel that mental health is an integral part of the human resources system, I don't think the psychology of this timing would allow that to take place. Rather than to bypass the end product which I think is essential, a unified mental health system, I would strongly support the establishment of a separate department into which St. Elizabeths would go and the separating programs of mental health currently under DHR would go.

Ms. MARTIN. You would support that for psychological rather than program reasons?

Mr. YELDELL. I don't think that practically we would have a chance to work it out.

Ms. MARTIN. Thank you.

The CHAIRMAN. Thank you very much, Mr. Yeldell.

Our next witness is Mr. Jonas Morris, appearing on behalf of the Community Mental Health Centers, A and B. Mr. Morris has also submitted a statement and he may proceed at this point.

STATEMENT OF JONAS MORRIS ON BEHALF OF THE COMMUNITY MENTAL HEALTH CENTERS A AND B, ACCOMPANIED BY REV. ANNIE WOODRIDGE, CHAIRMAN OF THE AREA B COMMUNITY HEALTH CENTER ADVISORY BOARD

Mr. MORRIS. I have asked Rev. Annie Woodridge to join me at the table. Rev. Woodridge is chairman of the area B Community Health Center Advisory Board. We are appearing here today on behalf of the advisory board and not the community health centers. These are community groups set up to advise the centers on how they run.

The centers are under the Department of Human Resources and I do have a prepared statement, Mr. Chairman, and I would ask that this be included in the record in its entirety and I would like to touch on some of the highlights in the statement and then expand on some thoughts.

The CHAIRMAN. Without objection, the entire statement will be placed in the record at the conclusion of your statement, Mr. Morris.

FAVOR LEGISLATION PROPOSED

Mr. MORRIS. I have pointed out what, from my point of view, are the advantages of a separate corporation to run St. Elizabeths Hospital. We are in support of your draft bill.

We think it is a fine beginning to the resolution of this problem which has been aggravating both the Federal Government and the District government and community for many years.

AMENDMENTS PROPOSED

We have one refinement that we urge you to take into serious consideration and that is to make it a private nonprofit corporation rather than a Federal corporation. That would in our view put it more squarely into the hands of community groups that the hospital is designed to serve.

We think that that is important. I will be expanding upon that. The basic reasons that we think the hospital should be in a separate corporate entity rather than as a party of the Department of Human Resources is for the administrative flexibility that is achieved through that.

Also the responsiveness it can achieve to the needs of the community is a principal reason. The responsibility of any governmental unit with regard to the delivery of services is that the Government is responsible for setting standards of care.

It has to oversee the operation, make sure that these standards are met and deal with the issue if it is not met. If the Department is running the program at the same time they are setting standards of care and trying to insure them, we find that that presents a conflict that is very serious.

My own experience, Mr. Chairman, through not only deep involvement with the community mental health center here in the District but throughout the country—and I think I am in the majority opinion here when I say that the most effective programs, community programs and center programs throughout the country are those run by private nonprofit agencies.

These are fully responsive to the community's needs. I was interested that Mr. Yeldell advocated the creation of a separate Department of Human Resources—separate Department of Mental Health within the city government.

I think that that is a significant switch in his position and I would suggest that the committee view that in the light of what it is, a tactical shift on the part of the Washington administration to head the Diggs bill off at the pass. They could have made this departmental reorganization at a later time if they wanted to.

Later on you will hear testimony that will advocate a similar approach. I think the issue of integration of services is a key one along with financing and that is something that the committee has to give serious consideration to. But I would point out that the Department could have achieved effective integration of services, assuming there is not that now, under the present structure particularly because they have District of Columbia General Hospital under their authority and that has inpatient services for the community mental health centers.

COMMUNITY MENTAL HEALTH CENTERS

The way we see, many of us, see community mental health is for greater and greater decentralization. Ultimately I would hope that in the District, the program could move to one where all the community mental health centers are run by community groups. Your bill suggests that area D go into that setting and of course the community health centers have been with us since 1975 and it has that thrust to it.

It says these should be run by the community they serve. This is a very important Federal policy now and we would hope it would be mirrored in the District of Columbia. I am surprised to learn that apparently HEW will be testifying for transfer of the hospital to the District of Columbia government.

Looking down the road a bit and the kind of program that can emerge and addressing the issue of integration of services, I think that if you have effectively operating community programs, then they can be very much a part of the governing structure of the hospital.

Indeed the hospital is there primarily to serve the community programs, to act as a backup. This is a direction that many communities are moving in. In Louisville, Ky., they have moved in this direction. I think you heard from a witness yesterday from Erie County in New York that they had gone that direction.

So if you look at it from the point of view of a community program being the basis from which services are provided, that the hospital itself is the backup for that, then the integration is complete, can be quite thorough.

The District has a significant and important role by setting the standards and insuring that those standards are met.

It can contract with both the hospital and the community programs for the delivery of services to individuals who are the direct responsibility of the District of Columbia government. It can have a key and important role in this whole operation.

Thus I compliment you, Mr. Chairman, on the development of this draft bill. I hope it will move speedily through your committee. I hope you will give serious consideration to changing its character somewhat so it becomes a private nonprofit corporation.

I think with that setting and that structure we can really finally achieve a thorough and effective integration of community mental health services in the District of Columbia.

Thank you.

The CHAIRMAN. Thank you very much for your constructive analysis.

[The complete statement of Mr. Morris follows:]

PREPARED STATEMENT OF JONAS V. MORRIS, DISTRICT OF COLUMBIA COMMUNITY MENTAL HEALTH CENTER ADVISORY BOARDS

Mr. Chairman, members of the Committee, my name is Jonas V. Morris and I am appearing today on behalf of the community advisory boards of two of the comprehensive community mental health centers in Washington City run by the District of Columbia government. My address is 1346 Connecticut Avenue, N.W.

The centers to which I refer are the Area A and Area B Mental Health Centers. I am a former officer of the Area A Advisory Board and am still very much involved in the program.

COMMUNITY HEALTH PROGRAMS

I speak to you today on behalf of these centers because the future of St. Elizabeths Hospital is very important to the city's community mental health program. Without a viable, effective, efficient inpatient psychiatric service capable of delivering active, quality treatment, the community programs—which are the vanguard of any mental health service—can only do half the job.

In its present structure, St. Elizabeths Hospital is not providing the service it should to its patients, and it would be virtually impossible for it to do so as long as it remains part of the federal system. The federal government is on record as wanting the hospital transferred out of the federal system. The District of Columbia government is on record for having it transferred out of the federal system. The community mental health center advisory boards are now on record for having it transferred out of the federal system. And you, Mr. Chairman, are to be complimented for having fashioned a bill which will give the hospital independent status in the community, which will ensure the hospital is responsive to the community's needs, which will make it possible for the hospital to deliver quality treatment, which will make it possible for the hospital to concern itself only with those patients who are in need of psychiatric treatment, and which will make it possible for the District of Columbia government to have a meaningful and helpful role.

FAVOR LEGISLATION PROPOSED

We hope, therefore, that this committee will give speedy consideration to the St. Elizabeths Hospital Corporation Act adopt the changes that we will recommend, and forward it with an affirmative recommendation to the full House.

Before I go to our suggested changes, however, I would like to speak a few moments about the problems of delivering health services, particularly mental health services, and some of the conclusions that my work has led me to. I devote most of my time to writing and consulting on health issues. For nearly seven years I have been deeply involved with community mental health programs, which has included representing centers here in Washington. I have observed first hand, and in considerable depth, centers run by community groups and those run by local governments—either state, county or municipal. By far the largest number of centers throughout the country are run by private, nonprofit corporations under the control of a board of directors of lay individuals and most frequently residents of the community the center serves. In some cases, centers are part of hospitals.

BACKGROUND

The community mental health centers program was initiated in 1963 because it was clear that the mammoth state mental hospital, run by the state department of mental health, was not providing the best care available to the mentally ill. The hospitals were cumbersome bureaucracies that failed to provide active psychiatric treatment. The hospitals were more warehouses than they were treatment facilities. The community mental health center program has changed much of that. The state hospitals have, across the land, been reduced substantially in scope, size and patient load; much of the active psychiatric treatment today is going on in community mental health centers. The mental hospitals, as inpatient facilities, are now reserved for persons who need to be confined on a short, medium or long-term basis because of mental illness.

A principal reason community mental health centers have been so successful is because they are run by the communities they serve. People from the communities knowing the needs of the community serve as the board of directors to establish policy, develop budgets and hire the director.

The principal of community control of course is widely used in other areas of health care. Most hospitals have community boards. Several cities have the so-called public hospital operated as a separate corporation; not part of the city government. Several states are ridding themselves entirely of the state mental hospitals, and at least one has been in the process of turning these hospitals over to the community mental health care centers.

Furthermore, it is the clear intent of Congress as expressed through the Community Mental Health Center Amendments of 1975 (PL 94-63), as well as the general movement of the body politic, to vest the responsibility for setting priorities and service delivery programs in community groups rather than in government control at any level.

There are a number of good reasons why a state government—or in this case the District of Columbia government—cannot effectively operate a facility such as St. Elizabeths. In my view the most important reason is that the primary responsibility of the District government is to ensure that quality care is provided in all health care facilities within its jurisdiction. It needs to set standards and then ensure that those standards are adhered to. Only the city government can effectively carry out this responsibility. Thus, if at the same time the city is actually running the program it is in an impossible position of conflict, for it ends up trying to regulate itself and attempting to impose sanctions when the facility doesn't perform properly.

It simply cannot be done effectively—Washington City or any place else. Governmental bureaucracies throughout this country are well known for their inability to deliver quality services; the nature of bureaucracy is to be responsive to its own needs, to diffuse both accountability and responsibility.

Another important reason for separating St. Elizabeths from the city government is for administrative flexibility. The best operating units are by and large the ones that are small, and have control over all aspects of their operation. Such a structure allows them to respond effectively and quickly to the needs of the people they serve. The city's personnel structure alone is very cumbersome, and if St. Elizabeths were part of the city government the individual responsible for running the hospital would not be able to shape and mold his staff to be fully responsive to the needs of the community and those being served by the hospital. Other aspects of a bureaucracy tend to hamper the administrative efficiency of such a service facility.

Furthermore, in the case of Washington City, the Department of Human Resources and its Mental Health Administration are straining to supply even the barest semblance of a community mental health program.

SEPARATE ENTITY REQUIRED

The best structure, therefore, for St. Elizabeths Hospital is as a separate entity—apart from both the District and federal governments. We do suggest several changes in your bill, however.

Rather than being a federal corporation, we believe St. Elizabeths should be structured as an independent, private, non-profit corporation. Its governing board should be composed of nine members, five of who shall be appointed as described in your bill and the remaining four appointed by the community boards of each of the four community mental health centers in the city (the proposed legislation would, of course, create Area D CMHC as a separate independent program).

The board of directors, who would not be full time and who should be paid at a rate commensurate with that for board members of major corporations, would be accountable for delivering inpatient hospitalization services to the city's mentally ill as well as providing outpatient, consultation and other services to individual clients, community mental health centers and other agencies through contractual relations. In addition, the Board of the corporation would contract with other groups or agencies for services deemed crucial to the continued growth and improvement of clients.

Since the corporations' task is to be legislatively defined as providing active psychiatric treatment for the facility's clients for which 24-hour psychiatric care is required, all other patients now in the hospital, (i.e. those identified as requiring community based alternative facilities) would become the responsibility of the appropriate mental health center or other care giving facility.

It is important, as the bill proposes, to make the Area D Community Mental Health Center a separate entity from the hospital and totally responsive to the community in keeping with the Community Mental Health Centers Amendments of 1975. We propose that the Act contain a provision which, in effect, mandates a grant to Area D in accordance with the provisions of the 1975 Amendments. That legislation requires that all centers started under its provisions be operated by community boards; local governments are not allowed to start up any more programs. By ensuring Area D a grant under the provisions of the 1975 Amendments the Congress would be ensuring that this program will be run in complete conformity with the 1975 Act.

One of the major concerns about the mental health system in Washington City has been the lack of continuity of care that results from two very separate

mental health operations—St. Elizabeths Hospital and the city's Mental Health Administration. Any change in governance at the hospital should be in a direction that would allow for an increasing integration of resources in order to enhance continuity and comprehensiveness of care. The proposed legislation will allow for this in several ways.

For example, the Board will be able to establish contractual relationships with any other mental health delivery system. The nature of these contractual relationships will allow for the clarity of responsibility that is now all too often absent in present relationships across organizational boundaries. Implicit in our proposal is the idea that the other three community mental health centers in the city would join Area D as independent community controlled organizations and that ultimately the hospital corporation would be the conjoint in-patient facility for these centers as well as providing other services they might wish.

FINANCING

The financing of the new St. Elizabeths Hospital is undoubtedly the most complex and difficult issue confronting this committee. In our view it is clear that the federal government will have to invest as much as it does now in the program for several years after the transfer is accomplished. But in time, the federal government's investment should be limited to the cost of providing treatment to individuals who are wards of the federal government, as well as through reimbursement programs that are now available to the District and any other jurisdiction. If the Congress does enact a system of National Health Insurance with appropriate coverage for mental illness, then NHI would finance much of the care in the hospital.

In addition, the hospital should, under the new arrangement, expect to be reimbursed from a variety of other areas—for example, from the criminal justice system for individuals placed in the hospital by the courts.

The District of Columbia government would be responsible for the cost of many of the patients at the hospital, in most cases through the centers.

I appreciate the opportunity to testify and hope that these comments have been helpful.

The CHAIRMAN. Mr. Fauntroy?

Mr. FAUNTROY. No questions, Mr. Chairman.

The CHAIRMAN. Mr. McKinney?

FUNDS FOR NONPROFIT CORPORATION

Mr. MCKINNEY. One of the problems I have with your idea of a nonprofit corporation is how do we guarantee the flow of funds? The flow of funds are now a problem of extreme importance. If you lose—let's put it this way—as bad as St. Elizabeths can get, the Government has to turn on the lights and keep the building up.

There is a possibility that if it becomes a nonprofit corporation, there would be a tenuous tie to the city's fiscal flow.

Mr. MORRIS. Contractual relationships should be established with the city and they would be responsible for paying for the cost of services to individuals who otherwise don't have financial support either through third party reimbursement or other.

Now if you look at the way payment for health services are going in this country and the payment for mental health services, I think that we are in the process now of attempting to stabilize this. Certainly the major issue is getting control on escalating health care costs. But beyond that, medicare and medicaid are open to reform so that more flow of dollars to those programs can go to mental health services.

Then there is in the offing the possibility of national health insurance and the coverage of this kind of services through that. There are

three possibilities at the Federal level of adequate or significant funding for the hospital.

In addition, the District of Columbia will have to make a significant financial commitment to the hospital to support its services.

Mr. McKINNEY. I was amazed in my city of Bridgeport. I served on several boards and one of them was the Kentucky Center for Handicapped Children. We had a tremendous amount of private inflow of cash. In fact our budget ended up probably being about 57 percent private donations.

I also served and started the Child Guidance Clinic of Bridgeport which deals with children who are mentally ill. We found it almost impossible to raise private funds.

For some reason or another a mother doesn't mind saying she has got a handicapped child or a brain-damaged child but she does not want to—people don't want to—identify with those who are mentally ill.

Do you think there is a possibility that a nonprofit private corporation could achieve substantial citizen participation in the form of extra funding?

Mr. MORRIS. No; I don't. This has been proven throughout the country. Very often this initial interest and support in starting it in is there but as the program gets to operating, it is extremely difficult to if not impossible. Foundations are willing to help get programs off the ground. They are not interested in sustaining operations.

Where private capital has been a significant factor is in some areas such as Rochester, N.Y., where there is a heavy industrial base or business base that has an interest in these programs and is willing to not only set their own health reimbursement insurance programs so that they can give significant support but also through their own philanthropic contributions.

But I would point out that there are perhaps 300 operating private nonprofit mental health centers throughout the country that get their funds through a variety of sources. A lot of it comes through a Federal program but a significant amount of it comes through States on a contractual basis or a grant basis.

There is the medicare and medicaid programs, there is title 20 and in some cases the SSI depending on the type services being offered. There are a variety of ways and the private nonprofit corporation is the one that has the flexibility to go out and capture these dollars.

In addition, the private insurance companies are more and more under pressure and I think giving some response to that pressure to make available—to finance and pay for the cost of mental health services.

The FEHB program has run into trouble and been somewhat regressive in recent years but I think that is a peculiar phenomena. But the other programs throughout the country have been growing slowly, much too slowly but they have been growing in this direction.

So private insurance is another area that I think you can look toward. Of course, not everybody is covered by private insurance.

Mr. McKINNEY. It seems to me State legislatures cut the prisons first, the court systems second, and the mental health systems third. I want to build in a protection factor.

Mr. MORRIS. I would agree with that but with an active community group supporting the increased funding, local governmental funding of these programs, the legislatures are often responsive to this. We can see a relationship to this phenomenon throughout the country.

The CHAIRMAN. Does counsel have any questions?

Ms. MARTIN. No questions, Mr. Chairman.

The CHAIRMAN. The Reverend Woodrich who is accompanying you is a representative of the advisory board. I wondered if she had any supplemental views to express.

Reverend WOODRICH. I want to reiterate the things he has told you. In working with mental health facilities around the city, I find that there are many inadequacies that have existed for quite sometime. There are many patients who come from St. Elizabeths Hospital who are sent out into the community and sometimes I think it is even before they are able to come out.

They are put in the care of mental health facilities around the city. In view of this fact, I think that the statement that has been given by Mr. Morris as well as Mr. Yeldell will be taken into account. With the economic pressures that are causing so many mental conditions among the people, it is extremely important that mental health be given one of the highest priorities.

Without proper mental health we cannot continue to exist as a viable community.

COMMUNITY INVOLVEMENT

The CHAIRMAN. I wondered if the gentleman from the District would agree with me that we appear to have some communication problem here with community groups as reflected in the audience today and yesterday.

I wondered whether or not this setting is inhibiting in some sort of fashion and whether or not there might be utility in having at least one hearing in the community? The kind of representations expressed by the Reverend Woodrich reflects community concern and is a matter of concern to me, that we in our processes here are communicating with people.

I wondered if the gentleman from the District would care to comment on that and whether or not he had any questions to ask the Reverend Woodrich.

Mr. FAUNTROY. Mr. Chairman, I think we have communications problems at two levels and at both levels I would like to see those problems addressed in the community by the community and without taking the time and attention of Members of this Congress or of this committee for that matter.

It seems to me we might do well to have a hearing with the city council and get the considered judgment of the duly elected legislators from the city and then if necessary—hopefully, they will have taken into consideration the views of citizens in arriving at their judgments.

Short of that, I certainly view first the urgency for our addressing this issue. HEW has been persistent and consistent in its effort to unload—maybe that is the improper term to use—this facility. We have for too long, I think, held this in limbo. So in short answer to

your question, I have rather mixed emotions about the committee having to go directly to people and bypassing in the process an elective process that we have established which I respect.

I certainly hope we get together before too long.

The CHAIRMAN. I did want to get the gentleman's views on the record and provide him an opportunity to make any inquiries of the gentlewoman who is in the witness chair that he would care to make.

Thank you very much.

Our next witness is Dr. James F. Dixon III, Deputy Assistant Secretary for Health, Department of Health, Education, and Welfare.

STATEMENT OF DR. JAMES F. DICKSON III, DEPUTY ASSISTANT SECRETARY FOR HEALTH, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY DALE SOPPER, DEPUTY ASSISTANT SECRETARY FOR HEALTH LEGISLATION; DR. BERTRAM S. BROWN, DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH; AND DR. ROGER PEELE, ACTING SUPERINTENDENT, ST. ELIZABETHS HOSPITAL

Dr. DICKSON. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Secretary, if you would identify your colleagues, you may proceed with your statement.

Dr. DICKSON. I have with me today Mr. Dale Sopper, our Deputy Assistant Secretary for Health Legislation. On my immediate left, Dr. Bertram Brown, Director of National Institute of Mental Health and on his left, Dr. Roger Peele, acting superintendent of St. Elizabeths Hospital.

Mr. Chairman, I do have a formal statement. With your permission I would like to submit it for the record and then make a few brief remarks informally before responding to your questions.

The CHAIRMAN. Without objection, the full statement of Dr. Dickson will be submitted in the record at the conclusion of his remarks.

You may proceed.

Dr. DICKSON. Thank you, Mr. Chairman. I would like to comment briefly on three items and they are the present status of St. Elizabeths Hospital, and second, the legislation that the Department intends to submit shortly for transfer of the hospital from the Department to the District and third, on the proposal for the transfer of authority for the hospital from the Department to an independent corporation.

STATUS OF ST. ELIZABETHS HOSPITAL

As for the status of the hospital at the moment, I would like to note that in 1975 the Joint Committee on Accreditation of Hospitals determined that the hospital would be liable to disaccreditation for reasons of noncompliance in the areas of patient safety, patient services, overcrowding, personnel levels and the like.

This determination by the Joint Commission has been appealed. I might note that at this moment, St. Elizabeths has not lost its accreditation. It still is accredited. The decision of the Joint Commission is under appeal and the decision is expected in December of this year.

During this period from the initial notification by the Joint Commission, there have been reprogrammed and appropriated funds that have been applied to meet the deficiencies that they addressed themselves to in the area of patient safety, personnel and patient services and also in the area of funds for planning to relieve overcrowding and the other problems that are extant there.

Also I might note that the administration does intend to submit a request for up to \$100 million for remodeling and construction of the facilities that are pertinent to carrying out the mission of St. Elizabeths Hospital. I would also like to note that in response to Judge Robinson's decision in the *Dixon vs. Weinberger* case on the matter of patient treatment under less restrictive conditions, that we are—that Dr. Brown as representative for Secretary Matthews has been meeting with District officials to establish responsibilities and duties pursuant to Judge Robinson's order.

We also believe that the administration's financial commitments to the hospital that I have referred to that have been ongoing and that are planned for the immediate future are also responsive to his decision.

HEW LEGISLATION

Second, as to the legislation that the Department intends to submit for the transfer of the hospital to the District, we feel that with enactment of the District of Columbia Self-Government and Governmental Reorganization Act the continued Federal operation of St. Elizabeths Hospital, which is primarily for care of District residents, is basically conceptually and in a pragmatic sense inappropriate.

Rather, we feel that the hospital should be controlled and in the end in time supported at the local level as an important part of a single mental health services delivery system. Accordingly, the administration as I mentioned will shortly propose legislation that would transfer St. Elizabeths Hospital to the District by September 30, 1979, or 120 days following accreditation of the hospital, whichever comes later.

This would provide, I believe, time to assure that the hospital has been improved and that its facilities and personnel are sufficient to gain the accreditation that it should have and that it will also provide the time that is necessary for a joint planning by the Department of Health, Education, and Welfare and the District administration for orderly transfer of responsibilities to the District.

I think also that this proposal will be in keeping with the administration 1977 additional budget proposals which authorize, as I have indicated, up to \$100 million for remodeling and for construction that is pertinent to a successful pursuit of the mission of St. Elizabeths Hospital.

OPPOSES INDEPENDENT CORPORATION

Finally, Mr. Chairman, as to the proposal for the transfer of authority for the hospital from the Department to an independent corporation, we have reviewed the draft staff proposal and in summary, we are opposed to it on four main points.

I think first that the hospital in the end is essentially a local mental hospital and continued Federal operation and control of it is not basically appropriate.

Second, the draft proposal does not provide for a single integrated administrative—a single mental health delivery system which would, we believe, be most appropriate for the District.

Third, we feel that it does not specify a plan for proceeding to continue the hospital's accreditation and finally, it does not specify hospital—how the hospital will be financed and how the present Federal support for the hospital might be phased out in some manner that would prove to be satisfactory and not detrimental to patient care.

These are my opening remarks, Mr. Chairman. If we may, I would like to ask Dr. Brown if he would care to amend them in some way.

Dr. BROWN. I would like to emphasize one point which has flowed through the morning, namely, how does one have a meaningful system over using the word system for inpatient outpatient care? If the proposal had been for an independent commission to deal with the total mental health system or the total system, it might have a different quality.

I think it was the philosophy of the Commission proposal. If that had been done, one major flaw in the bill might have been corrected. But it would leave the other problems that Mr. McKinney and others mentioned, about financing, funding, support, and the like.

Dr. DICKSON. Thank you, sir.

The CHAIRMAN. I think I am correct in observing that you gentlemen were here earlier during the testimony of Mr. Yeldell?

Dr. DICKSON. Yes, sir.

SEPARATE MENTAL HEALTH DEPARTMENT

The CHAIRMAN. I would like to get your comments with respect to the alternate proposal that he submitted this morning. He talked about establishing a separate mental health department.

Dr. DICKSON. I defer to Dr. Brown.

Myself, I don't really have any comment on that. I think the position of the Department is that that was a decision as to how that should be managed inhouse administrative is a decision to be made by the people of the District of Columbia.

The CHAIRMAN. I understand that but based upon your experience, Mr. Secretary, surely you have got some informal evaluations here of the concept. Surely that would not prevent you from making a comment.

For the record, we won't consider this the official position of HEW or the administration. But collectively at the witness chair we have people who have had experience with this matter.

I would also like to find out from Dr. Peele just what his views are, since he is the acting superintendent of the hospital.

Dr. DICKSON. I think I could say this.

Basically I don't feel it is a good thing to separate mental health administration away from a consideration of the administration of health in general. One of the reasons happens to be that we clearly live in a period when aspirations in a national sense and in a health

sense completely outdistance our resources and tough decisions have to be made with respect to health as a total entity. I don't find mental health considerations necessarily flourish the best if separated from overall administrative considerations of health in terms of the development of policy both for mental health in the District and for the setting of priorities for both health and mental health and the guidance of implementation.

That is the primary comment I would have to make.

Dr. PEELE. I will just make a brief comment and with all the risks attendant, as Senator Muskie said on the one hand, and on the other hand, as an administrator nationally, we are asked how you feel about a department of mental health vis-a-vis umbrella agencies.

I am appropriately cautious not to say one way or another. In terms of the needs of the mentally ill in the District, I am delighted by the shift of Mr. Yeldell, be it tactical or not.

Dr. PEELE. I would second Mr. Brown's support of Mr. Yeldell's shift.

The CHAIRMAN. Dr. Peele, would you care to make any other comments on any of the other testimony you heard this morning, as the person who has been most directly involved in this matter? The committee would particularly want to get your views on the record.

LEGISLATION PROPOSED

Dr. PEELE. The hospital has reviewed the proposed bill in some detail. First, I appreciate the opportunity to make some comments, and second, I would like to express the hospital's appreciation of the hospital committee's interest in the hospital.

The hearings in this committee of April 1975 were probably the most important positive public event for the hospital in this decade. Even though we cannot fully state our position on this bill because we do not yet know what other options are available to the hospital in detail, we do feel that the bill is clearly an attempt to enable the hospital to better service its patients.

AMENDMENTS PROPOSED

Again, without stating whether the hospital is in favor or against the bill, I would like if I may to make a few suggestions as to how we think the bill might be improved.

To avoid a sense of limbo that has been alluded to earlier this morning, we would like to see the language now indicate that the proposed corporation is perpetual and can only be modified or dissolved by an act of Congress. This would conclude the sense of limbo and postponement which has characterized the situation during the Nixon years.

We think that language should indicate that the President of the United States appoints the board members in consultation with the relevant congressional committees and the District of Columbia City Council. We think that the bill would be improved if there were language in it to guard against conflict of interest by indicating that board members should not hold District of Columbia or Federal offices while

on the board. We think the board should only be accountable to the President of the United States.

We think the bill would be improved if there were some provisions for resolving deadlock and tie votes and some indication whether proxy votes by board members are acceptable. We think the bill would be improved if the board members were paid executive board level.

We think the bill would be improved if the Federal Tort Claims Act were applicable to the corporation. That bill is quite clear as to our liability. The bill should also be clear as to our protection. We think the bill would be improved with language to indicate that future employees will have the same civil service status as present employees. Also there should be language to indicate that public health service officers may be assigned to St. Elizabeths Hospital.

We think the bill would be improved with language indicating that the board should be accountable for insuring that humane care is provided for those patients for whom the hospital is legally responsible. We prefer that to that listed in section 4(a) of the bill.

We think there should be lines to indicate the corporation will encourage collaboration with NIMH or other appropriate entities on matters of mutual interest.

There should be language recognizing the need for additional personnel required for assuming additional services currently provided to St. Elizabeths Hospital by the Department of Health, Education, and Welfare. We think that the bill would be improved if language were added which gave the superintendent authority to appoint such employees which may be necessary for the conduct of the business.

We think the bill should include language qualifying the Civil War cemetery at St. Elizabeths Hospital for receiving restoration funds under the act. We think there should be the power for the corporation to reimburse costs.

We don't have any expertise in appropriations issues, but we would wonder whether it might be useful to have it in the bill that it is the sense of the bill that the Government of the United States and the District of Columbia intend to make reimbursement and include a maximum figure.

I would thank you again for this opportunity.

The CHAIRMAN. Mr. McKinney?

Mr. McKINNEY. Thank you, Mr. Chairman.

FUNDS REQUIRED

Mr. McKINNEY. Mr. Dickson, how much money is it going to take to get St. Elizabeths back in shape?

Dr. DICKSON. We believe it will take up to \$100 million to remodel and carry out the construction that is necessary to have it perform the way it should.

Mr. McKINNEY. What to your way of thinking are the key factors in its losing its accreditation?

Dr. DICKSON. I think that the specific and immediate items had to do with failure of compliance with the Commission's regulations with respect to patient overcrowding, patient services, personnel levels, and so forth.

Mr. McKINNEY. In other words, basically budgetary problems?

Dr. DICKSON. Well, I think the main remedy for the problems—one of the main remedies is monetary.

Mr. McKINNEY. That is always the main remedy in this building. If it is overcrowding, lack of staff, and poor condition of the facilities, I have to assume it is lack of money that has caused the lack of accreditation. Wouldn't that be right?

Dr. DICKSON. I think that is one of the main reasons, yes.

EFFECT OF NONACCREDITATION

Mr. McKINNEY. In losing accreditation, what does this do as far as patient services are concerned?

Dr. DICKSON. There is an additional comment I would like to make with respect to what you just said. The hospital presently is accredited. It has not lost its accreditation.

Mr. McKINNEY. I know it is under appeal but there is a finite line. The people who say it should or should not have said it should not. It is under appeal.

Dr. DICKSON. It has not lost its accreditation.

Mr. FAUNTROY. Technically.

Mr. McKINNEY. Technically, I can always count on Reverend Fauntroy to come through. What has—

[Laughter.]

Mr. McKINNEY. What does lack of accreditation do to patient services?

Dr. DICKSON. What it does, it makes it difficult to attract a type of personnel you would like to have in the end both administering the services of the hospital and also providing the professional care that is desirable.

Dr. BROWN. What it does is hurt patient care in terms of what led to the disaccreditation itself. If there are inadequate buildings, whether it is accredited or not, there are inadequate buildings. Being formally discredited does have an impact on staff and the like. It has an impact on training activities.

Also perhaps most important in this day of dollars it has implications for garnering third party payments from medicare, medicaid and other financial resources.

Mr. McKINNEY. That was going to be my next question, how would this lack of accreditation affect the hospital's ability to collect Federal funds?

Dr. BROWN. In some cases it would be important. It would be minimal impact on medicaid. Medicare it might have some. It has not been a big issue for St. Elizabeths because the third party reimbursements come from the same Federal Government that appropriates the funds through HEW.

Mr. McKINNEY. And the same Federal Government is running the hospital. But this would not be true if the same Federal Government was not running the hospital.

Dr. BROWN. That is correct.

Mr. McKINNEY. I understand you to state that no transfer of this facility would take place until this facility were approved and accredited fully, not technically? Is that the administration's position?

Dr. DICKSON. Yes, sir.

Mr. MCKINNEY. Given the money falling from the ceiling here in great quantities, what is the first priority out at St. Elizabeths?

Dr. DICKSON. Well, we have been through—would you say the question again?

PRIORITIES AT ST. ELIZABETHS

Mr. MCKINNEY. Given the fact that the door opens and the money falls, what is the first priority at St. Elizabeths?

Dr. BROWN. Well, the first priority is well underway and I will defer quickly to Dr. Peele who has the ongoing daily responsibility. The first priority has been to get adequate housing and patient safety requirements so that there are reasonable living quarters for the patients.

A second requirement would be in the arena of patient services that relate somewhat to housing but are often over and above housing.

Dr. PEELE. I would agree with Dr. Brown. The first priority is to improve the safety of the buildings in which the patients are housed.

Mr. MCKINNEY. What is the average age of the buildings at St. Elizabeths?

Dr. PEELE. I don't know the average age but the vast majority were built before World War II and a large portion were built before World War I.

Dr. BROWN. If I could expand on that point, there is always a tendency I think in these settings to give St. Elizabeths, I think, worse marks than it deserves. Perhaps it deserves some and we are dealing with those issues and casting appropriate blame.

When St. Elizabeths came under the aegis of NIMH, there were 7,000 patients, a large majority of which were in buildings built before World War I. There has been perhaps more progress than the negative picture constantly brings out.

Mr. MCKINNEY. It is not my intention, believe me, to cast any more stones at St. Elizabeths. Enough have been cast in the 6 years I have been on this committee. My only intention is to No. 1 make sure that it is a functioning mental health institution, and how it can best function, No. 2.

Far more important, I think it is important that we don't receive a gift in bankruptcy. The Federal Government's magnanimous interest in home rule which I did not notice that week when the President signed something into legislation, I want to make sure we are getting something that is a functioning, operating, standup organization that will stand without driving the city budget into chaos.

HEW FUNDING FOR ST. ELIZABETHS

Dr. DICKSON. With respect to the commitment that we are making at the moment to remedy the problems you are addressing yourself to, I would like to make a couple of specific comments on that. The Department has reprogramed some \$1.2 million for the facility improvement funds to meet some of the deficiencies that do exist now such as fire safety, privacy, and services.

Of that in excess of \$100,000 is allocated for a planning study to determine the most effective deployment of facilities in order to

try and do something about the overcrowding and also the 1976 appropriation provides \$5.4 million to further try to correct deficiencies in safety, privacy, and service deficiencies that were identified by the Joint Commission.

The Department has also received some \$5 million in supplemental appropriations which are supposed to be directed toward deficiencies. The 1976 supplemental request also includes some \$350,000 to finance 104 positions at the hospital.

As I indicated before, in addition, the administration will shortly submit legislation for the authorization of appropriations up to \$100 million to get after the problems that exist with respect to remodeling and construction per se.

I think these things are necessary to gain not only accreditation but to set an environment that people of stature will be anxious to participate in either from an administrative or a professional point of view.

Mr. MCKINNEY. Just a tactical question. This is my last one. You don't have to answer if you don't want to. Should we just junk the whole hospital and start fresh somewhere else?

Dr. DICKSON. No, sir. There are people with a longstanding, serious commitment to the hospital.

Mr. MCKINNEY. I am talking facilitywise.

Dr. DICKSON. No, sir.

The CHAIRMAN. Mr. Fauntroy?

Mr. FAUNTROY. Thank you, Mr. Chairman.

I would like to pick up on the last question by Mr. McKinney. It relates to the possible placement of patients presently at St. Elizabeths in the community.

COMMUNITY ROLE

I wondered what role HEW is prepared to play in facilitating that process in order to comply, for example, with the *Dickson v. Weinberger* decision which, while it is on appeal, certainly seems to be consistent with what we have been saying about dispersal of these kinds of services into the community.

Dr. DICKSON. I believe this is a serious and a key question here. It reflects not only an attempt to get after the real needs of the situation but it reflects action taken to respond to the judge's decision. It reflects the nature of the commitment by the Department at this moment. I may say that in the funds up to \$100 million that we are proposing be authorized, that the first priority for the use of those funds would be for remodeling and construction of the hospital per se depending on what the needs prove to be there with this initial outlay.

It would be a second order of priority to get on with the establishment of community settings so that the patients could be cared for elsewhere than in the hospital environment itself.

So we, No. 1, recognize the need and, No. 2, are taking this step to move in that direction. I think it remains to be seen how much of that money would have to be spent on remodeling and construction of the hospital itself. As I say, that has first priority—

Mr. FAUNTROY. Would it make a difference if the entity to which the money is made available for programs for the community program were a department of the District government or an independent corporation such as is being considered in this bill?

Dr. DICKSON. I don't have anything further to say on that point beyond what I said before. My basic feeling about the administration as a personal comment is that I am not in favor of separating mental health administration from overall general health administrative efforts. But Dr. Brown and Dr. Peele may wish to comment.

Dr. BROWN. Your question is a good probe into the independent corporation vis-a-vis the Department of Mental Health as to how the money would be used. In my administrative thinking, this shows the floor of the bill, that if you were to have sufficient money available and there was a powerful independent corporation reporting to the President worked out and thought through, it clearly would give not only first priority to building on the hospital grounds but the only priority, if you see my point.

If you had an excellent Department of Health, with inpatient, outpatient community centers and what have you, it would balance out, the community care versus the inpatient care.

There would be an entity that could deal with that issue. So my answer would be that the independent corporation would be a poorer handler of the total needs of these kinds of funds.

NONACCREDITATION REPORT

Mr. FAUNTROY. Dr. Dickson, you mentioned in your statement on page 3 that the conclusions drawn by the survey team were unwarranted. You may have given some examples but I wondered if you would care to expand on that?

Dr. DICKSON. I would like to ask Dr. Peele to respond.

Dr. PEELE. We would be eager to submit for the record our total feelings about the JCAH survey and where we felt they were inaccurate. But I would like to say in general that we think that the criticism of the quality of the staff was markedly incorrect and that the training program at the hospital also compares favorably with other hospitals.

We feel that their remarks indicating that those programs were deficient, that these remarks were incorrect. We feel there are exaggerations in terms of their feelings about the services. If allowed to do so, we will submit a complete answer to that question.

The CHAIRMAN. Without objection, the record will be left open at this point so that such a response can be forthcoming.

[The material referred to follows:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
NATIONAL INSTITUTE OF MENTAL HEALTH,
Washington, D.C., October 1, 1976.

COMMITTEE ON THE DISTRICT OF COLUMBIA,
Longworth House Office Building,
Washington, D.C.

DEAR MR. HUGHES: At the September 14 and 15, 1976, Hearings, requests were made for Saint Elizabeths to submit additional information for inclusion in the record.

Attached you will find a document dealing with the Hospital's analysis of the Joint Commission on Accreditation's Report, and a listing of research projects approved at Saint Elizabeths since April 1975.

It is my understanding that this data fulfills the Committee's request for data that is to be supplied by Saint Elizabeths.

If further information is needed, please do not hesitate to get in touch with me at 574-7034.

Sincerely yours,

HAROLD A. THOMAS,
Special Assistant to the Superintendent.

ANALYSIS OF DISCREPANCIES IN THE JCAH SURVEY
REPORT OF SAINT ELIZABETHS HOSPITAL

The management of Saint Elizabeths Hospital does not concur with many of the findings and implied deficiencies contained in the report of the Joint Commission on Accreditation of Hospitals (JCAH). We feel that their recommendations are often vague, inconsistent and imply conditions and situations which are contrary to fact. The following paragraph outlines the position of the administration of the Hospital with specific examples of our differences with JCAH. To anticipate the following discussion, we feel the Joint Commission erred in three major areas: (1) they did not take sufficient note of the tremendous progress made by the Hospital since the 1973 survey; (2) the Hospital has some issues with its governing body which are unique and if properly weighed would warrant at least one additional year of accreditation; and (3) their recommendations are vague and their implications inaccurate. As an example of the latter, a recommendation that "all physicians on the medical staff should be licensed to practice medicine" implies that not all St. Elizabeths' physicians are licensed. In fact, they all are licensed and JCAH has since admitted their inaccuracy. Our position is that such a serious allegation to be made erroneously suggests a deficiency in the survey process.

We feel that recommendations characterized by unspecified quality or quantity statements without any indication as to the objective grounds on which they were made are vague. For example, what is "enough" or "sufficient?" In addition, there were inconsistencies between the comments of the surveyors at the wrap-up session and the list of recommendations. For example, at the wrap-up session, surveyors praised progress notes and nursing notes, but the list of recommendations cited these as deficiencies. Again, the implication of the recommendations were contrary to the findings of the surveyors. In fact, it appears to the administration of the Hospital that so many recommendations were listed so as to justify nonaccreditation by the sheer number of recommendations alone. Psychological services were in full compliance but had *nine* recommendations listed.

There are other important issues. First, there is no difference in the staffing, record keeping, or environment and safety between the Medical and Surgical component and the rest of the Hospital. How then does one account for non-accreditation for the rest of the Hospital and a one year accreditation for the Medical and Surgical Department? Second, the Hospital was exceptionally open to the surveyors. The surveyors saw and heard the basic problems in a manner uncommon in hospital surveys. Far from locking the closet, we paraded our skeletons before them. Given that openness, and since the essential difficulties of the Hospital were even then being discussed at higher levels of the governing body, we feel that the final one year accreditation would have sent the message home. Third, the uniqueness of the governing body of our institution, and the JCAH's relationship to that governing body, call into question the credibility of their findings. That relationship had been public knowledge for some time before the survey. The survey "discovered" a number of problems by reading official Hospital Work reports, those problems have existed for years, were known to previous surveyors, but did not result in loss of accreditation. It was when the JCAH was challenged by the Hospital's governing body that these problems became official deficiencies.

The Hospital's strongest disagreements with the JCAH are in the areas of patient treatment, medical staff, and medical records. (Those three areas plus safety and environment are considered the five major areas by the JCAH in deciding about accreditation. The many, many recommendations in the other areas are considered of less importance. This is another example where, in the opinion of the Hospital administration, the JCAH seemed to overload the number of recommendations in order to make a more massive document, even in areas of relative minor importance.) The most serious problem concerning patient treatment and medical records is the lack of documentation. In fact, over the last

two years there have been massive and major improvements in the Hospital in terms of documenting and individuating treatment plans. The Hospital agrees that these are not yet very sophisticated, but they did pass the much more stringent requirements of the Medicare surveyors, a fact of which JCAH was well aware.

Other recommendations concerning patient care and medical records provide further examples of implying situations contrary to fact. For instance:

1. "All personnel engaged in the therapeutic process should make entries in the medical record." That we are in full compliance was noted in the wrap-up.

2. "All entries in the medical records should be dated and authenticated." Again, the wrap-up session noted full compliance.

3. "The record should contain observations of patients." This is done thoroughly.

4. There were a number of inaccurate statements about the Medical Staff By-laws.

In fact, what is found is not an ideal situation, but compared with the situation at the time of the survey two years prior to this one (when one year accreditation was obtained) the Hospital has improved considerably and in comparison to other public hospitals is certainly no worse.

Environment is another area where many specific recommendations, for example those about crowding imply a situation contrary to fact. There is of course overcrowding in the Hospital. The Hospital has documented that fact and provided the documentation to the JCAH. However, the environment (especially privacy for patients) has been much improved over the past two years (a fact JCAH noted in the wrap-up) but yet this time around there is nonaccreditation, even where there is well documented improvement.

Finally in the safety area there is no doubt that the Hospital buildings do not meet the Life Safety Code standards. There is no doubt of this because the Hospital did its own survey in anticipation of obtaining funds to improve its facilities. The securing of funds was already in the works at the time of the survey, a fact which was made available to the JCAH and which they used as the primary reason for nonaccreditation. Now it is interesting that instead of giving one more year of accreditation, enabling the Hospital to make visible progress, the JCAH gave nonaccreditation around the very area in which there was an argument with HEW (that is the JCAH's failure to examine Life Safety Code issues closely enough).

There are other small areas, for example, mental health workers and nursing services were the Hospital and JCAH are in total disagreement. We feel we are in compliance in these areas. We feel we are appropriately staffed in social work. Written plan, policies and procedures are in existence. This list could go on, but this brief statement should give at least the flavor of our disagreements.

MARSHALL D. FITZ, M.D.,

Chief, Office of Quality Assurance, Saint Elizabeths Hospital.

Mr. FAUNTROY. Mr. Chairman, I have one final question and that again goes to the question of what the basic problem is. Yesterday, we attempted in questioning the panel from the Joint Commission on the Accreditation of Hospitals to determine whether or not the basic problem was money.

Quite frankly, contrary to the answer we received today, there was considerable representation that a major part of the problem was lines of authority, management, and as a matter of fact one witness yesterday stated that the management situation was so confused at one point that he did not know who to turn to to get a fire put out.

PROBLEMS AT ST. ELIZABETHS

To what extent—what is the situation in your judgment?

Dr. DICKSON. Well, I think one of the major things is we have a bifurcated administrative system at the moment as far as getting on with mental health problems in the District is concerned.

We have the Federal role on one hand exerting its leadership views or whatever and on the other side you have the community health services. I think that bifurcation, that split is basically an unhealthy and in the end unworkable situation, particularly as one gets after mental health in general, in terms of a comprehensive approach to it.

Dr. Brown?

Dr. BROWN. I would find it difficult without having been here, Mr. Fauntroy, to respond. I would say that saying money is the only problem is never correct. When there is a lack of money for long enough, one begins to get deficiencies in subparts of the situation that begin to affect others.

Money and the management situation are really parts of the same problem. It is obviously both some managements cannot operate if they don't have enough money, no matter how good they are.

Mr. FAUNTROY. Thank you, Mr. Chairman.

The CHAIRMAN. Does counsel have any questions?

APPEALS ON NONACCREDITATION

Ms. MARTIN. Thank you, Mr. Chairman. On page 3 of your testimony you say that you expect a final decision from the JCAH on the appeal to be made in December 1976.

Yesterday, we heard testimony from officials of this organization which indicated that you had already gone through three levels of appeal, I believe, and that they sounded pretty firm in their position.

I suppose they will be your adversary in the appeals process. What happens if in December 1976 your appeal is denied? I ask the question in the context of testimony yesterday that nothing can happen for 6 months if a hospital loses its accreditation.

RESURVEY REQUEST

Dr. BROWN. We have discussed this with the joint commission staff and we will request a resurvey or a site survey earlier than within 6 months with some fair chance of receiving that earlier attention. I can't speak for them because the appeals process is not over.

We are hopeful we can have a new look at our program earlier than 6 months. As you heard from Secretary Dickson, one of the basic issues is the overcrowding of the hospital facility, the construction of the buildings.

That is an overwhelming issue. By that time, I am certain there will be an administration bill that clearly proposes up to \$100 million, which is the kind of evidence that the Joint Commission on Accreditation insists on. They want that kind of promissory note.

Ms. MARTIN. I assume that their decision will be made on the evidence that was before them at the time of the review, and not on the basis of either the things you have listed on pages 3 and 4 and—or on the administration's bill.

Dr. BROWN. I thought your question was what would happen on the resurvey. The resurvey will be able to take into account the many factors that Dr. Dickson mentioned, the physicians, the personnel, the administration bill, the—up to \$100 million and on and on and all

the extraordinary improvements Dr. Peele has brought about in the last year.

APPROPRIATIONS

Mr. MARTIN. On page 4, you said that the Department has received \$5.4 million in supplemental appropriations. Did you ask for the supplement and do you plan to use any of it, all of it, or what?

Dr. BROWN. We did not ask for it but we were sure glad to get it.

Mr. MARTIN. Why didn't you ask for it?

Dr. BROWN. Because of the financial constraints of the Government economy impairing everybody's pocketbook.

Mr. MARTIN. How much of that do you plan to use?

Dr. BROWN. All of it.

Ms. MARTIN. How about the \$5.4 million?

Dr. BROWN. All of it.

Ms. MARTIN. How much of that did you ask for?

Dr. BROWN. We did ask for that \$5.4 million in terms of dealing with the 1974 accreditation problems.

Ms. MARTIN. The President's budget for fiscal 1976, I believe, contained a \$75 million—I don't want to use the word "request" because that is a little strong. It was more like an indication that \$75 million would be made available to St. Elizabeths. Whatever happened to that \$75 million?

Dr. BROWN. It metamorphasized into up to \$100 million.

Ms. MARTIN. Nothing happened during the present fiscal year?

Dr. BROWN. That is correct.

Ms. MARTIN. When do you plan to introduce your bill? Are you going to wait until have the decision of the accrediting association?

Dr. DICKSON. We are hopeful to have it up within the next 2 weeks.

RESEARCH PROGRAMS

Ms. MARTIN. To what extent has St. Elizabeths Hospital been used by NIMH for high level research purposes? To be more specific, could you give us a list of the research programs that are going on out there and the quality of the staff carrying it on?

Dr. BROWN. We will be glad to submit that for the record. There is a division that we call special mental health research which carries out basic studies in the chemistry of the brain. That is approximately a \$1 million budget with 80 or so staff. I think the staff is quite outstanding.

St. Elizabeths staff might also be called high level but not so basic. We could submit that for the record.

[The material requested follows:]

RESEARCH PROJECTS APPROVED AT SAINT ELIZABETHS HOSPITAL BETWEEN APRIL 1975 AND SEPTEMBER 1976

Submitted by: Luther D. Robinson, M.D., Acting Director, OTRD.

1. "Incompetents to Stand Trial at SEH. Judicial Safeguards or Commitment Violating Due Process."
2. "Effectiveness of Retrieval Cues in Marijuana and Alcohol Intoxication."
3. "Therapeutic Trial of Intravenous Synthetic Salmon Calcitonin in Affective Disorders and Psychoses With Affective or Periodic Components."
4. "A Clinical Trial of 7-hydroxychlorpromazine in Schizophrenic Patients."
5. "A Study of the Dangerousness of a Sample of Criminally Insane Patients as Assessed by Ward Staff—Applying a Conceptual Framework."

6. "The Motivation of the Premorbid-Dysfunctional Family to Seek Therapeutic Intervention."
 7. "Aversive Conditioning for Pseudo Petit Mal Seizure."
 8. "The Effect of Two Listening Plans on Attention and Information Processing: A Clinical Analogue."
 9. "The Health of Blacks in the Ante-Bellum South."
 10. "Evaluation of the Adequacy of Area A Community Mental Health Center Services Offered to Area A Residents Who Have Been Admitted and Discharged from SEH."
 11. "Laterality Effects and Marijuana Intoxication."
 12. "The Use of Lithium Carbonate in Combination With Other Neuroleptics in the Treatment of Schizophrenia and Schizo-Affective Psychosis."
 13. "Effect of Age-Segregation on Psychogeriatric Patients."
 14. "In Vivo Labeling of Biogenic Amine Metabolites With Oxygen 18 in Humans: A Pilot Study."
 15. "The Effect of the Doubling Technique on the Learning of Listening Skills."
 16. "Determination of Competency to Stand Trial: Practices & Processes at SEH."
 17. "An Analysis of Roles Within the Social Matrix of Both a Natural and a Psychodramatic Crisis Situation."
 18. "A Clinical Trial of Baclofen (Lioresal: CIBA-GEIGY) in Chronic Schizophrenic Patients."
 19. "A Cooperative Community Residence Within the Aftercare System: A Reasibility Study."
 20. "The Cutaneous Response to Intradermal Histamine in Schizophrenia."
 21. "A Functional Assessment of Virgin Islands Patients at SEH. The Use of Videotaped Interviews in Communicating the Progress of Virgin Islands Patients."
 22. "Biographical Search of Records of James Gilpatrick Blunt."
 23. "Incidence of Stress Diseases in Schizophrenics."
 24. "Testing for Heterozygosity (Carrier) for Phenylketonuria."
 25. "The Effect of a Social Living Class Upon Locus of Control in Elementary School Children."
 26. "Self-Disclosure of the Therapy Group Leader as a Means of Facilitating the Therapeutic Process."
 27. "The Effect of Psychodrama on Psychiatric Inpatient Initiative."
 28. "A Study of the Effects of Low Phenylalanine Diet in Chronic Schizophrenics."
 29. "Biofeedback Therapy: Two Clinical Trials."
 30. "The Use of "Nonverbal Doubling" To Increase Emotional Expressiveness in Schizophrenic Patients."
 31. "The Effect of a Psychodrama Group on the Self-Esteem of Hospitalized Patients."
 32. "Role Playing and Spontaneity in Teaching Social Skills to Deaf Adolescent Patients."
 33. "Socialization and Retention of Psychiatric Aide Trainees: A Feasibility Study."
 34. "Biographical Search of Records of Macon B. Allen, the First Black in the Legal Profession Who Died Here in 1894."
 35. "Therapeutic Trial of Oral Zinc Sulfate in Patients With Schizophrenic or Affective Psychoses."
 36. "General Informed Consent."
 37. "A Comparative Study of the Warming Up Process in Psychotic and Non-Psychotic Individuals."
 38. "Food Likes and Dislikes of Selected Groups of Patients in a Mental Hospital."
- The significant findings that have come from the Saint Elizabeths' research efforts over the past two years include:
- a. New Behavioral techniques for measuring human social interaction.
 - b. A better understanding of the negative and positive influences of Legal Service Patient Advocates on the Hospital wards with respect to the course of hospitalization for emergency admissions.
 - c. A better understanding of contestual and social factors associated with the occurrence of physical violence on the hospital wards between patient pairs.

Ms. MARTIN. Let me go back to the question about the bill you intend to introduce. Why are you submitting a bill 2 weeks before Congress is scheduled to adjourn?

ADMINISTRATION BILL

Dr. DICKSON. What we are trying to do is work as hard as we can within the executive branch process to get this bill out that has been promised before and that has not come up. I think we have to just keep pushing as hard as we can to get the thing out or else it—

Mr. MCKINNEY. Would counsel yield?

Ms. MARTIN. Yes.

Mr. MCKINNEY. Would it be correct that you are waiting for the Office of Management and Budget to move?

Dr. DICKSON. Not exactly. There have been interactions between our legislative staffs and the Office of Management and Budget. Those are in process.

Dr. BROWN. I would like to pick that up. This is one of those times I did—I can say where the Office of Management and Budget has not been the hand from above holding things back. A good part of this is the complexity, protecting the employees of the hospital so that when and if a transfer were to take place, their rights and prerogatives were protected. I would say the complexity has played a real heavy role in time.

Mr. MCKINNEY. That is indeed a historic occasion.

[Laughter.]

Dr. DICKSON. Also a final point to your question which is an important one, we are anxious also to get up here to have some physical evidence of the commitment beyond conversation.

TRANSFER CONDITIONS

Ms. MARTIN. In your discussion of your proposed draft, you place some prior conditions on the hospital or the situation of the hospital prior to transfer. Would you propose to place any prior conditions on the District government in terms of its operation or structure before such transfer would take place?

Dr. DICKSON. This matter has been under discussion for some time with Dr. BROWN and his group.

Dr. BROWN. I think there is no way we can give formal requirements of the District. This is something that might come before your committee as a legislative aspect of the transfer when and if it takes place.

I think that is why this morning we did hear Mr. Fauntroy and others highlight a very important shift in Mr. Yeldell's stance.

Ms. MARTIN. He was very clear that his change was on the basis of psychology and he would use the word "politics."

Dr. BROWN. Psychology plus politics equals program.

[Laughter.]

PERSONNEL BENEFITS

Ms. MARTIN. On page 8, you talked about the benefits that would be retained by the employees of the hospital. Will the employees of the hospital be satisfied with this arrangement to your knowledge?

Dr. BROWN. I will defer to Dr. Peele, but from 3 years as deputy and 6 as director, I would say for the most part they may feel that adequate staff work has been done for maximum protection but that they will not be satisfied.

Dr. Peele?

Dr. PEELE. I would agree with Dr. Brown's summary.

Ms. MARTIN. The day before yesterday I believe, or maybe it was 2 days ago, there was a job, at St. Elizabeths Hospital, regarding staff shortages. I wondered if it is your opinion that that job action was justified, unjustified, or what?

Dr. PEELE. The job you are referring to is the one on Monday morning in which two employees during their probation period were being evaluated by their supervisors who felt they should not be retained.

One of those is in the process of being reevaluated at the present time. We don't yet have a final decision on what we are going to do on that action. But the other one we did feel was quite proper on reevaluation and that the employee in question should not be retained.

Ms. MARTIN. My last question is this, Are there any facilities similar to St. Elizabeths Hospital under the jurisdiction of NIMH or HEW and is it in the same situation with respect to its accreditation?

Dr. BROWN. No.

Ms. MARTIN. Thank you. I might ask, Why?

Dr. BROWN. The two other facilities that we administered for many years, Fort Worth and Lexington, have been successfully transferred to the Bureau of Prisons.

Ms. MARTIN. The Federal Bureau of Prisons?

Dr. BROWN. Yes.

The CHAIRMAN. Lorton, here we come.

[Laughter.]

The CHAIRMAN. Thank you very much.

[Secretary Dickson's prepared statement follows:]

STATEMENT BY JAMES F. DICKSON III, M.D., DEPUTY ASSISTANT SECRETARY FOR HEALTH

Mr. Chairman and members of the committee: It is a pleasure to have this opportunity to provide the Committee with a status report on the St. Elizabeths Hospital and to preview for you the legislation we intend to submit to the Congress to transfer the Hospital from the Department of Health, Education, and Welfare to the District of Columbia Government. We also will briefly comment on your staff's informal draft of a bill to transfer authority of St. Elizabeths Hospital from HEW to an independent corporation.

Prior to a discussion of the Administration's proposal, let me briefly recount the organizational history of the hospital, and update certain pertinent information which we offered this Committee in April 1975.

BACKGROUND OF ST. ELIZABETHS HOSPITAL

St. Elizabeths Hospital was established by the Congress in 1855 as a public health facility for psychiatric care of beneficiaries of the Federal government and residents of the District of Columbia. Prior to 1940, the hospital was organizationally located in the Department of the Interior. Since 1940, St. Elizabeths Hospital has been a part of the Department of Health, Education, and Welfare, and its predecessor, the Federal Security Agency.

St. Elizabeths Hospital provides mental health services to approximately 3,000 outpatients and 2,500 inpatients. Virtually all the outpatients and more than 85 percent of the inpatients are D.C. residents. In addition, the Hospital has gained an international reputation as an outstanding facility of mental health-

related training, as well as for pioneering in the adoption of new methods in the treatment of psychiatric disorders.

HOSPITAL ACCREDITATION

Accreditation and the order of the U.S. District Court for the District of Columbia in the *Dixon v. Weinberger* case are two of the many issues related to the Hospital which have recently generated considerable interest and activity within this Department. Both issues are of importance to the Department, and we believe that it would be appropriate at this point to briefly discuss the developments to date.

The 1973 and 1974 Joint Commission on Accreditation of Hospitals (JCAH) reports granted St. Elizabeths Hospital one year accreditations in order that the Hospital could initiate corrective measures to enable it to gain full two year accreditation. However, in 1975 the Commission's report stated that the Hospital was to be disaccredited, citing, among other reasons, noncompliance with Commission standards in the areas of overcrowding of patients, patient safety, inadequate personnel levels, and patient services. We have subsequently discussed the disaccreditation decision with the JCAH, and we have appealed the decision to withdraw accreditation from the Hospital. The appeal was based on our belief that a number of the conclusions drawn by the Survey Team were unwarranted. We are now following the procedures of the appeal process, and during this period the hospital retains an accredited status. We expect a final decision from the JCAH on the appeal in December 1976.

HEW RESPONSE TO DISACCREDITATION REPORTS

Since the JCAH survey and reports on the Hospital, the following actions have been taken:

This Department has reprogrammed \$1.26 million of the facility and improvement funds to meet some of the critical deficiencies in the safety, privacy and services areas of which \$125,000 is allocated for a planning study to determine the most effective deployment of facilities in order to relieve overcrowding;

The 1976 appropriation provides \$5.4 million to correct deficiencies in patient safety, privacy and services identified in the 1974 JCAH survey report;

The Department has received \$5.2 million in supplemental appropriations to correct additional deficiencies in patient safety identified by the 1975 Commission survey and to develop plans and specifications for construction or remodeling of facilities to relieve overcrowding;

The 1976 supplemental request also contains \$375,000 to finance 104 positions at the Hospital; and

In addition, the Administration will shortly submit legislation to transfer the Hospital to the District of Columbia and—as part of the transfer legislation too—authorize appropriations of up to \$100 million to construct and remodel facilities to relieve overcrowding as well as complete essential work in areas of patient safety and privacy.

RECENT COURT DECISIONS

In the *Dixon v. Weinberger* case, a class action suit was initiated on behalf of several named plaintiffs and approximately 1,300 other St. Elizabeths Hospital patients who have been or will in the future be recommended for placement in alternative care facilities in a less restrictive environment than St. Elizabeths Hospital.

With respect to the "overcrowding" concerns and the need for an aggressive outplacement program expressed by JCAH, on December 23, 1975, Judge Robinson issued the following decision:

The Court has ruled that (1) the 1964 Hospitalization of the Mentally Ill Act requires that patients confined in St. Elizabeths Hospital pursuant to the Act receive suitable care and treatment under the least restrictive conditions, (2) the District of Columbia and the Federal defendants have a joint duty to provide such care and treatment where appropriate, and (3) this duty has been violated by the failure to place plaintiffs and members of their class (inpatients at the Hospital who have been determined suitable for placement in less restrictive alternatives to the Hospital, as it is

presently constituted, such alternatives including but not being limited to nursing homes, foster homes, personal care homes, and half-way houses. We are meeting with officials of the District to establish responsibilities and duties pursuant to the judge's order in the *Dixon* case. Although this matter is still before the courts, we believe that progress to assure appropriate care for the 1,300 D.C. residents will be made as a result of the court order.

ADMINISTRATION'S PROPOSAL

In the near future, the Administration will propose legislation to the Congress to transfer St. Elizabeths Hospital to the District of Columbia. Presently, District of Columbia residents comprise an overwhelming majority of the hospital inpatient population, and all of its outpatients are District of Columbia residents. St. Elizabeths Hospital serves primarily as a local mental institution.

With the enactment of the District of Columbia Self-Government and Governmental Reorganization Act, continued Federal operation of St. Elizabeths Hospital, primarily for the benefit of the District of Columbia, is wholly inappropriate. The proposed transfer reflects our view that the Hospital should be controlled and supported at the local level, serving the people of the District of Columbia as an effective and important part of a single mental health services delivery system. This would be in keeping with the modern practice of comprehensive programs for mental health care, which include: inpatient services, outpatient services, day care, emergency services, and consultation and education in a unitary, community-based system. It is our belief that the transfer of the Hospital to the District Government, with adequate Federal funding to support corrective actions, is the most judicious approach to the myriad problems and issues surrounding the Hospital.

Our bill would (1) set a future date for transfer, contingent upon accreditation, (2) maintain the Federal subsidy at fixed percentage until two years after the transfer date and gradually reduce the subsidy over a thirteen year period, and (3) authorize appropriations of \$100 million for construction and/or renovation of mental health facilities connected with St. Elizabeths Hospital, taking into consideration the needs of the District of Columbia.

The transfer would be effected on September 30, 1979, or the 120th day following accreditation of the Hospital by the Joint Commission on Accreditation of Hospitals, whichever is later. This provision is to assure that the Hospital is improved so as to regain accreditation before its transfer to the District of Columbia, and to provide sufficient time for joint planning by the Department of Health, Education, and Welfare and the District Government.

The transfer would alter the Hospital's obligation to care for Federal beneficiaries, for whom the Federal government would reimburse the Hospital for its costs.

Employees of the Hospital at the time of the transfer would be transferred with the Hospital, and those with competitive status would retain the protection of that status or the equivalent status in the District Government merit system. In addition, all positions at Hospital would continue to be or would be established in the competitive service or the District Government's merit system unless excepted as provided by title 5 of the United States Code or other law.

COMMITTEE LEGISLATIVE PROPOSAL

We have examined the staff's proposal to transfer "exclusive authority over St. Elizabeths Hospital" from the Department of Health, Education, and Welfare, to an independent Federal corporation. Sole management responsibility for the Hospital is to be vested in a five-member board of directors, to be appointed in part by the Secretary of the Department of Health, Education, and Welfare, and in part by the District of Columbia. The Board would assume all functions of the Secretary with respect to St. Elizabeths Hospital and appoint the Superintendent of the Hospital. A separate entity would operate the community mental health center currently within the Hospital. The bill vests all real property of the Hospital in the corporation. Upon receipt of the National Capital Planning Commission land use plan, the Board may sell or lease any St. Elizabeths Hospital land or buildings deemed to be unnecessary for the operation of the Hospital.

The bill specifies a number of reports to be prepared and transmitted by the Board to the Congress, the Department of Health, Education, and Welfare, and

the District of Columbia. The bill does not otherwise specifically delineate the precise responsibilities of the corporation or the Board to either the Department of Health, Education, and Welfare, or the District of Columbia. Moreover, the bill does not specify how the operating expenses and capital expenditures for the Hospital are to be financed.

OPPOSE LEGISLATIVE DRAFT

We oppose enactment of the legislative draft we have reviewed for the following reasons:

Control of the Hospital.—The District of Columbia—and not an independent Federal corporation—should have the authority and responsibility for managing a facility which primarily serves the needs of District residents. The Hospital is essentially a local mental hospital and continued Federal operation and control is unwarranted.

Integration of District Mental Health Services.—The establishment of an independent Federal corporation would not ameliorate the problems of the Hospital and may even exacerbate them. An independent corporation would create an additional administrative layer, fragmenting planning for and implementation of programs to meet District mental health needs. Progressive principles and policies of mental health delivery—enunciated in Federal and State statutes and in JCAH standards—specifically requires an integrated approach to mental health services. Moreover, this bill is not in keeping with Federal and District Government policy to seek the establishment of a single administrative community mental health delivery system for the District of Columbia under local government jurisdiction.

JCAH Accreditation of the Hospital.—Unlike the Administration proposal, this bill does not specify a plan for obtaining JCAH accreditation for the Hospital.

Financing the Hospital's Operating Expenses and Capital Improvements.—Unlike the Administration proposal, this bill does not specify how the Hospital is to be financed and how the Federal support for the Hospital is to be phased out, over time, with the assumption by the District of its financial responsibility for the Hospital.

In summary, we believe that substantial progress has been accomplished in working with the District Government to develop an Administration proposal to transfer an accredited St. Elizabeths Hospital to the District of Columbia before 1980. In our view, this is the appropriate and responsible course of action.

Thank you for the opportunity to share our views with the Committee on this most important matter. My colleagues and I would be pleased to answer any questions you or members of the Committee may have.

The CHAIRMAN. The Alliance for Psychiatric Progress is a panel represented by Dr. Essex C. Noel III, the president, and Dr. Martin Booth, member. Would you please come forward?

You may proceed, gentlemen.

STATEMENT OF DR. ESSEX C. NOEL III, PRESIDENT, ALLIANCE FOR PSYCHIATRIC PROGRESS

Dr. NOEL. Thank you, Mr. Chairman. Dr. Booth is the vice president of the Alliance for Psychiatric Progress. Mr. Chairman, members of the House District Committee, counsel for the committee, staff, and friends, on behalf of the Alliance for Psychiatric progress, an organization of mental health professionals concerned with mental health affairs in the Washington area, I wish to express the sincere appreciation of our membership for the interest and concern that you are showing for mental health programs benefiting our citizens.

We share that interest and concern and thank you very much for giving us the opportunity to participate in your planning for the future of St. Elizabeths Hospital.

We hope that our testimony on this vital subject will prove useful and valuable in your work, and that you will not hesitate to call on us if we can be of further service.

RECOMMEND MENTAL HEALTH SYSTEM

The alliance feels that this is a critical moment for the future of mental health programs in the District of Columbia and that the decisions made at this time are all important in launching the type of mental health system that we all would like to see.

You will note our use of the term "mental health system," for this term will recur frequently throughout our presentation. We stress mental health system because we recognize that there are at present several components of a mental health system existing which should be brought together and fused into a single unified and unitized system to serve our communities with policies and procedures that are consistent and coordinated.

The Alliance for Psychiatric Progress recognizes St. Elizabeths Hospital as the most important potential component of such a system as we envision. We would propose that it be viewed as the central hub of a system like unto a giant wheel covering the District of Columbia with four spokes radiating out into the communities as the four community mental health centers in health areas A, B, C, and D.

Such a system would eliminate forever that sense of isolation that has characterized mental hospitals in the past, and would provide for a flow of the system's services from that central hub out into the patient's home community so that his return into society would be gradual and supportive as opposed to bidding him goodbye at the hospital's front door.

The community mental health centers would provide for him, and for his community, the full range of essential services required by NIMH, but this time as extensions of one unified system instead of the dual structures that currently exist.

Mr. Chairman, the opportunity is at hand. The District of Columbia is an ideal laboratory in which to construct a model mental health system. St. Elizabeths Hospital is our single State hospital and can be merged into the system with minimum difficulty as compared to a State with a number of State hospitals.

We think you will agree that a model system is possible, and that it would have great value as a demonstration model for the Nation. It should continue to work closely with NIMH to test and develop and demonstrate new treatment methods and modalities, and to develop a training center of international stature.

DISTRICT GOVERNMENT ACTION NEEDED

The question is asked, "What should the District of Columbia do to prepare for the transfer?" At present, the Superintendent of St. Elizabeths Hospital reports to the Director of NIMH, and the Administrator of the Mental Health and Developmental Disabilities reports to the Director of the Department of Human Resources.

The alliance respectfully submits that the District of Columbia should establish a Department of Mental Health and Developmental Disabilities, appoint a Director with the experience, training, vision,

and enthusiasm to lead this department and have these elements merged together under an appropriate organizational superstructure.

This department would be accountable to the executive and legislative branches of the government of the District of Columbia—that is, to the Mayor and the City Council—would be represented on the Mayor's cabinet, and would be required to provide an annual report.

The alliance supports the concept of home rule for the District of Columbia, and feels that the functions of its government should remain organizationally accountable to the citizens through their duly elected representatives, the Mayor and the City Council.

We think such a department would meet this objective better than a separate government body, be it an authority or a corporation. We fear that this trend will weaken our young city government, and erode away its potential before it has a chance to grow.

We will not bother to expand on our reasons for opposing any proposal to transfer the hospital to the District of Columbia Department of Human Resources, as this should be self-evident. We do support both the Medical Society of the District of Columbia, and the Medico-Chirurgical Society of the District of Columbia in their position that all of health should be separate from the Department of Human Resources.

SEPARATE ENTITY REQUIRED

Under our proposed Department of Mental Health, St. Elizabeths Hospital would maintain the maximum autonomy and, in fact, would utilize its existing organizational elements to form the basis of the new department.

Personnel, budget, payroll, maintenance, and other existing functions would thus remain in this mental health system and no employee would worry that he would ever be assigned duties outside his own system.

In effect, Mr. Chairman, St. Elizabeths Hospital would thus become the Department along with the elements of the District's Mental Health Administration, as it already has a structure equivalent to a city department.

From the standpoint of cost effectiveness, considerable savings can be anticipated by the elimination of the expensive duplication perpetuated under dual systems. We would have the current Mental Health Administration moved physically to the central hub that I mentioned before at St. Elizabeths Hospital, along with the Department superstructure, thereby saving large rentals.

From the standpoint of program effectiveness, there is wide agreement that a single, unified system is much to be preferred over a dualistic system, and that functioning on the program delivery level is greatly enhanced when there is one policy source.

The alliance favors a single step transfer of all facilities, programs, and personnel of the hospital and the Mental Health Administration to the Department of Mental Health rather than suffer the uncertainties of a phased or delayed step-by-step approach.

FUNDING

Funding and support of the training and research activities should continue under NIMH, and the Director, who preceded this presenta-

tion, has previously indicated his willingness to support training there indefinitely.

That figure was derived from the budget item that the counsel to the committee had mentioned earlier in the President's 1976 budget proposal. Of course, I was delighted to hear the representatives of the National Institutes of Mental Health present a more realistic figure of \$100 million.

That should be established for physical plant improvement, and full accreditation by the JCAH should be a condition of the transfer.

Federal support of the operation of the hospital should continue for a minimum of 15 years according to an acceptable percentage formula.

ORGANIZATIONAL STRUCTURE

Finally, Mr. Chairman, may we commend to you for your most serious consideration the following position statement on organizational structure of State mental health programs approved by the board of trustees of the American Psychiatric Association just last year.

A state mental health program can function most effectively when there is a separate and easily identified organizational component such as a Department of Mental Health with full responsibility for the program.

The Director of the Mental Health Program should be a qualified psychiatrist with an appropriate administrative background, and he should have a qualified business administrator as one of his principal assistants.

The Director requires authority commensurate with the responsibility and accountability of the position.

Direct access to the governor and to the legislature is necessary for the director to adequately perform the duties of his position.

The organizational placement of state services for the mentally retarded as a separate program or as a program combined with mental health services is most appropriately determined by consideration of the size and complexity of the program for the mentally retarded.

This then is the official position of America's oldest and most eminent psychiatric association. The Alliance for Psychiatric Progress supports this position and believes the District of Columbia should do the same.

A discussion draft of proposed legislation containing the elements in which we believe is attached for your review.

Thank you.

[The document referred to follows:]

A BILL To establish a Department of Mental Health and Developmental Disabilities as a Department of the government of the District of Columbia, to transfer Saint Elizabeths Hospital to the District of Columbia Department of Mental Health and Developmental Disabilities, and for other purposes

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

TITLE I—DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

Sec. 101. Establishment of the Department of Mental Health and Developmental Disabilities.

There is hereby created an agency of the government of the District of Columbia to be known as the District of Columbia Department of Mental Health and Developmental Disabilities (hereinafter in this Act referred to as "the Department"). The Department shall have jurisdiction over all District of Columbia

facilities, personnel, programs, activities, and other functions pertaining to the mental health and developmental disabilities of the citizens of the District of Columbia, as provided in this Act.

Sec. 102. Definitions.

(a) The definitions set forth in this section apply for the purposes of this Act.

(b) The term "mental health" shall include all aspects of mental illness, alcoholism, drug addiction, and similar or related emotional and mental problems.

(c) The term "developmental disabilities" shall include mental retardation, cerebral palsy, epilepsy, and all other developmentally related neurological deficits which adversely affect the individual to the degree that treatment or rehabilitation is required.

(d) The term "Secretary" means the Secretary of Health, Education, and Welfare; and

(e) The term "Mayor" means the Mayor of the District of Columbia.

Sec. 103. Director, Department of Mental Health and Developmental Disabilities.

(a) The Department shall be under the exclusive supervision and control of a Director of Mental Health and Developmental Disabilities (hereinafter in this Act referred to as "the Director") to be appointed by the Mayor of the District of Columbia, who shall execute and enforce all laws and regulations relating to mental health and developmental disabilities, and carry out the functions and duties of the Department as set forth in this Act.

(b) The Director shall be a physician with a current and unrestricted license to practice the Healing Arts in the District of Columbia. He shall have established eligibility or certification as approved by the American Board of Psychiatry, Incorporated, and shall have a minimum of five (5) years of administrative experience with mental health facilities or agencies, or have documentation of equivalent administrative training acceptable to the U.S. Civil Service Commission.

(c) The Director shall devote full-time to the duties of this office, and may make or retain such professional or such academic affiliations as may be desirable as a part of such duties.

(d) The Director, under the general administrative supervision of the Mayor, shall establish such organizational components as he may deem necessary and appropriate, and thereafter may alter, change, or modify such components in conformance with approved District of Columbia policies.

(e) Except as otherwise provided, and subject to applicable laws, rules, regulations, and Mayor's Orders or Directives issued pursuant to Mayor's Orders, the Director shall have full authority over the Department and all functions, resources, officials and personnel assigned thereto including the power to redelegate authority and assign functions in such degree as is necessary to establish and maintain efficiency and good management.

(f) The Director shall be responsible for the accomplishment of all appropriate statutory and regulatory duties that are imposed by applicable laws and regulations of the Federal agencies concerned, and will be designated as the signatory authority for all functions pertaining to "single state agencies" and "state plans" within the Department. In this capacity he is assigned the operating responsibility of the Department of Mental Health and Developmental Disabilities as pertains to P.L. 79-725, P.L. 88-164, P.L. 88-577, P.L. 90-174, P.L. 91-211, P.L. 88-597, P.L. 91-490, P.L. 90-452, P.L. 91-517, P.L. 91-616, P.L. 92-255, and Public Laws concerning mental health and developmental disabilities as may be enacted by the Congress.

(g) The Director is responsible for proposing, developing, and administering a comprehensive mental health program for the prevention, treatment, and rehabilitation of mental illness and developmental disabilities, for the administration and direction of all program components included in this Act, and for the provision of: (1) community-based mental health and developmental disabilities programs; and (2) patient facilities, both open and with security, for short-term, chronic, and long-term hospitalization.

Sec. 104. General Provisions.

(a) All the powers and duties, including policy-making functions, pertaining to mental health and developmental disabilities vested in other District of Columbia Departments and Agencies, and in Federal Agencies specifically affected by this

Act, are hereby transferred to and vested in the District of Columbia Department of Mental Health and Developmental Disabilities.

(b) All the powers, duties, functions, and responsibilities pertaining to mental health and developmental disabilities assigned to other District of Columbia or specifically affected Federal officials on the effective date of this Act are hereby transferred and assigned to the District of Columbia Department of Mental Health and Developmental Disabilities.

(1) Section 6-101 of Title VI of the District of Columbia Code is hereby amended by inserting after the phrase "public health and vital statistics" the phrase "but excluding all laws and regulations relating to mental health and developmental disabilities."

(2) Commissioner's Order No. 69-96, dated March 7, 1969, as amended, is further amended as follows:

(a) By adding at the end of paragraph 2 the following: DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

(3) Paragraph 4 of Commissioner's Order No. 69-96, as amended, designating the Department of Human Resources responsibility for "institutional care for the mentally ill and retarded" be deleted, inserting in lieu thereof the phrase "but excluding all other aspects of mental health and developmental disabilities."

Sec. 105. Transfer of Agencies from Department of Human Resources to Department of Mental Health and Developmental Disabilities.

(a) Department of Human Resources Organizational Memorandum No. 12 dated November 5, 1970, Subject: "Establishment of the Mental Health Administration" is hereby rescinded, and those parts of all Department of Human Resources Orders, Directives, and Instructions issued pursuant thereto as pertains to the Mental Health Administration are hereby cancelled.

(b) The functions and activities listed below are transferred to the Department of Mental Health and Developmental Disabilities upon the effective date of this Act:

1. The Mental Health Administration;
2. The Narcotics Treatment Administration.

(c) All positions, personnel, properties, records, and unexpended balances of appropriations, allocations, and other funds available or to be made available relating to the above functions are hereby assigned to the Department of Mental Health and Developmental Disabilities.

(d) The duties, powers, and authorities of all officials and personnel of these agencies as they existed immediately prior to the effective date of this Act, are hereby assigned to the Department of Mental Health and Developmental Disabilities.

Sec. 106. Transfer of Facilities from the U.S. Department of Health, Education, and Welfare to the District of Columbia Department of Mental Health and Developmental Disabilities.

(a) The functions and activities listed below are transferred to the Department of Mental Health and Developmental Disabilities upon the effective date of this Act:

1. Saint Elizabeths Hospital;
2. The Area "D" Community Mental Health Center.

(b) All positions, personnel, properties, records, and unexpended balances of appropriations, allocations, and other funds available or to be made available relating to the above functions are hereby assigned to the District of Columbia Department of Mental Health and Developmental Disabilities.

(c) The duties, powers, and authorities of all officials, personnel, and other staff temporarily or permanently assigned to these facilities as they existed immediately prior to the effective date of this Act are hereby assigned to the District of Columbia Department of Mental Health and Developmental Disabilities.

(d) Transfer of Saint Elizabeths Hospital, and the Secretary's Function Respecting it, to the Mayor:

(1) The Secretary's function of supervising the administration of Saint Elizabeths Hospital, including the authority delegated by Section 3(2) of Executive Order 11609, (36 F.R. 13747) (July 24, 1971) pertaining to the establishment of per diem rates for care, is hereby transferred to the Mayor (or the official designated by the Mayor). To the extent necessary or ap-

propriate to perform these functions, the Mayor may exercise, after the transfer, any authority available by law to the Secretary prior to the transfer.

(2) *Statutes Affected.*—For the purpose of effectuating the transfer of function, the Mayor shall, upon the transfer succeed to the authority of the Secretary under the laws governing Saint Elizabeths Hospital, which shall include, but not be limited to—

1. Sections 4839, 4851, 4852, and 4858 of the Revised Statutes (24 U.S.C. sections 165, 211, 211a, and 170, respectively);
2. the Act of June 23, 1874, 18 Stat. 251 (24 U.S.C. 212);
3. the Act of June 30, 1906, 34 Stat. 697, 730 (24 U.S.C. 177);
4. section 1 of the Act of June 12, 1917, 40 Stat. 105, 179 (24 U.S.C. 196);
5. the Act of October 6, 1917, 40 Stat. 345, 373 (24 U.S.C. 200);
6. the Act of March 6, 1920, 41 Stat. 503, 513 (24 U.S.C. 176);
7. the Act of June 5, 1920, 41 Stat. 874, 920 (24 U.S.C. 166);
8. the Act of July 18, 1940, 54 Stat. 766 (24 U.S.C. 196b);
9. the joint resolution of May 9, 1941, 55 Stat. 186 (24 U.S.C. 180);
10. the Act of November 7, 1941, 55 Stat. 760 (24 U.S.C., sections 181, 182, 183, and 184); and
11. the Act of August 4, 1947, 61 Stat. 751 (24 U.S.C. sections 169a, 135, and 195a).

(3) *Transfer of Property.*—Effective upon the effective date of the transfer, there are also transferred to the District of Columbia all right, title, and interest of the United States in certain lands in the District of Columbia, together with all buildings and improvements thereon and, except as may be otherwise provided, all personal property used in connection therewith (as determined by the Secretary) known as Saint Elizabeths Hospital.

(4) *Implementing Agreement.*—Prior to the effective date of the transfer, the Secretary and the Mayor shall enter into an agreement containing—

(A) a description of the boundaries of the land transferred by paragraph (3);

(B) an inventory (in such detail as the Secretary and the Mayor may agree) of the other property transferred by paragraph (3);

(C) a specification of the financial obligations of Saint Elizabeths Hospital respectively assumed by the Secretary and the District of Columbia upon the transfer;

(D) the agreement of the Mayor to receive at the hospital beneficiaries of the Federal Government on a basis that would reimburse the hospital for its costs in connection with such beneficiaries;

(E) such other terms and conditions, consistent with this Act, as the Secretary and the Mayor deem appropriate.

(5) *Transfer of Unexpended Balances.*—Effective upon the effective date of the transfer, all unexpended balances of appropriations, allocations, and other available funds of the hospital, including funds appropriated for construction of buildings and facilities thereof, are transferred to the District of Columbia for use as provided by law in the operation of the hospital, except to the extent required to meet obligations already incurred and not assumed by the District of Columbia.

(6) *Provision for Employees of Saint Elizabeths Hospital and the Area "D" Community Mental Health Center.*—Each person employed by the hospital on the day before the effective date of the transfer shall be transferred in his position, and shall retain all of the rights, benefits, and privileges pertaining thereto held prior to such transfer, consistent with applicable U.S. Civil Service rules and regulations, wherever located in the government of the District of Columbia.

(7) *Transitional Payments.*—There are authorized to be appropriated to the Secretary, to enable the Secretary to pay to the District of Columbia part of the cost of operating and maintaining the hospital during the period of its integration into the programs of the District of Columbia Department of Mental Health and Developmental Disabilities—

(A) for the first fiscal year beginning after the fiscal year of the transfer, an amount not exceeding 68 per centum of the costs of the hospital, nor less than 63 per centum, not otherwise met, for the preceding year (adjusted to take into account the rate of inflation).

(B) for each of the next four fiscal years, the amount determined under paragraph (A), adjusted to take into account the rate of inflation; and

(C) for each of the second five fiscal years beginning after the transfer, an amount not exceeding the following percentages of the amount determined under paragraph (B) for the last year referred to therein:

1. 84 per centum for the first such fiscal year,
2. 68 per centum for the second such fiscal year,
3. 52 per centum for the third such fiscal year,
4. 36 per centum for the fourth such fiscal year, and
5. 20 per centum for the fifth such fiscal year.

(8) *Renovation of Hospital.*—For the fiscal year of the transfer, and for each fiscal year thereafter, there are authorized to be appropriated to the Secretary, for transfer to the District of Columbia for expenditure under the direction of the Mayor (or the official designated by the Mayor) to renovate Saint Elizabeths Hospital, such sums as may be necessary for the construction of buildings and facilities, including the purchase or fabrication of equipment, and for remodeling of existing buildings (including repair and replacement of equipment), except that the aggregate of such appropriations and the amounts transferred for these purposes may not exceed \$48,000,000.

(9) *Forgiveness of Prior Debt.*—Upon the effective date of the transfer, the proviso to the item captioned "SAINT ELIZABETHS HOSPITAL" in the Department of Health, Education, and Welfare Appropriation Act, 1955 (68 Stat. 443), is repealed. Obligations that would accrue, and be payable by the District of Columbia, under such proviso for the fiscal year of the transfer and for fiscal years beginning thereafter, are forgiven. Amounts paid by the District of Columbia in full or partial discharge of any such obligation in the fiscal year of the transfer shall be refunded to the District.

(10) *Continuity for Prior Agency Action.*—All orders, determinations, rules, regulations, permits, contracts, certificates, licenses, and privileges:

(A) which have been issued, made, granted, or allowed to become effective in the performance of the function transferred in this Act; and

(B) which are in effect upon the effective date of the transfer, shall continue in effect according to their terms until modified, terminated, superseded, set aside, or resolved by the Mayor or other authorized official, or a court of competent jurisdiction, or by operation of law.

(11) *Claims and Pending Proceedings.*—No suit, action, or administrative proceeding to which the Secretary is party, nor any claim against the Secretary, respecting the functions transferred by this Act, shall abate by reason of the transfer. Such suit, action, or administrative proceeding shall be continued as though this Act had not been enacted, but with the District of Columbia substituted for the Secretary. Such claim, if in contract and if filed after the transfer, shall be brought against the District, in lieu of the Secretary, and shall be governed by such procedures as may then apply to claims against the District of Columbia in like cases. Such claim, if in tort and if arising before the transfer, shall not be brought against the District.

TITLE II—ADVISORY COUNCIL

Sec. 201. Establishment of the Advisory Council.

There is hereby established an Advisory Council for Mental Health and Development Disabilities (hereinafter in this Act referred to as "the Council") which shall consist of fifteen (15) members.

Sec. 202. Membership of the Council.

(a) The Director of the Department of Mental Health and Developmental Disabilities and his immediate predecessor, if available, shall be members of the Council Ex Officio.

(b) The remaining members of the Council shall consist of the original selectees of the Psychiatric Advisory Council to the Mental Health Administration of the District of Columbia Department of Human Resources, their elected successors, and such other members as may be duly selected by the Council to complete its membership roster.

Sec. 203. Organization and Functions of the Council.

(a) The Advisory Council shall have complete freedom over its organization and composition as established by its Constitution and By-Laws, and may appoint such standing and special committees from time to time as it may deem necessary and desirable.

(b) The Council shall meet at the call of its Chairman, but not less often than four (4) times a year.

(c) The Council shall, from time to time, make recommendations to the Director with respect to overall planning and policy, and the objectives and priorities of all District of Columbia mental health and developmental disabilities programs.

Sec. 204. Compensation and Expenses.

Members of the Council (other than members who are officials or employees of the United States or the District of Columbia) shall, while serving on business of the Council, be entitled to receive a per diem allowance at rates not to exceed the daily equivalent of the rate authorized for grade GS-18 of the General Schedule, with each day or major portion thereof considered a full day. Each member of the Council, while so serving away from the District of Columbia may be allowed actual travel expenses and per diem in lieu of subsistence as authorized by Section 5703 of Title V of the United States Code for persons in the Government service who are employed intermittently.

TITLE III—TRAINING CENTER

Sec. 301. Establishment of the District of Columbia Mental Health Training Center.

(a) The Director, in cooperation with the National Institute of Mental Health, Area Medical Schools and other acceptable training facilities, shall establish a District of Columbia Mental Health Training Center (hereinafter in this Act referred to as "the Center"). The Center shall develop, conduct, and support a full range of training programs relating to mental health and developmental disabilities. The Director shall supervise the construction and operations of the Center, and shall be responsible for its policies and directions. It is the intent of this Act that the Center shall be developed on the campus of Saint Elizabeths Hospital.

(b) The Center shall conduct or arrange for training programs, seminars, meetings, conferences, and other related activities, including the furnishing of training and educational materials for use by others.

(c) The services and facilities of the Center shall, in accordance with regulations prescribed by the Director, be available to:

1. Federal, State, and local government officials, and their respective staffs,
2. medical and paramedical personnel and educators, and
3. other persons requiring training or education in mental health and/or developmental disabilities, and related disciplines.

(d) Existing training and research programs of Saint Elizabeths Hospital, the National Institute of Mental Health, area universities, and other training facilities may jointly participate in the programs of the Center as a District of Columbia Mental Health Training Consortium as proposed by the National Institute of Mental Health.

(e) The provisions of all titles, sections, and parts of this Act become effective on the ninety-first day after enactment of this Act.

The CHAIRMAN. Thank you, Doctor. Mr. McKinney?

SEPARATE CORPORATION

Mr. MCKINNEY. Doctor, we have had some discussion today that we set up a separate corporation, a nonprofit corporation and other suggestions have been made. Do you really think a politician can run a hospital?

Dr. NOEL. The answer, sir, is in the negative. I don't think politicians can or should wish to run hospitals. I think this is properly the province of those individuals who are trained both from the program and professional standpoint and also have the necessary adminis-

trative skills to fuse these programs and administration in an effective unit.

Mr. McKINNEY. Now, I will put that in a subtle form. Do you think that by making this a political entity of government that there is a danger that political considerations will come before patient considerations?

This is vis-a-vis budget, personalities, and so forth.

Dr. NOEL. I would opt for a situation where these problems would be less likely to exist. However, recognizing the realities of the situation, funding comes from above and the politicians are involved with this.

We would hope to generate their support. But in direct response to your question, I do not feel that it is proper for politicians to attempt to operate a hospital of this complexity or any other hospital or any other discipline which is as esoteric as psychiatry and mental health is.

Mr. McKINNEY. Though certainly not in the field of mental health, I was—I guess I had the experience of being ranking member of the Committee that took up New York City's past and complex problems. One of the things that was so interesting to us was the tremendous dichotomy between the private/nonprivate hospital in New York City and the city administered hospitals in utilization and priorities and building care and hall days, as they are called, and so on and so forth.

It gave me some concern that perhaps politics enters into the decisionmaking that should not have any politics in it. For instance, New York City's hospital delivery care has turned into not a patient delivery problem but a political problem.

This is the kind of thing that bothered me. You don't think that that would be necessarily a problem?

Dr. NOEL. Mr. McKinney, I am glad that you brought up the hospital and health cooperation of the city of New York. I don't believe that there could have been a better illustration introduced as to the type of chaos and unworkable situations that result.

I happen to know Dr. Lolliman who is the president of that situation and I talked to him several weeks ago in Nashville, Tenn., at the National Medical Association convention.

It is just nearly an unworkable situation. We feel that it should be part of the operational/organizational structure of the government of this jurisdiction.

Mr. McKINNEY. Well, we can always hope for better days.

The CHAIRMAN. Mr. Fauntroy?

Mr. FAUNTROY. Thank you, Mr. Chairman.

Dr. Noel, let me say to you how grateful I am for the very detailed and I think precise testimony you have given in support of a position which certainly is appealing to me. I would like you to be a little more specific on identifying the several components which are now dispersed within DHR which should in fact be brought together under this unified and, as you say, unitized system.

Would you care to comment from your own knowledge of the DHR?

DISTRICT ORGANIZATIONAL SET-UP

What components should be taken from under the authority of the Director and, as you say, brought together and fused into this single system?

Dr. NOEL. Yes, sir, Mr. Fauntroy. I will be happy to answer that question. But as a preface to that, I suppose I should introduce some background information that I had thought was irrelevant, really, for this presentation.

I suppose you should be made aware that when the Mental Health Administration was established within the Department of Human Resources on November 5, 1970, under Organizational Memorandum No. 12, I was appointed by the Mayor of the District of Columbia as its first Director. In that capacity, a position that I held for nearly 2 years, I assembled and organized the present Mental Health Administration.

I established all of its bureaus and wrote the organizational memorandums which brought them into existence. So I am quite closely familiar with each of the components that exists within the District government.

They consist of a Bureau of Alcoholism, a Bureau of Developmental Disabilities which is located within the Mental Health Administration, and which has the responsibility for the operation of Forest Haven and for other programs designed to assist those with developmental disabilities.

It also contains a Bureau of Community Mental Health Services under which are located the three community mental health centers operated by the District of Columbia government; namely, areas A, B, and C.

As I am sure you already know, area B is located physically upon the campus of St. Elizabeths Hospital in the Dix Building and is operated by the Federal Government. Also within that Bureau of Community Mental Health Services is the Suicide Prevention and Emergency Consultation Services and a small unit located out at Glenndale Hospital which has the responsibility of providing mental health services for those patients located there.

So I think all of these elements that compose the District's Mental Health Administration including the Bureau of Development Disabilities in this instance should be transferred to this proposed new department that I have attempted to describe for you.

In addition to that, eventually, it is my belief that the Narcotics Treatment Administration which has to do with substance abuse but which also impacts upon the mental health of the individual should properly be located within this new department.

Mr. FAUNTROY. Thank you, Dr. Noel. Thank you, Mr. Chairman. The CHAIRMAN. Counsel?

Ms. MARTIN. Thank you, Mr. Chairman.

Dr. Noel, in light of your feelings about home rule and self-determination, do you feel that it is appropriate for this committee to undertake the task of reorganizing an agency of the city government?

We do have exclusive jurisdiction over St. Elizabeths Hospital. But we have heard lots of testimony about the need to intergrate these programs. Is it appropriate for this committee to draft legislation that would in effect reorganize an agency of the city government?

DISTRICT GOVERNMENT'S JURISDICTION

Mr. NOEL. I think not, Ms. Martin. I think this is a proper function of the government of the District of Columbia and more specifically I think it is a function of the legislative branch. There is a branch within the City Council which is the legislative branch of the District Government headed by Dr. Arrington Dixon, which is the committee on governmental operations or governmental affairs.

I am not sure I have the exact title. But I think it is proper for the District government through its legislative activities to introduce the legislation necessary to establish this department. In other words, as I said before, the question has come up just what exactly should the District do in preparation for the transfer.

This is what I think it should do. I don't think that that is the responsibility of your committee. I certainly think that your committee should oversee and make sure that there is a cooperation between those elements in such draft legislation.

Of course, the draft legislation that I have attached here I would hope that the City Council would at least review and consider as a possible guide or at least to consider some of the elements in preparing the legislation under which it would establish such a department.

There is also another alternative. I do believe that the executive has certain organizational powers by which this group could also be used. But one way or the other, I think it should be done by the city government.

DISTRICT COMMITTEE'S FUNCTION

Ms. MARTIN. You think this committee should take no action with respect to St. Elizabeths Hospital until the District government, either the legislative or the executive, has taken some action.

Dr. NOEL. No; I do not. I gather that your mission and your activity at this time is a fact finding serving one engendered through your interest in this overriding problem, and hoping to develop a system which will more adequately serve the needs of the citizens of this community.

There are other elements of course, but I certainly think that the committee should proceed forward with what it is doing. It is listening to testimony and I think it should properly involve itself with its oversight of the hospital and at the same time, simultaneously, I think the District should get out of its lack of action and get busy and prepare.

I think, really, that it is most unfortunate that the preparations have not been made in the past. I think planning should be done years ago and that this planning should have been coordinated with St. Elizabeths and its plans so that when the move is finally made, the planning will have been established prior to the execution.

PROBLEMS AT ST. ELIZABETHS

Ms. MARTIN. What types of problems would you envision in coordinating treatments and other services with the District government if the hospital were an independent corporation as contemplated by the staff draft?

Dr. NOEL. We would experience the same difficulties that we are experiencing day by day at present. My present assignment is that of a clinical psychologist working with emergency mental health services. While we have a great deal of cooperation and understanding from the authorities at St. Elizabeths Hospital, still when we get down to the program delivery level where the peons, like myself, are trying to solve the problems we are faced with at 2 or 3 o'clock in the morning, there is certain territoriality that comes into effect.

Because of this, there are many instances in which patients are ping-ponged back and forth. I think that if there were a central policy source, that these things could then work in one system where I feel that if we set up a separate corporation, we are going to perpetuate the same system with the same problems as are in existence at the moment.

I am talking about the mundane problems that exist at the program delivery level.

RECOMMENDATIONS RE ST. ELIZABETHS

Ms. MARTIN. You said you were the first Administrator of the Mental Health Administration. In that capacity, did you ever have occasion to think about how St. Elizabeths Hospital ought to be incorporated into the total system? Do you have a plan in your bottom drawer?

Dr. NOEL. Yes, indeed.

Ms. MARTIN. Would you share it with us so we can perhaps share it with the District government?

Dr. NOEL. Therein lies a story. In 1972, during my tenure first as the Mayor appointed me and later as I was renamed Administrator, I established liaison with the Director of the National Institutes of Mental Health who presented me with what I thought was the most exciting support that could be imagined.

We wanted to go about systematically developing a plan. But we have limited resources. He was willing to provide through an existing contract the services of a management and consulting firm that would have helped us work out a plan that could have evolved and been changed as necessary with changing conditions where we would have been prepared and the planning would have been a matter of record to perform this activity.

But, unfortunately, we were not permitted to proceed with that.

Ms. MARTIN. Not permitted by whom?

Dr. NOEL. Well—

Ms. MARTIN. If you don't feel free to answer, it is all right.

Dr. NOEL. I don't mind answering your questions, Ms. Martin. This fact was presented to the Director with a request for approval so that I could proceed with Dr. Brown's help and the helpful management consulting firm.

But for reasons that I am sure were crystal clear to the executive direction and support of the department, this was declined. A memorandum was sent to me to that effect.

Ms. MARTIN. If you still have a copy of that, I am sure—well, it is not a public document but if you don't consider it privileged communication, I think the committee would be interested to know why several years ago when there was an opportunity to work out a plan to

transfer St. Elizabeths Hospital to the District government free to the District and with some expertise that that did not come about.

Dr. NOEL. This can be found in the Archives—in the files of the present Mental Health Administration.

The CHAIRMAN. Thank you, Doctor. I have no further questions. Dr. Simon, please come forward. The gentleman approaching the witness chair is Dr. Gottlieb C. Simon, chairman of the Public Affairs Committee of the District of Columbia Mental Health Association.

May I also ask for Dr. Ives, past president of the District of Columbia Psychological Association? I am going to ask her to step up also and the gentlewoman approaching the other witness chair is Dr. Margaret Ives. Do you have any of your colleagues, either one of you, that you wish to sit with you?

We have testimony submitted in advance by Dr. Simon that we have had an opportunity to review. We were also provided this morning with testimony from Dr. Ives which we note is very similar to some of the principal points made by the Acting Director of St. Elizabeths, Dr. Peele.

So we are going to without objection place her full statement in the record.

After Dr. Simon makes his remarks, then I will recognize Dr. Ives.

STATEMENTS OF DR. GOTTLIEB SIMON, CHAIRMAN, PUBLIC AFFAIRS COMMITTEE, DISTRICT OF COLUMBIA MENTAL HEALTH ASSOCIATION, AND DR. MARGARET IVES, PAST PRESIDENT, DISTRICT OF COLUMBIA PSYCHOLOGICAL ASSOCIATION, ACCOMPANIED BY DR. F. J. PEPPER, IMMEDIATE PAST PRESIDENT, THE MEDICAL SOCIETY OF ST. ELIZABETHS HOSPITAL

Dr. SIMON. My statement is brief and I will try to stick somewhat closely to it in order to keep from wandering over the broad front that has been extended this morning.

We are here today to comment on proposed legislation which would transfer authority for St. Elizabeths Hospital to an independent, government corporation.

We believe that the value of this proposal lies in its utility in resolving the serious problems currently and persistently enveloping the hospital. To the extent that creation of a hospital corporation contributes to the dissolution of these difficulties it deserves our support; to the extent that it does not, other alternatives must be sought.

PROBLEMS AT HAND

The first step then is to list the problems. And the second step is to measure the degree to which a corporate superstructure reduces or eliminates these problems. Our list of problems includes the following:

Hospital buildings require extensive renovation and repair to assure patient safety.

The quality of care does not fully meet professional standards.

A large proportion of hospital residents are inappropriately hospitalized.

Facilities for youth are inadequate.

Old people are subjected to abuse and even death.

JCAH has recommended removing the hospital's accreditation.

The reputation of the hospital locally and nationally is in decline.

Staff morale is low and recruitment more difficult.

The future of the hospital remains in limbo.

Hospital services are poorly coordinated with D.C. government mental health services.

We have asked ourselves which of these problems might be solved, or at least, made less intractable by transferring the hospital from the Department of Health, Education, and Welfare to an independent corporation.

Ironically, this proposal does not even clear up the central, troubling issue of the hospital's future since the corporation board would be required to recommend possible future increases in control over St. Elizabeths Hospital by government of the District of Columbia; so here again the issue of control would once again be postponed and uncertainty allowed to continue.

FINANCING

The question then is what is the problem to which the corporation is a solution?

It has been noted that the superintendent of SEH is at the low end of the HEW totem pole, subordinate to the Director of NIMH, the Administrator of ADAMHA, and the Secretary of HEW, and it appears that the SEH budget has not emerged unscathed running this gauntlet to OMB.

This problem would be solved if the hospital were transferred since it would submit its budget directly to OMB. This assumes that OMB would provide a more sympathetic hearing than HEW does. Perhaps it would. But certainly a powerful case has not been made that this would be so.

And we are not convinced that SEH will enjoy significantly greater visibility and attention if it is put in the same class with such well known Government corporations as the U.S. Spuce Production Corporation, the Inter-American Navigation Corporation, or Warrior River Terminal Company.

In any event, the hospital's problems are not exclusively financial. The inability of hospital and District of Columbia officials to coordinate their services to provide adequate continuity of care, a serious problem, is not caused by the hospital's location on HEW's organizational chart, and it won't be solved by making the superintendent responsible to a corporation, either private or Federal.

We are concerned that the proposed transfer will not improve conditions at the hospital or its budget. We fear that the transfer may result in the hospital becoming a bureaucratic bastard with no clear organizational parentage or patronage.

OPPOSES HOSPITAL TRANSFER

Accordingly the District of Columbia Mental Health Association continues to oppose the transfer of the hospital to an independent, government corporation—or to the District of Columbia government—until its accreditation problems are fully solved and all existing deficiencies have been corrected.

Let me add, however, that we are not opposed to the draft bill in its entirety. The idea that the hospital should be required to develop a comprehensive plan for its programs, provide semi-annual reports on its operations, and that SEH and District of Columbia officials should meet regularly is excellent—we suggested something similar in our testimony before the committee in April 1975.

These innovations, though, can all be enacted without also creating a hospital corporation, and we encourage the Congress to do so.

In summary, we do not believe that a case has been made for the appropriateness of a corporation as a solution to St. Elizabeths Hospital's current problems. We therefore oppose transferring the hospital from the executive branch of the Federal Government.

QUESTIONS RE DRAFT LEGISLATION

We have not given deep consideration to some of the aspects of and details of the corporation because we were not persuaded that that was the direction to go in. I would say, however, that we found the concept of the hospital corporation as outlined in the draft proposal—and I realize it is a discussion draft—one requiring some additional clarification.

Let me give you some indications of what those might be. The Board of Directors of the TBA to which allusion has been made as a possible model are prohibited from engaging in any other business. What would be the status of the hospital corporation board members?

What would be the conditions under which they might be removed from office and by what means? Might there be some opportunity for citizen recall petitions should that be deemed appropriate?

Personnel policies of the corporation once the corporation has gone into effect are somewhat unclear. Presumably there would be some helpful language regarding the need for its decisions to be made on merit and that it would be prohibited from using political influence in its personnel decisions.

Issues also relate to competitive bidding, a host of similar issues of this sort and I think it would be helpful to consider were the corporation concept to be pursued but we are opposed to that.

ST. ELIZABETHS HOSPITAL TRANSFER

We adamantly oppose the transfer of the hospital, therefore, until the following conditions can be met.

(1) correction of existing deficiencies; such as management, programs, staffing and physical facilities and the achievement of full, unqualified accreditation.

(2) assurance of continued federal funding at adequate levels through direct grants, budgeting or other arrangements.

(3) continued availability of Public Health Service personnel in the overall comprehensive mental health delivery system.

(4) protection of employees of St. Elizabeths Hospital and all other mental health facilities and services in order that their status not be jeopardized or downgraded in any way with regard to salaries and retirement benefits.

(5) development of a viable plan of orderly transfer of control to the District of Columbia.

Thank you.

The CHAIRMAN. Thank you very much.

Dr. Ives, do you have supplemental views?

Dr. Ives. I was surprised since I had not consulted with Dr. Peele, but we apparently had similar sources, that there was so much overlap. However, the first part of my presentation I think, is the more important part.

[Dr. Ives' prepared statement follows:]

My name is Margaret Ives; I am the immediate past president of the District of Columbia Psychological Association, which I represent here. It happens that I was on the staff of Saint Elizabeths Hospital as a psychologist for thirty years, from 1943 to 1973 and was in charge of the Psychology Branch for 21 years.

The proposed Bill to establish an independent corporation with exclusive authority over Saint Elizabeths Hospital raises the possibility of a welcome change from the present situation and may provide an opportunity to bring the Hospital back to its former position of excellence, leadership, and national and international acclaim. In my testimony of April 1975 before this Committee, I reported that as late as 1968, at the twentieth anniversary celebration of the World Federation for Mental Health, the founding of Saint Elizabeths Hospital was acclaimed as the outstanding accomplishment of the United States of America in the field of mental health in the nineteenth century. Yet in less than ten years its reputation has fallen to the point where it has lost its accreditation as an adequate hospital.

Something must be done. It seems to me that it is important to the United States to be known for the excellence of this, its federal hospital, to which in the past students from all over the world came for training. This Bill raises again the hope that perhaps the United States does consider it important to demonstrate its excellence and competence in this very important area of mental health.

The Hospital has not been well served by the stewardship of the National Institute of Mental Health. During the first hundred years of its existence, there were five superintendents of Saint Elizabeths Hospital, of outstanding reputation, chosen under the final authority of the President of the United States. In the last fourteen years there have been four superintendents, if one counts the present acting superintendent. The Hospital has lost its accreditation, its buildings are deteriorating, staff morale is low, and there is difficulty in recruiting competent new staff. It is my understanding that the yearly budget proposed by the Hospital, which used to go directly to the Bureau of the Budget, has been in the past few years delayed at the NIMH level, so that it never reached the Bureau of the Budget at all.

On the other hand it is well known that the District of Columbia, while interested in the Hospital, is engaged to the limit of its resources in an attempt to modernize and improve its services to needy citizens. Community Mental Health Centers, institutions for dependent and delinquent children, jails and prisons, hospitals, and other institutions are all in need of its attention and assistance. The addition to its load of a large mental hospital which has lost its accreditation would be a disaster. Yet at the present time the large majority of the patients at Saint Elizabeths are residents of the District of Columbia.

AMENDMENTS PROPOSED

Therefore the proposal of an independent corporation with representation from both the Federal Government and the District of Columbia has much merit. However in order that the Board may better accomplish the desired renaissance, the following suggestions are offered:

1. To assure continuity of patient care and treatment, as well as to enhance staff morale and encourage recruitment of outstanding people, it should be stated that the Corporation is perpetual, to be modified or dissolved only by an act of Congress. (Section 2)

2. The ultimate authority of the Federal Government should be restated and should include the involvement of the President of the United States, as in the past. The President, in consultation with relevant Congressional Committees and with the D.C. City Council, should appoint the Board members. (Sec. 2(b)).

3. The Board should be ultimately accountable only to the President. To guard against conflict of interest, Board members should not jointly hold other Federal or D.C. positions.

4. It should be made clear that the Federal Tort Claims Act applies to the Corporation.

5. Provision should be made for resolving deadlock within the Board with indication as to whether proxy votes will be acceptable.

6. Sec. 3(d) (page 8) ensures that present Saint Elizabeths Hospital employees will retain their rights under Civil Service. It is equally important that such assurance to be given to future employees if recruitment of outstanding staff is to be facilitated. The availability for assignment to the Hospital of Public Health officers should be continued. They have been of great help in the past.

7. Sec. 4(a) (page 9) of the Bill, in addition to providing for training and research, should include a statement that the Board will be accountable for ensuring humane and effective mental health treatment at the Hospital for those patients for whom it is legally responsible.

8. It is suggested that the Superintendent be given authority to appoint the additional personnel necessary to provide the services now given by DHEW. Also he should be given authority to recruit such employees as may be necessary for the conduct of business in accordance with this Bill.

9. In implementing the provisions under Sec. 4(b) (1) (page 10), it is suggested that the Corporation be given power to bill users and to set reimbursible rates.

10. It is suggested that under the Act to provide for the preservation of historic American sites, the Civil War cemetery at Saint Elizabeths Hospital be qualified to receive such funds.

In conclusion, may the Corporation and the employees of Saint Elizabeths Hospital be reinforced and encouraged in the conviction that Saint Elizabeths is a federal hospital dedicated to providing a standard of excellence and competence for all to follow.

Respectfully submitted,

MARGARET IVES, PH. D.,
Past President,

District of Columbia Psychological Association.

Dr. IVES [continuing]. I do feel that I should reiterate the fact that I think a corporation with representations from both the District and the Federal Government would form an excellent alternative to either the Federal Government or the District alone in command.

In that way, it would seem to me, contrary to what some of the people have said, there would be an opportunity through the corporation for much better coordination of the Federal Government with the District than there is if these are separated.

I also want to stress the fact that this idea of the President having something to do with the whole situation which did obtain during the 100 years of St. Elizabeths existence when the hospital was so universally acclaimed abroad and in the United States nationally and internationally, and I see no reason why if both Roosevelts could help with the appointment of a commission or a corporation why it can't be done again and why we can't therefore have a situation in which the person who is in charge at St. Elizabeths Hospital is sponsored by the highest authority.

I think the rest of my statement, as I say, has been presented very well by Dr. Peele. I think that is enough for me to say.

The CHAIRMAN. Thank you very much, Doctor. Mr. McKinney?

Mr. MCKINNEY. No questions.

The CHAIRMAN. Does counsel have any questions?

OPPOSES TRANSFER OF ST. ELIZABETHS

Ms. MARTIN. Just one question. On page 3 of your testimony, Dr. Simon, you say that we fear that the transfer may result in the hospital becoming a bureaucratic bastard. Don't you think that is what it already is?

I have the feeling that HEW as indicated in their own testimony, is not requesting appropriations. It is being pushed on them by the Appropriations Committee. Is your association satisfied with the existing arrangement?

Dr. SIMON. The association is not satisfied with the existing arrangement. We are not satisfied with the history of NIMH's stewardship of the hospital. We recognize that to some extent those are problems that have been exacerbated by an unsympathetic executive department, by an unsympathetic Office of Management and Budget which has taken the attitude that repair and maintenance of the hospital is unnecessary since it will be shortly thrust upon the backs of the citizens of the District of Columbia.

We feel that the precipitous decision to transfer the hospital in 1969 unilaterally by the Secretary of HEW, I understand, in an effort to meet staffing attrition requirements led to a rather demoralizing impact upon NIMH's interest in helping fulfill its mandate of turning the hospital into a model situation, of turning a State mental hospital into a community oriented mental health facility.

We are not persuaded, however, that orphaning the hospital and putting it in competition with the departments would measurably improve its situation. But I would offer this suggestion. It would be instructive, I think, were we able to determine the extent to which NIMH had not forwarded the hospital's original budget requests over the last 5 to 10 years.

Ms. MARTIN. Assuming the hospital is accredited at some point, would your organization feel the same way about this draft legislation?

Dr. SIMON. Our fundamental position is that the hospital should not be transferred to anybody until the Federal Government has fulfilled its manifest responsibilities for bringing it up to an adequate mental health facility.

We are at the same time very much concerned that the District citizens have available to them a unified mental health system. We are between a rock and a hard place on these questions.

Ms. MARTIN. Assuming it meets those concerns of yours, then what would your suggestion be done with the facility? It is a good facility with accreditation in place.

Dr. SIMON. The association's board of directors has taken the position it will not take a position at this time on the future arrangements that may be made.

The CHAIRMAN. Thank you very much. The committee stands adjourned.

[Whereupon, at 12:10 p.m., the committee adjourned subject to call of the Chair.]

[Subsequently, the following material was received for the record:]

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

[Civil Action No. 74-2851]

WILLIAM DIXON, ET AL., PLAINTIFFS

v.

CASPAR WEINBERGER, ET AL., DEFENDANTS

OPINION

This class action is brought by District of Columbia residents who are patients confined pursuant to the 1964 Hospitalization of the Mentally Ill Act, 21 D.C. Code § 501, *et seq.* (hereafter referred to as the 1964 Act), in St. Elizabeths Hospital, a federally administered mental institution located in Southeast Washington. The defendants include the federal officials responsible for the administration of St. Elizabeths Hospital and District of Columbia officials responsible for implementation of the provisions of the 1964 Act. The case is currently before the Court on Plaintiffs' Motion for Partial Summary Judgment, the Federal Defendants' Motion for Summary Judgment and the District of Columbia Defendants' Opposition to Plaintiffs' Motion.

A wealth of material has been presented to the Court for assistance in resolving the motions currently pending. Although plaintiffs raise both statutory and constitutional grounds for the relief sought, the Court concludes that the statutory grounds are sufficient for resolution of this matter and this discussion is confined accordingly. The current motion is brought by the class of plaintiffs comprised of inpatients confined pursuant to the 1964 Act. In the estimation of the Hospital's clinical staff, approximately 43% of these inpatients currently require care and treatment in alternative facilities. Alternative facilities are defined as including but not limited to nursing homes, personal care homes, foster homes and halfway houses. Simply stated, the plaintiffs seek a judicial declaration that under the 1964 Act they have a right to treatment which includes placement in facilities outside St. Elizabeths Hospital where such placement is determined to be consistent with the rehabilitative purposes of the 1964 Act, that the federal and District of Columbia governments have a joint duty to provide for such treatment where appropriate, and that this duty has been breached because there are numerous individuals in the Hospital who have been determined in need of placement in alternative facilities but who have been denied due to a lack of same. Plaintiffs ask that this Court require defendants to initiate a plan for the development of alternative facilities and the placement of appropriate individuals therein.

Both governmental defendants oppose the requested relief. The District of Columbia defendants challenge the contention that the plaintiffs' right to treatment includes placement in alternative facilities, and, alternatively, argue that even if such a right exists, the responsibility for meeting the requirement is upon the federal government, and not the District of Columbia. The federal defendants on the other hand, deny that plaintiffs have met the burden of establishing their right to such treatment and vigorously dispute their responsibility for providing the facilities in which plaintiffs seek placement.

After extensive review of the pleadings and the record in this case, the lengthy legislative history of the 1964 Act, and the cases of this jurisdiction which have fleshed out the language of the statutory provisions in question, the Court concludes that plaintiffs' position is the correct one. In reaching this conclusion, the Court has considered two issues: Whether the right to treatment mandated by the Act includes the outpatient placement these plaintiffs seek, and if so, whether the federal or District governments, or both, are responsible for providing such facilities and effecting placement therein. The following discussion details these two considerations.

The first question is whether the 1964 Act mandates the type of treatment plaintiffs seek. The fundamental goal of the 1964 Act was to return the mentally ill through care and treatment to a full and productive life in the community as soon as possible, given the patients' conditions. To implement this broad goal, Congress established a statutory right "to medical and psychiatric care and treatment." 21 D.C. Code § 562. This language has been interpreted as requiring governmental authorities with respect to each patient to make a "bona fide" effort "to

provide treatment which is adequate in light of present knowledge," and which must be "suited to his particular needs" as determined by a frequently evaluated, individually tailored, program. *Rouse v. Cameron*, 373 F. 2d 451 at 456 (D.C. Cir. 1966).

The purpose of the Act and the judicial recognition of its broad mandate are not in issue. Further the defendants do not dispute that St. Elizabeths Hospital staff are responsible for making care and treatment decisions regarding patients on the Hospital's rolls and for decisions that determine status as inpatients or outpatients. Nor do they dispute that the Hospital staff has determined that plaintiffs' treatment needs include placement outside the Hospital. Yet defendants construe the above cited statutory language and the cases of this jurisdiction to conclude that plaintiffs are not entitled to the treatment sought by this action.

The District of Columbia defendants argue that 21 D.C. Code 545(b) which requires judicial consideration of any "alternative course of treatment which the Court believes will be in the best interests of the person or of the public" should be applied only at the commitment stage (as the statutory scheme indicates) and not expanded to the treatment stage. These defendants assert this position despite judicial determination that "[t]he principle of least restrictive alternative is equally applicable to alternative dispositions within a mental hospital," *Covington v. Harris*, 419 F. 2d 617, at 623 (D.C. Cir. 1969), and despite a declaration that "deprivation of liberty solely because of the dangers to the ill persons themselves should not go beyond what is necessary for their protection." *Lake v. Cameron*, 364 F.2d 657, at 660 (D.C. Cir. 1966). These defendants construe these cases narrowly and contend that only persons criminally committed who seek removal from maximum security are entitled to considerations of "least restrictive alternatives."

The federal defendants take a rather different approach. They do not dispute the fact that least restrictive alternatives must be considered in making treatment choices. However, the defendants contend that plaintiffs have failed to meet their burden of establishing that placement in the alternative facilities sought by this action is a less restrictive environment than hospitalization at St. Elizabeths for these plaintiffs. This argument is based upon the allegation that the plaintiff class includes individuals whose serious medical needs makes placement in an alternative facility most difficult.

The Court finds these arguments without merit. The District of Columbia defendants' position is totally unjustified in light of the statutory language and its legislative history as recognized in the case law. And the federal defendant's contention goes more to the allocation of responsibility in an individual case, and not to the question of whether the placement is required under the Act.

The extensive legislative history of the 1964 Act as recited by plaintiffs, reviewed by the Court and referred to at length in *Rouse, supra*, clearly indicates that the "medical and psychiatric care and treatment" mandated by the Act must be broadly construed. And the record before the Court in this case convincingly demonstrates that "suitable care and treatment in light of present knowledge" includes placement in alternative facilities in numerous instances. Thus, under the statutory language as interpreted, these plaintiffs have a right to the treatment sought in this action where the Hospital has determined that such treatment is appropriate.

The underlying controversy in this case, however, arises from the statutory creation of a right to the best possible care and treatment for the mentally ill without the delineation of the responsibility for providing the full range of care and treatment mandated. The fact that Congress did fail to definitely assign responsibility makes this Court's decision a more difficult one. The statutory language clearly mandates a right to treatment for patients. And the legislative history is replete with discussions of the likelihood of placement in facilities less restrictive than a mental hospital where such is determined to be appropriate treatment. Yet a delineation of responsibility for patient needs during the course of a treatment program was only mentioned as a potential bottleneck due to the financial interrelationship between the Hospital and the District, and was deferred for study at a later time.

The primary responsibility for exploring and providing alternative facilities at the commitment level is upon the District of Columbia, and other Courts have so held. *In re Johnson*, 103 Wash. Law Rep. 505 (1975); *In re Melvin*, M.H. No. 48-74 (D.C. Supp. Ct. 1975). A recent case from Superior Court of the District

of Columbia has gone even further than earlier cases and recognized the propriety of placement in a less restrictive alternative facility during the course of treatment (i.e. after an initial confinement in the Hospital) and the duty of the District of Columbia to provide promptly for such placement despite the lack of staff and facilities or budgetary limits. *In re Johnson*, 103 Wash. Law Rep. 1913 (Nov. 10, 1975). It is beyond dispute that St. Elizabeths Hospital is responsible for providing suitable care and treatment for patients while confined in the Hospital.

Therefore, at the commitment stage and for those patients determined to be in need of only custodial care, completely independent from any care or treatment generated by St. Elizabeths, the primary responsibility is upon the District government to provide suitable alternative arrangements. (But in this case the class of plaintiffs includes individuals who are in neither category and as to these persons, the responsibility cannot be the District's alone.)

Although Congress failed to clearly define the responsibilities for providing the full range of treatment mandated by the Act, the Court infers the necessary Congressional intent that the responsibility be a joint one from the manner in which funds have been appropriated to St. Elizabeths for the treatment of these plaintiffs over the past years. The Hospital receives its financing from Congressional appropriations channeled through the National Institute of Mental Health. As a public facility in which individuals are confined pursuant to the 1964 Act, St. Elizabeths is responsible for providing adequate care and treatment for mentally ill patients who are on their rolls. More than 85% of the patient population are District of Columbia residents. The cost of treating these individuals is approximately \$53 per day; of this cost the District pays approximately \$25 and the Hospital pays the balance. Therefore, it is obvious that the Hospital receives significant sums for treating patients confined pursuant to the 1964 Act, and, to this extent the Hospital shares the responsibilities imposed by the Act to provide a full range of treatment as required in an individual case.

The practicalities of treatment further support the Court's conclusion that Congress intended the responsibility to be a joint one. As noted earlier, one of the primary goals of the 1964 Act was to provide suitable care and treatment directed to returning individuals to the community to the extent possible. The responsibility and involvement of the Hospital in working toward this goal does not abruptly cease as a patient slowly moves from restrictive confinement in the Hospital to the less restrictive atmosphere of an alternative facility, pursuant to a plan of *treatment* dictated by the Hospital staff. To determine otherwise would be to disregard the fact that "housing" (as the government puts it) is integrally related to "treatment" within the purposes of the 1964 Act, and has been determined to be such by the Hospital staff.

Therefore, it is concluded from the statutory scheme, the legislative history, and the Congressional intent which can be inferred from the appropriations allocated to St. Elizabeths for the care and treatment of these plaintiffs over the years, that the duty to effect placement in alternative facilities where appropriate is a joint one. The Court makes this determination with a realization that the division of responsibility will vary in an individual case and that the Hospital's primary responsibility is for psychiatric care and treatment. But as an individual's need for such treatment decreases and need for mere custodial care increases, the Hospital's responsibilities will correspondingly decrease. Individuals who are determined to be solely custodial cases, without need for psychiatric care or treatment in the broadest sense and for whose care the Hospital receives no funds, are more properly the responsibility of the District of Columbia government.

The record before the Court indicates that there are many individuals currently confined in the Hospital who are desperately in need of care and treatment which the Hospital staff has determined includes placement in facilities outside St. Elizabeths Hospital. The record further reflects that the named plaintiffs, at the very least, are among the individuals who are still in need of psychiatric care despite their readiness for placement in alternative facilities. Thus as to these individuals and others like them, the duty to provide such treatment by placement in alternative facilities is a joint one.

Upon the foregoing, it is this 23d day of December, 1975,

Ordered that Plaintiffs Motion for Partial Summary Judgment be, and hereby is, granted; and it is further

Adjudged and decreed that the 1964 Hospitalization of the Mentally Ill Act requires that patients confined in St. Elizabeth's Hospital pursuant to the 1964 Act receive suitable care and treatment under the least restrictive conditions as such conditions are required in an individual case consistent with the purposes of the Act; that the District of Columbia and the Federal Government defendants have a joint duty to provide such care and treatment where appropriate; that both defendants have violated the 1964 Act by failing to place plaintiffs and members of the class, who are inpatients at St. Elizabeths Hospital and who have been determined suitable for placement in alternative facilities in proper facilities that are less restrictive alternatives to the Hospital, as it is presently constituted, such alternatives including but not being limited to nursing homes, foster homes, personal care homes and half-way houses; and that, therefore, such failure is unlawful and invalid; and it is further

Ordered that, forty-five (45) days from the date of this Order, the defendants shall submit to the Court an outline of a plan which shall detail the manner in which and the timetable by which defendants will meet their duty to provide plaintiffs who are and who will be inpatients at the Hospital with care and treatment in suitable residential facilities under the least restrictive conditions consistent with the purpose of the 1964 Act; that the outline shall include but shall not be limited to:

(a) a statement of the number of inpatients confined at the Hospital pursuant to the 1964 Act who require alternative placement at the time the outline is submitted and the type of and reasons for alternative care required;

(b) a statement of the estimated number of inpatients who are/or who will be confined pursuant to the 1964 Act who will need alternative placement in the next six months, twelve months and eighteen months, in addition to the patients identified in (a), and the type of alternative care required;

(c) a statement of the major problems inhibiting alternative placement of those plaintiffs who are or who will be inpatients at the Hospital confined pursuant to the 1964 Act on the date the outline is submitted;

(d) a statement of the tentative solutions to the problems inhibiting alternative placement which defendants will propose in the completed plan;

(e) a tentative statement of the standards that will govern the care and treatment and the conditions in the various types of alternative facilities to which the inpatients identified in (a) and (b) will be outplaced;

(f) a tentative statement of the procedures and personnel to be used in monitoring the care and treatment and conditions in the various types of alternative facilities to which the inpatients identified in (a) and (b) will be outplaced;

(g) a statement describing tentative changes in budgetary patterns and/or sources of funding for implementing the solutions and aspects of the treatment process identified in (d-f);

(h) a tentative timetable for implementing the solutions identified in (d).

(i) a statement of the respective roles to be played by the Federal and District of Columbia defendants in preparation of the plan, including specification of the type and number of personnel to be provided by each of the defendants;

(j) a tentative statement of the respective responsibilities of the Federal and District of Columbia defendants in implementing the plan, i.e. in providing suitable, least restrictive care and treatment in alternative facilities to the inpatient plaintiffs; and it is further

Ordered that, after submission of the outline by defendants, after any further submissions by plaintiffs, and after approval of the outline of the plan by the Court, defendants shall, four (4) months from the date of the Court's order approving the outline of the plan, submit a final plan; and it is further

Ordered that the Court shall retain jurisdiction over this action to consider appropriate measures to be taken for the implementation of the plan submitted.

AUBREY E. ROBINSON, JR.,
U.S. District Judge.

STATEMENT OF GEORGE J. McMAHON, PRESIDENT OF THE WASHINGTON PSYCHIATRIC SOCIETY, TO THE HOUSE DISTRICT OF COLUMBIA COMMITTEE

The Washington Psychiatric Society is a voluntary, professional organization which represents 900 psychiatrists practicing in the greater metropolitan area. The members of the Washington Psychiatric Society have a deep concern for the future of St. Elizabeths Hospital. There have been several plans proposed to

reorganize St. Elizabeths. We do not favor one plan over another, but we believe that whatever plan is adopted and however St. Elizabeths Hospital may be reorganized in the future it is essential that the following three elements be achieved through any reorganization :

1. Accreditation be restored.
2. Long-term financial stability must be created for the hospital.
3. The local medical and psychiatric professional societies have an input into the administration of the hospital.

St. Elizabeths Hospital is the major hospital providing medical psychiatric services for the District of Columbia and is essential for the entire medical mental health delivery system for the District of Columbia. At one time St. Elizabeths Hospital was considered one of the foremost mental hospitals in the United States. This is no longer true. No longer is it accredited by the Joint Commission on Accreditation of Hospitals. One reason for this loss of accreditation is that St. Elizabeths Hospital has not been adequately funded. It is imperative that if the hospital staff is to provide the needed services and that the facilities be maintained, improved, and brought up to modern standards, long-term financial stability must be achieved. Any plan for reorganization must provide an adequate funding procedure.

To achieve the best possible administration of St. Elizabeths Hospital, we believe that the local medical and psychiatric professional societies should be consulted in choosing and appointing members of the board to administer the hospital and that several medical psychiatric doctors should be on that board. This would ensure that the hospital was maintaining the proper medical standards required so that the patients receive the treatment to which they are entitled.

The Washington Psychiatric Society wishes to thank and commend the District of Columbia Committee for its interest in the future of St. Elizabeths Hospital and for letting us make this statement as part of the record to the Committee.



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