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MENTAL HEALTH SYSTEMS ACT, 1979



HEARINGS
BEFORE THE
SUBCOMMITTEE ON
HEALTH AND SCIENTIFIC RESEARCH
OF THE
COMMITTEE ON
LABOR AND HUMAN RESOURCES
UNITED STATES SENATE
NINETY-SIXTH CONGRESS

FIRST SESSION

ON

S. 1177

TO IMPROVE THE PROVISION OF MENTAL HEALTH SERVICES
AND OTHERWISE PROMOTE MENTAL HEALTH THROUGHOUT
THE UNITED STATES, AND FOR OTHER PURPOSES

MAY 24 AND JUNE 11, 1979

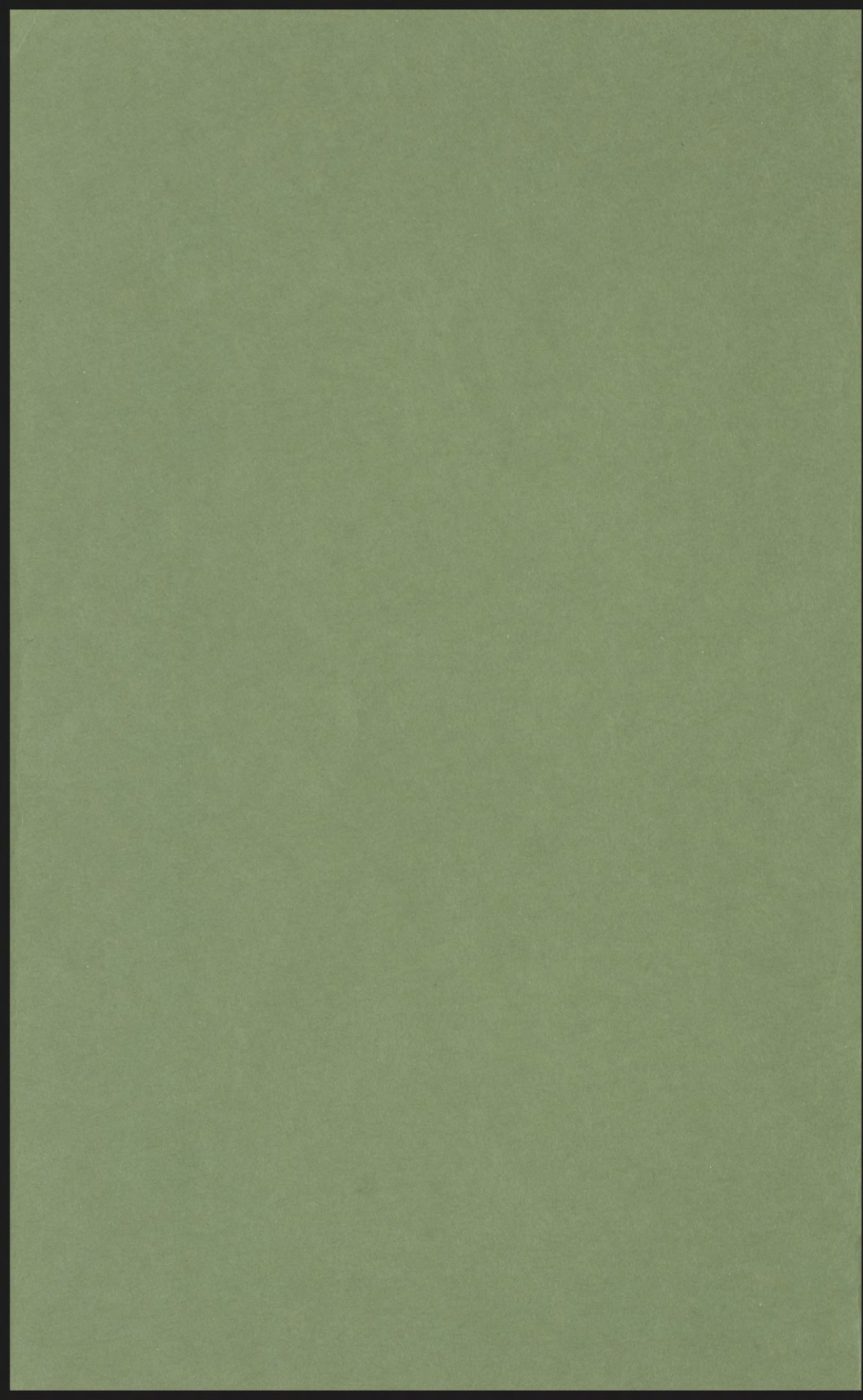
DOCUMENTS



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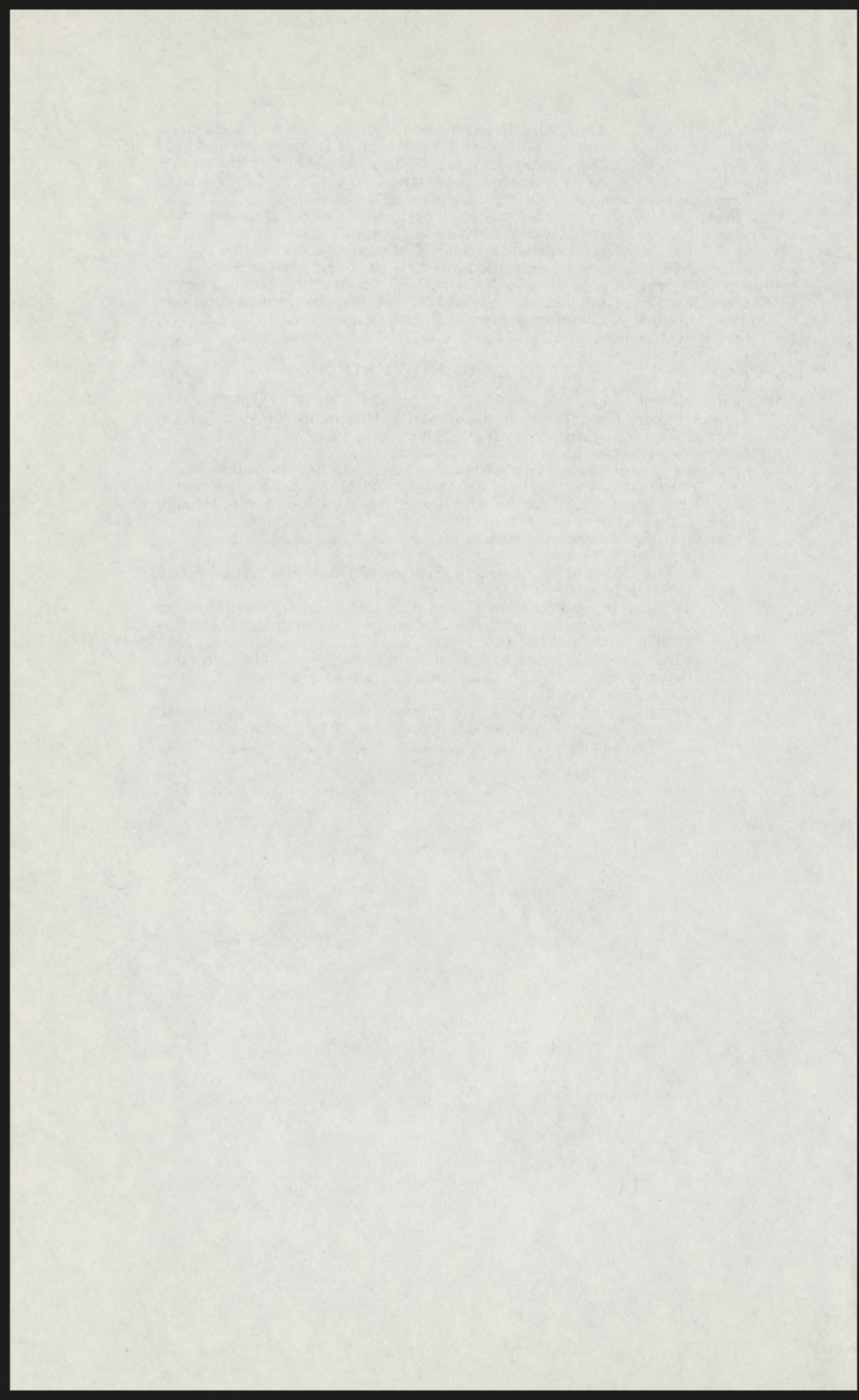
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MENTAL HEALTH SYSTEMS ACT, 1979

WEDNESDAY, MAY 24, 1979

U.S. SENATE,
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9:55 a.m., in room 5110, Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

Present: Senators Kennedy, Javits, and Schweiker.

Staff present: Stuart Shapiro, M.D., David Riemer, J.D., and David Winston.

OPENING STATEMENT OF SENATOR KENNEDY

Senator KENNEDY. We will come to order. I am pleased to open the second in our series of hearings on mental health policy and the Mental Health Systems Act which I introduced 1 week ago. This legislation stems from the report of the President's Commission on Mental Health which was organized under the energetic and perceptive leadership of Mrs. Rosalynn Carter. This legislation is an important first step and goes a long way toward refining the Community Mental Health Centers Act of 1963 and 1975. There remain, however, additional areas which I believe must be addressed in order to insure that comprehensive, coordinated mental health services are available to all Americans.

Mental health services have long been of concern to me and my family. It was in February 1957 that Senator John F. Kennedy successfully cosponsored a resolution calling for an objective national analysis and reevaluation of the human and economic problems of mental illness. This study eventually led to the Community Mental Health Centers Act of 1963 which then President Kennedy endorsed and signed into law. That act called for a bold new approach to the treatment of the mentally disabled through the establishment of a network of community mental health centers and a departure from our dependence on those human storage facilities we called State hospitals. Today there are about 700 such centers, serving millions of our citizens.

While this program offered real hope for both creative and humane treatment methods, combining the latest scientific knowledge with the active participation of our community systems, today far too many of our citizens who are mentally ill still suffer from abandonment, stigma, and an unresponsive society.

Even with the large gains in community mental health service, the national policy of deinstitutionalization has not been effectively

implemented. In fact, the plight of the deinstitutionalized patient is an affront to us all. Almost daily we hear about patient abuses from California to New York; we also read about it here in our Nation's Capital.

In some cases these patients have been discharged to fend for themselves or placed in nursing homes or boarding homes more inadequate than the discharging institution. Painfully we have come to understand that many of these community residences are more concerned about their reimbursement than the patient's need for quality care in a stimulating environment. In addition to having the stigma of mental illness, patients' employment, housing, and other social service needs have been poorly met. In many cases their problem is compounded by a supplemental security income system that is not synchronized with their discharge plan. This results in many patients being discharged with no SSI benefits and this often leads to rehospitalization or exposes patients to those in the community who would exploit their presence.

In general, previous legislation has not effectively served this population. The community support program, as outlined in this bill, begins to focus on services and responsibilities. However, without accompanying improvements in titles XVIII, XIX, and XX of the Social Security Act, the program, I believe, is doomed to failure. During the hearings I hope witnesses will address the question of change in these programs.

The discontinuity of services at all levels further complicates the system and often leaves the patient to wander aimlessly in a morass of overlapping bureaucracies. According to a recent GAO report, there are 11 agencies and 135 programs dealing with the mentally disabled—89 operated by the Department of Health, Education, and Welfare alone.

We need to define clearer and better lines of responsibility for providing services at all levels of government. We need to develop a closer partnership between the Federal and State governments and a better working relationship between Federal, State, and local governments and communities. Conflicting and overlapping Federal statutes need rewriting. We must develop the necessary resources to care for the deinstitutionalized patient. Past policies of simply moving people out of their beds and onto the streets can no longer be tolerated.

The President's Commission on Mental Health appropriately focused on the need to develop informed and aggressive systems of advocacy for the mentally ill. This highly vulnerable population is often least able to protect itself against encroachment in the area of their civil rights. Congress recently enacted advocacy programs on behalf of the elderly and developmentally disabled. Can we do less for the mentally ill?

I am sure the Secretary will explain the fact that we have not got that part of it in the program.

There can be no question that community mental health centers have effectively demonstrated their utility in responding to many of America's mental health service needs. Millions of people have been helped through these centers and they have become an extremely valuable part of our health care system. Not only have they established and maintained relevant services, but they have

been on the cutting edge of community education in mental health, and we are all familiar with the relationship between education and prevention. A major mental health service barrier is stigma, and the community mental health centers have offered the structure for changing the public's misunderstanding about the mentally ill.

The community mental health centers have actively involved many of our citizens in the decisionmaking process through membership on local boards of governance and a sense of shared participation and responsibility. While we must continue to seek out and implement progressive changes in this program, we can never retreat from our commitment of providing quality care through these community-based services and facilities. Throughout the hearing I hope the witnesses will address ways to improve this important program and develop closer linkages to the physical health system.

[The text of S. 1177 follows:]

96TH CONGRESS
1ST SESSION

S. 1177

To improve the provision of mental health services and otherwise promote mental health throughout the United States, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MAY 17 (legislative day, APRIL 9), 1979

Mr. KENNEDY (for himself, Mr. WILLIAMS, and Mr. PELL) introduced the following bill; which was read twice and referred to the Committee on Labor and Human Resources

A BILL

To improve the provision of mental health services and otherwise promote mental health throughout the United States; and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 That so much of this Act as precedes title VII, along with
4 the following table of contents, may be cited as the "Mental
5 Health Systems Act".

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PART C—AUTHORIZATIONS

- Sec. 641. Authorizations of appropriations.

TITLE VII—MISCELLANEOUS

- Sec. 701. Community Mental Health Centers Act appropriations.

1 FINDINGS AND PURPOSE

2 SEC. 2. (a) The Congress hereby finds—

3 (1) Despite significant progress in the availability
4 of community mental health services and improving
5 residential mental health facilities, certain groups in
6 the population, such as children and youth, the aged,
7 the chronically mentally ill, racial or ethnic minorities,
8 poor persons, and persons in rural areas, often lack
9 access to adequate mental health services and other
10 health or social or other support services.

11 (2) Even where mental health services are availa-
12 ble, the lack of coordination, among governmental and
13 private agencies and entities, of the mental health
14 services, other health services, and social or other sup-
15 port services provided often leads to neglect or unnec-
16 essary institutionalization of persons with chronic
17 mental disabilities.

18 (3) Millions of persons with some level of mental
19 disorder have contact with the primary health care

1 system where opportunities for effective mental health
2 care and treatment are often lost because of inadequate
3 mental health training of general health care personnel
4 and the lack of mental health personnel in primary
5 health care settings.

6 (4) Present efforts to prevent mental disability
7 through discovery and elimination of the causes of
8 mental illness and through early detection and treat-
9 ment programs are far too limited.

10 (b) It is, therefore, the purpose of this Act to provide
11 more flexibility in the funding of mental health services and
12 to encourage development of a partnership, in the delivery of
13 mental health services, other health services, and social or
14 other support services, among Federal, State, local govern-
15 ment, or private providers of such services, in order to im-
16 prove mental health, prevent mental illness, and provide ef-
17 fective treatment and rehabilitative services in the least re-
18 strictive setting for persons of all ages and cultural back-
19 grounds who are suffering from mental illness or disability or
20 are potential sufferers therefrom. To help carry out that pur-
21 pose, the objectives of this Act are—

22 (1) to foster the most effective use of available
23 Federal, State, local government, or private resources,
24 by encouraging States to improve the administration of
25 their mental health services programs and to coordi-

1 nate services under those programs with other health
2 services and social or other support services;

3 (2) to develop community-based services for un-
4 served, underserved, or inappropriately served popula-
5 tions, especially children and youth, the aged, the
6 chronically mentally ill, racial or ethnic minorities,
7 poor persons, and persons in rural areas;

8 (3) to minimize unnecessary or inappropriate
9 institutionalization and ensure that persons requiring
10 long-term residential care due to mental illness or dis-
11 ability receive such care in the least restrictive settings
12 possible;

13 (4) to increase the integration of general health
14 services and mental health services through inservice
15 mental health training of primary care providers and
16 through placement of mental health professionals in
17 primary care programs;

18 (5) to encourage States to develop prevention
19 programs;

20 (6) to encourage mental health professionals to
21 locate in unserved and underserved areas; and

22 (7) to facilitate accomplishment of that purpose
23 and these objectives through more effective planning
24 that is consistent with the mental health aspects of
25 overall State health planning.

DEFINITIONS

1

2

3

SEC. 3. For the purposes of this Act, unless the context otherwise requires—

4

5

6

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8

(1) The term "State" includes (in addition to the fifty States) the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Trust Territory of the Pacific Islands, and the Northern Mariana Islands.

9

10

11

(2) The term "Governor" means, in the case of a State which does not have a Governor, the chief executive officer of the State.

12

13

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

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(4) The term "nonprofit", as applied to any entity, means an entity which is owned and operated by one or more corporations or associations no part of the net earnings of which inures or may lawfully inure to the benefit of any private shareholder or individual.

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24

(5) The term "State Agency" means the agency or authority of a State established or designated under the State plan (approved under this Act) of that State to assume responsibility for administration of the plan and the other aspects of its mental health services program.

1 (6) The term "Area Mental Health Authority"
2 means the public or nonprofit private entity (and there
3 may be only one) in a mental health services area des-
4 ignated by the State Agency to be responsible for plan-
5 ning the mental health services program of the area
6 and (at the option of the State) any one or more other
7 mental health services areas, and for the coordination
8 and development of mental health services in that area
9 or areas.

10 (7) The term "Core Service Agency" means a
11 public or nonprofit private entity designated by the
12 State Agency to assume responsibility in any mental
13 health services area for planning, coordinating, devel-
14 oping, and providing the mental health services and
15 support services that are necessary for the care of
16 those members of any one or more priority population
17 groups in the area who need both mental health serv-
18 ices and support services.

19 (8) The term "support services" means health
20 services (other than mental health services), and the
21 social services and other support services specified by
22 the Secretary.

23 (9) The term "priority population group" means
24 any of the following groups which are unserved by any
25 mental health services program or are underserved by

1 such a program or programs: children and youth, the
2 aged, the chronically mentally ill, any racial or ethnic
3 minority, Indians and urban Indians (as those terms
4 are defined in the Indian Health Care Improvement
5 Act), the poor, rural residents, or any other group de-
6 termined by the Secretary to have a special need for
7 services under such a program.

8 (10) The term "mental health services area"
9 means a geographic area established for purposes of
10 planning and provision of mental health services.

11 (11) The term "comprehensive mental health
12 services" means the services described in section
13 201(b) of the Community Mental Health Centers Act.

14 TITLE I—MEETING THE NEEDS OF THE
15 CHRONICALLY MENTALLY ILL

16 PURPOSE

17 SEC. 100. (a) It is the purpose of this title—

18 (1) to provide assistance to States and communi-
19 ties to develop or improve mental health services and
20 other services for chronically mentally ill adults and
21 children;

22 (2) to do this under a program—

23 (A) clearly defining the respective Federal,
24 State, and local public or private roles and re-
25 sponsibilities in achieving, and

1 (B) under which, if the States meet, provide
2 for meeting, or furnish satisfactory assurances of
3 meeting specified conditions and prescribed per-
4 formance standards (adapted where appropriate to
5 the peculiar circumstances of each State or com-
6 munity), they will receive Federal support in
7 achieving,
8 the national goal of developing responsive, coordinated,
9 community-based service systems to meet the needs of
10 those adults and children with chronic mental illness
11 who are capable of living in the community if provided
12 with adequate mental health, rehabilitation and train-
13 ing, housing, or other support services.

14 (b) It is the further purpose of this title, in providing
15 that assistance under such a program, to facilitate State ef-
16 forts to carry out the State responsibility for—

17 (1) providing appropriate care for those adults and
18 children whose mental illnesses are so severe that they
19 require inpatient care on a short or long-term basis;
20 and

21 (2) making the transition from institution-based to
22 coordinated community-based service systems through
23 closing or converting to other appropriate use public
24 mental hospitals and other long-term care facilities and

1 through providing retraining and job placement for per-
2 sonnel displaced by the closure or reduction in use.

3 SERVICES FOR THE CHRONICALLY MENTALLY ILL

4 SEC. 101. The Secretary may make grants to any State
5 Agency for any project for payments by it to a Core Service
6 Agency in any mental health services area for any one or
7 more of the following:

8 (1) planning for the development of a system of
9 mental health services and support services, for the
10 chronically mentally ill in the area who need both
11 mental health services and support services, and for
12 members of their households, that may assist the
13 chronically mentally ill to live outside of institutional
14 settings;

15 (2) coordination of the operations of any agencies
16 or entities having responsibility for any mental health
17 services or support services for the chronically mental-
18 ly ill in the area;

19 (3) identifying barriers to the ready availability of
20 any of such services to the chronically mentally ill in
21 the area and devising measures to help overcome those
22 barriers;

23 (4) improving the competency of personnel of enti-
24 ties providing any of such services for the chronically

1 mentally ill through inservice or other training or re-
2 training;

3 (5) assuring the availability, for each chronically
4 mentally ill patient who needs both mental health serv-
5 ices and support services, of an individual to assume
6 responsibility for seeing to it that the patient receives
7 any of such services that he needs;

8 (6) providing or arranging for the provision of any
9 such services needed by any such patient and not oth-
10 erwise available;

11 (7) providing educational or informational services
12 to educate the population of the area on the problems
13 of the chronically mentally ill and the need for commu-
14 nity involvement in the programs to resolve those
15 problems outside of institutional settings, and on what
16 is available or needed to help those programs succeed;

17 (8) preparing and providing such reports to the
18 State Agency, containing such information, as the
19 State Agency may find necessary to evaluate the Core
20 Service Agency's activities with respect to the chron-
21 ically mentally ill.

22 ASSISTANCE TO STATE AGENCIES

23 SEC. 102. The Secretary may make grants to any State
24 Agency for any project for any one or more of the following:

1 (1) planning for the development of a system of
2 mental health services and support services, for the
3 chronically mentally ill in the State who need both
4 mental health services and support services, and for
5 members of their household, that may enable the
6 chronically mentally ill to live outside of institutional
7 settings;

8 (2) coordination of the operations of State or in-
9 trastate regional agencies having responsibility for any
10 mental health services or support services for the
11 chronically mentally ill;

12 (3) identifying State-level barriers to the ready
13 availability of any of such services to the chronically
14 mentally ill and devising measures to help overcome
15 those barriers;

16 (4)(A) improving the competency of personnel of
17 entities providing any of such services for the chron-
18 ically mentally ill through inservice or other training or
19 retraining, and (B) job placement for and retraining (for
20 work in community-based mental health programs) of
21 former employees of mental (inpatient care) institutions
22 adversely affected by reduced use of such institutions;
23 or

24 (5) assisting mental health services areas in the
25 continuing process of identifying the chronically men-

5 TITLE II—PREVENTION OF MENTAL ILLNESS

19 PROJECT GRANTS FOR PREVENTION OF MENTAL ILLNESS

(1) providing assistance, through collection and dissemination of information, workshops, and other appropriate means, to mental health or other health personnel, entities, and groups, and to volunteer or other

1 citizen organizations and groups, in the development of
2 programs aimed at preventing mental illness;

3 (2) inservice training and other training of mental
4 health, other health or other appropriate personnel in
5 early identification of the potential causes of mental ill-
6 ness and early application of measures designed to pre-
7 vent occurrence or aggravation of mental illness;

8 (3) providing information to the general public on
9 the importance of preventing mental illness and of the
10 services available to help in early identification of po-
11 tential causes of mental illness and early handling of
12 those causes;

13 (4) planning, and other activities at the State or
14 intrastate regional level to develop and coordinate,
15 services to help prevent mental illness; or

16 (5) demonstrating, in one or more mental health
17 services areas of the State, the various means of pre-
18 venting mental illness and otherwise promoting mental
19 health.

20 TITLE III—STATE MENTAL HEALTH SYSTEMS
21 IMPROVEMENT

22 PURPOSE

23 SEC. 300. It is the purpose of this title, in recognition of
24 the financial and administrative roles of the States in the
25 mental health sector, to assist them to improve their capacity

1 to carry out their responsibilities for administering their
2 mental health services and related programs.

3 IMPROVING STATE ADMINISTRATION

4 SEC. 301. For the purpose of assisting States to im-
5 prove administration of State mental health programs, the
6 Secretary may make grants to any State Agency for any
7 project for any one or more of the following:

8 (1) improving State Agency capacity to collect
9 and analyze statistics and other data and to otherwise
10 meet the monitoring or reporting requirements under
11 this Act;

12 (2) improving the planning and other administra-
13 tive functions of the State Agency; or

14 (3) improving the ability of the State Agency (A)
15 to set performance standards for mental health services
16 projects and programs, (B) to enforce those standards,
17 and (C) to evaluate performance under any other as-
18 pects of such projects and programs through data anal-
19 ysis, studies, and other means.

20 OTHER STATE ACTIVITIES

21 SEC. 302. The Secretary may make grants to any State
22 Agency for any project for any other activities, included in
23 the State plan approved under this Act, which are designed
24 to improve the provision of mental health services in the
25 State or the administration of State or local mental health

1 programs and which the Secretary determines to be of partic-
2 ular significance in the light of the purposes of this Act.

3 TITLE IV—COMMUNITY MENTAL HEALTH
4 SERVICES

5 PURPOSE

6 SEC. 400. The purpose of this title is to assure the initi-
7 ation and improvement of mental health services for children
8 and youth, the aged, the chronically mentally ill, any racial
9 or ethnic minority, Indians, the poor, rural residents, or any
10 other group with special needs, and the development of com-
11 prehensive mental health services for them and others in
12 their communities through creating necessary services where
13 none exists; recognizing the close relationship between
14 mental health services and other health or support services;
15 supporting the maintenance of existing non-revenue produc-
16 ing functions after basic support has terminated, and continu-
17 ation of comprehensive mental health services programs al-
18 ready begun; supplementing or improving existing services
19 where they are inadequate; and increasing the flexibility of
20 communities in planning a comprehensive network of services
21 which assures continuity of care.

22 PREPARATION FOR PROVISION OF SERVICES

23 SEC. 401. (a) For the purpose of assisting public or non-
24 profit private entities to prepare for providing mental health

1 services in a mental health services area, the Secretary may
2 make a grant to any such entity for a project to—

3 (1) assess the needs of the area for mental health
4 services;

5 (2) design a mental health services program for
6 the area based on such assessment;

7 (3) obtain within the area financial and profession-
8 al assistance and support for the program; and

9 (4) initiate and encourage continuing community
10 involvement in the development and operation of the
11 program.

12 The amount of any grant under this section may not exceed
13 \$75,000.

14 (b) Only one grant may be made under this section with
15 respect to a mental health services area.

16 (c) No grant may be made under this section with re-
17 spect to any mental health services area if a grant has previ-
18 ously been made under this title or under the Community
19 Mental Health Centers Act with respect to the same area, or
20 with respect to a catchment area (within the meaning of that
21 term in the Community Mental Health Centers Act) any sub-
22 stantial (as determined by the Secretary) part of which is
23 included in that mental health services area. The prohibition
24 in the preceding sentence does not apply if the earlier grant
25 (referred to therein) under this Act was made under section

1 402 for one or more, but less than all, of the comprehensive
2 mental health services, and comprehensive mental health
3 services are not being provided in the area, or if the earlier
4 grant (so referred to) under the Community Mental Health
5 Centers Act was made under section 224(b) of that Act as in
6 effect before July 29, 1975. As used in the preceding sen-
7 tence, the term "comprehensive mental health services" does
8 not include any such service for an area if there is not suffi-
9 cient need for it in the area, as determined by the Secretary,
10 or if the Secretary determines the need for it is being met.

11 INITIATION OF SERVICES FOR THE UNDERSERVED

12 SEC. 402. (a) The Secretary may make grants to any
13 public or nonprofit private entity for any project for the pro-
14 vision of mental health services to one or more priority popu-
15 lation groups. In making such grants under this section, the
16 Secretary shall give preference to any entity serving a
17 mental health services area which has no community mental
18 health center (as defined in the Community Mental Health
19 Centers Act) servicing it and with respect to which no grant
20 has been or is being made under section 403.

21 (b) A grant may be made under this section for any
22 project only if—

23 (1) the project will provide at least one of the
24 services, included in comprehensive mental health serv-

1 ices, to meet the needs of at last one priority popula-
2 tion group, as determined under the State plan;

3 (2) the entity demonstrates that the project will
4 lead to increased or more appropriate mental health
5 services for an underserved priority population group
6 or groups or to development of mental health services
7 for an unserved priority population group or groups;

8 (3) the entity provides satisfactory evidence that
9 members of the priority population group or groups to
10 be served by the project have had a reasonable oppor-
11 tunity to comment on the proposed project during its
12 preparation and satisfactory assurances that members
13 of the group or groups will be afforded reasonable op-
14 portunity to comment on performance under the proj-
15 ect; and

16 (4) in the case of an entity which does not provide
17 comprehensive mental health services in the mental
18 health services area, there is in effect, or the entity
19 provides satisfactory assurances that there will before
20 the end of the period of the initial grant under this sec-
21 tion for the project be in effect, an agreement of affili-
22 ation with an entity (if there is one) providing addition-
23 al mental health services in the area which can be
24 made available to members of the priority population
25 group or groups for which the project is designed.

1 The requirement of paragraph (4) does not apply if the appli-
2 cant for the grant provides satisfactory evidence that the fail-
3 ure to have such an agreement within the period specified is
4 due to an unreasonable refusal by the other entity or entities
5 to enter into the agreement.

6 (c) Only five grants may be made under this section to
7 the same entity for mental health services for the same prior-
8 ity population group or groups; and the fourth and fifth such
9 grants may not exceed sixty percent and thirty percent, re-
10 spectively, of the costs of the project for which the grants are
11 made.

12 (d) For a further limitation on the number of grants
13 under this section, see section 403(d).

14 DEVELOPMENT OF COMPREHENSIVE MENTAL HEALTH
15 SERVICES

16 SEC. 403. (a) The Secretary may make grants to any
17 public or nonprofit private entity for any project to develop
18 mental health services or to expand the mental health serv-
19 ices provided by it.

20 (b) Any such grant may be made for a project for serv-
21 ices in a mental health services area only if such entity—

22 (1) has not received, under section 203(a) of the
23 Community Mental Health Centers Act, or under sec-
24 tion 220 of that Act as in effect before July 29, 1975,
25 or as continued in effect after that date by section

1 203(e) of that Act, or under section 406 of this Act, all
2 of the grants available to it under those sections;

3 (2) provides satisfactory assurances that it will, in
4 accordance with a plan and time schedule for the pro-
5 vision and addition of mental health services approved
6 by the Secretary, provide for the area at least those
7 services (other than a service for which there is not
8 sufficient need in the area, as determined by the Secre-
9 tary, or the need for which in the area the Secretary
10 determines is being met) which are included in compre-
11 hensive mental health services or are prescribed by the
12 Secretary;

13 (3) provides satisfactory assurances that priority
14 will be accorded, in progressing toward provision of
15 such mental health services for all of the population of
16 the area, to services needed by priority population
17 groups, in accordance with the State plan approved
18 under this Act; and

19 (4) provides satisfactory assurances that it will
20 have an agreement of affiliation with an entity in the
21 area that receives or has received a grant under sec-
22 tion 402, if requested to do so by such entity, unless
23 relieved of this requirement by the Secretary because
24 the agreement so requested is unreasonable.

1 (c)(1) Only eight grants may be made under this section
2 to the same entity for services in the same mental health
3 services area; and no such grant (after the first one) may
4 exceed the following percentage of the cost of the project
5 with respect to which it is made;

6 (A) 90 per centum in the case of the second such
7 grant;

8 (B) 80 per centum in the case of the third such
9 grant;

10 (C) 70 per centum in the case of the fourth such
11 grant;

12 (D) 60 per centum in the case of the fifth such
13 grant;

14 (E) 50 per centum in the case of the sixth and
15 seventh such grant; and

16 (F) 45 per centum in the case of the eighth such
17 grant.

18 (2) For purposes of this subsection, a grant under any of
19 the following is considered a grant under this section:

20 (A) section 406;

21 (B) section 203(a) of the Community Mental
22 Health Centers Act; or

23 (C) section 220 of the Community Mental Health
24 Centers Act as in effect before July 29, 1975, or as

1 continued in effect after that date by section 203(e) of
2 that Act.

3 (d) No grant may be made under this section or section
4 402 to any entity for services in any mental health services
5 area after the total of the following grants for services in that
6 area reaches ten—

7 (1) grants under this section, section 402, or sec-
8 tion 406;

9 (2) grants under section 203(a) of the Community
10 Mental Health Centers Act; or

11 (3) grants under section 220 of the Community
12 Mental Health Centers Act as in effect before July 29,
13 1975, or as continued in effect after that date by sec-
14 tion 203(e) of that Act.

15 MENTAL HEALTH SERVICES IN AMBULATORY HEALTH

16 CARE CENTERS

17 SEC. 404. (a) For the purpose of assisting ambulatory
18 health care centers to participate appropriately in the provi-
19 sion of mental health services to their patients, the Secretary
20 may make a grant to any public or nonprofit private entity
21 which—

22 (1) provides mental health services that include at
23 least 24-hour emergency services, outpatient services,
24 and consultation and education services (as described in
25 section 201(b) of the Community Mental Health Cen-

1 ters Act) and has in effect an agreement of affiliation
2 with an entity which is, as determined by the Secre-
3 tary, an ambulatory health care center; or

4 (2) is, as so determined, an ambulatory health
5 care center and has in effect an agreement of affiliation
6 with an entity providing at least the mental health
7 services referred to in paragraph (1).

8 Such an agreement of affiliation must—

9 (A) describe the geographical area in which each
10 party to the agreement provides and proposes to pro-
11 vide its services;

12 (B) provide for employment by the center of at
13 least one mental health professional to serve as liaison
14 between it and the other entity, and include a descrip-
15 tion of the required qualifications of that person and of
16 any other professional mental health personnel to be
17 employed by the center under the agreement;

18 (C) provide satisfactory assurances that the entity
19 providing the mental health services will make such
20 services available to patients of the center referred to
21 it by the liaison or other mental health professional;
22 and

23 (D) include the transportation arrangements and
24 other arrangements for effecting referral to the entity

1 from the center of patients needing the services of such
2 entity.

3 (c) Any grant under this section may be made for a proj-
4 ect for any one or more of the following—

5 (1) the costs of liaison or other mental health pro-
6 fessionals providing services in the ambulatory health
7 care center in accordance with the agreement of
8 affiliation;

9 (2) mental health services provided by the other
10 personnel of the center which the other entity deter-
11 mines such personnel can appropriately provide;

12 (3) consultation and inservice training on mental
13 health provided to personnel of the center by the other
14 entity; and

15 (4) establishing liaison between the center and
16 other providers of mental health services or support
17 services.

18 (d) Only three such grants may be made under this sec-
19 tion for projects involving the same ambulatory health care
20 center and the same entity providing mental health services;
21 and the third such grant may not exceed 75 per centum of
22 the cost of the project for which it is made.

23 NON-REVENUE-PRODUCING ACTIVITIES

24 SEC. 405. (a) For the purpose of assisting public or non-
25 profit private entities to provide, in their mental health serv-

1 ices areas, mental health services which generally do not
2 generate revenues, the Secretary may make grants to any
3 public or nonprofit private entity which—

4 (1) has received a grant under section 203(a) of
5 the Community Mental Health Centers Act, or under
6 section 220 of such Act as in effect before July 29,
7 1975, or as continued in effect after that date by sec-
8 tion 211 of that Act, or under section 403 or 406 of
9 this Act; and

10 (2) because of the limitations on the period for
11 which an entity may receive such grants or on the
12 number of such grants the entity may receive, is no
13 longer eligible to receive such grants.

14 (b) A grant under this section may be made for a project
15 for any one or more of the following:

16 (1) consultation and education services described
17 in section 201(b) of the Community Mental Health
18 Centers Act;

19 (2) activities directed at prevention of mental ill-
20 ness, including education of the general public on mat-
21 ters related thereto;

22 (3) the additional cost of case finding with respect
23 to members of a priority population group and of assur-
24 ing that each member of the group receives the mental
25 health services and support services he needs;

1 (4) coordination of the entity's services with other
2 mental health services and with support services; or

3 (5) evaluation of the entity's mental health serv-
4 ices program.

5 (c) A grant may be made under this section to an entity
6 for any project only if the entity provides—

7 (1) satisfactory assurances that it will sign an
8 agreement of affiliation with any other entity providing
9 mental health services in the same mental health serv-
10 ices area and which has received a grant under section
11 402, if it is requested to do so by such other entity,
12 unless relieved of this requirement by the Secretary be-
13 cause the agreement so requested is unreasonable;

14 (2) a satisfactory plan describing the steps it pro-
15 poses to take in order to obtain financing from other
16 sources for the activities included under the project
17 when financing therefor is no longer available under
18 this section; and

19 (3) satisfactory assurances that it will give priority
20 under its mental health services program to meeting
21 the needs of priority population groups.

22 (d) Only five grants may be made under this section to
23 any entity; and no such grant may exceed an amount equal to
24 \$1.00 multiplied by the population (as indicated in the State's

1 plan approved under this Act) of the mental health services
2 area of the recipient.

3 CONTINUED SUPPORT FOR COMMUNITY MENTAL HEALTH
4 CENTERS

5 SEC. 406. (a) For the purpose of assisting public or non-
6 profit private entities to continue to provide mental health
7 services, the Secretary may make project grants to any such
8 entity which received a grant under section 203 (a) or (e) or
9 211 of the Community Mental Health Centers Act and which
10 would be eligible for another grant thereunder from appropri-
11 ations for any fiscal year ending after September 30, 1979, if
12 such appropriations were made. The number of such grants
13 which may be made to any entity, and the amounts thereof,
14 are, respectively, the number and the amounts prescribed
15 under that section; and such grants shall be made in accord-
16 ance with the other terms and conditions applicable to grants
17 under that section, except as provided in subsections (b) and
18 (c) of this section.

19 (b) No grant may be made under this section to any
20 entity unless it provides satisfactory assurances that it will
21 sign an agreement of affiliation with any recipient of a grant
22 under section 402 providing mental health services in the
23 same mental health services area, if requested to do so by
24 that recipient, unless relieved of this requirement by the Sec-
25 retary because the agreement so requested is unreasonable.

1 (c) In the case of any entity which received a grant
2 under section 203(a) of the Community mental Health Cen-
3 ters Act, and to which the initial grant under such section
4 was made from appropriations for the fiscal year ending Sep-
5 tember 30, 1979, a grant may not be made under subsection
6 (a) to such entity from appropriations under this Act for any
7 year unless the Secretary determines, at the request of the
8 entity, that there is good reason to make such grant to it for
9 that year and no grant has previously been made to it under
10 section 403.

11 TITLE V—PILOT PROJECTS FOR STATE

12 ADMINISTRATION OF GRANTS

13 AGREEMENTS AUTHORIZED

14 SEC. 501. The Secretary may enter into an agreement
15 with the State Agency of any State, which is able and willing
16 to do so, for a demonstration project under which such
17 Agency will, on behalf of the Secretary—

18 (1) pay Federal funds due to entities in the State
19 for such of the projects under section 101 or title IV
20 as may be designated in the agreement;

21 (2) review performance under such projects and
22 report to the Secretary the extent to which such per-
23 formance complies with applicable requirements; and

1 (3) perform such other functions of the Secretary
2 with respect to that State as the State Agency and the
3 Secretary may agree upon.

4 COST OF AGREEMENTS

5 SEC. 502. Of the sums appropriated under section 641
6 for any fiscal year, the percentage determined by the Secre-
7 tary is available for paying all, or such portion as the Secre-
8 tary determines to be appropriate, of the cost to any State
9 Agency of carrying out its agreement under section 501.

10 TITLE VI—REQUIREMENTS FOR PARTICIPATION;

11 AUTHORIZATIONS

12 PART A—STATE PLANS

13 REQUIREMENT OF STATE MENTAL HEALTH SERVICES

14 PLANS

15 SEC. 601. (a) In order for the State Agency of or any
16 entity in a State to be eligible to receive a grant under this
17 Act for any year, such State must have in effect a State
18 mental health services plan which has been prepared by an
19 agency of the State designated by the Governor and been
20 submitted to the Secretary through the Governor, which is
21 consistent with the provisions, relating to mental health serv-
22 ices, of the State health plan prepared in accordance with
23 section 1524(c)(2) of the Public Health Service Act, and
24 which has been approved by the Secretary as meeting the
25 requirements of this Act.

1 (b) The Secretary may not finally disapprove a State
2 plan (or any modification thereof) except after reasonable
3 notice and opportunity for a hearing to the State.

4 (c) Whenever the Secretary, after reasonable notice and
5 opportunity for a hearing to the State Agency of a State,
6 finds that the State plan approved under this Act has been so
7 changed that it no longer complies with this Act, or that in
8 the administration of the plan there is a failure to comply
9 substantially with any provision of this Act, the Secretary
10 shall notify the Agency that further payments will not be
11 made to the Agency or to any other entity in the State under
12 this Act (or, in his discretion, that further payments will not
13 be made to any such Agency or entity with respect to any
14 project or activities affected by such failure), until he is satis-
15 fied that there will no longer be any such failure. Until he is
16 so satisfied, the Secretary shall make no further payments to
17 any such Agency or entity or shall limit payments to projects
18 or activities not affected by such failure.

19 CONTENTS OF STATE PLANS

20 SEC. 602. To be approved under this Act a State
21 mental health services plan must be submitted in such form
22 and manner as the Secretary prescribes and must—

23 (1) identify the mental health services areas
24 within the State, which areas must cover the entire
25 State and each of which must, except to the extent and

1 in the cases permitted by the Secretary (including ex-
2 ceptions made for interstate areas), have boundaries
3 which conform to or are within the boundaries of a
4 health service area established under title XV of the
5 Public Health Service Act and, to the extent practica-
6 ble, conform to boundaries of one or more school dis-
7 tricts or political or other subdivisions in the State;

8 (2) set forth (A) the need of each mental health
9 services area in the State for mental health services, as
10 determined after consideration of all relevant matters,
11 including the demographic, economic, or social charac-
12 teristics of the population of the area, with special at-
13 tention to the need of priority population groups for
14 services as well as to the need for services and activi-
15 ties designed to prevent mental illness from occurring,
16 (B) the public or private facilities, mental health per-
17 sonnel, and services available, and the additional facili-
18 ties, personnel, and services required, to meet those
19 needs, (C) the methods used to determine those needs
20 and evaluate the facilities, personnel, and services, (D)
21 the way in which and the order in which those needs
22 will be met through use of existing Federal, State, or
23 local resources and otherwise, and (E) similar informa-
24 tion for the State not included under clause (A), (B),

1 (C), or (D) which is of significance for more than a
2 single mental health services area;

3 (3) provide for establishment or designation of a
4 single agency of the State (in this Act referred to as
5 the "State Agency") to assume responsibility for ad-
6 ministration of the plan and the other aspects of the
7 State's mental health services program and include, in
8 the methods of administration of the plan, methods re-
9 lating to establishment and maintenance of personnel
10 standards on a merit basis which are in accord with
11 standards prescribed by the Office of Personnel Man-
12 agement;

13 (4) identify each Area Mental Health Authority
14 which has been designated by the State Agency and
15 the mental health services area or areas it serves;

16 (5) include or be accompanied by (A) documenta-
17 tion and other evidence showing that, in the process of
18 its development and before the plan was submitted to
19 the Secretary, a reasonable opportunity was afforded to
20 interested agencies, organizations, and individuals to
21 present their views and to comment on the proposed
22 plan; and (B) satisfactory assurances that, after submis-
23 sion of the proposed plan to the Secretary and
24 preaval by him, a reasonable opportunity was
25 ed to interested agencies, organizations, and indi-

1 to comment on administration of the plan and on any
2 proposed modification of the plan;

3 (6) describe the steps that are proposed to be
4 taken at the State level and the local level in an effort,
5 which the Secretary determines to be reasonable (A) to
6 coordinate the provision of mental health services, and
7 (B) to coordinate, in the case of the chronically mental-
8 ly ill and any other priority population group designat-
9 ed by the Secretary, the various kinds of services for
10 members of such groups who need both mental health
11 services and support services;

12 (7) describe the legal rights of persons in the
13 State who are mentally ill or otherwise mentally
14 handicapped and what is being done in the State to
15 protect those rights;

16 (8) provide for emphasizing outpatient mental
17 health services for patients instead of institutional inpa-
18 tient treatment wherever appropriate and include fair
19 and equitable arrangements (as determined by the Sec-
20 retary after consultation with the Secretary of Labor)
21 to protect the interests of employees affected adversely
22 by actions taken to emphasize such outpatient treat-
23 ment, including arrangements designed to preserve em-
24 ployee rights and benefits and to provide training and
25 retraining of such employees, where necessary, for

1 work in mental health or other fields and including ar-
2 rangements under which maximum effort will be made
3 to place such employees in employment;

4 (9) provide that any statistics or other data in-
5 cluded in the State plan or on which the State plan is
6 based will conform to such criteria, standards, and
7 other requirements relating to their form, method of
8 collection, content, or other aspects as the Secretary
9 prescribes in order to provide Nationwide comparability
10 of the data;

11 (10) provide that the State Agency will make
12 such reports, in such form and containing such infor-
13 mation, and keep such records as the Secretary may
14 require, and afford such access to those records as the
15 Secretary may find necessary to assure the correctness
16 of and to verify such reports;

17 (11)(A) provide that an agency of the State desig-
18 nated by the Governor will from time to time, and in
19 any event not less often than triennially, review the in-
20 formation and other material in or accompanying the
21 State plan, as well as the proposed objectives of or ac-
22 tivities under the plan, and submit to the Secretary
23 through the Governor any necessary modifications
24 thereof, except to the extent excused by the Secretary
25 because the modifications are of minor significance; and

1 (B) provide that an agency of the State designated by
2 the Governor will submit to the Secretary through the
3 Governor any other modifications in the plan or in
4 such information, material, objectives, or activities that
5 are necessary for any other reason, except to the
6 extent so excused by the Secretary; and

7 (12) contain or be accompanied by such additional
8 information or assurances and meet such other require-
9 ments as the Secretary prescribes in order to achieve
10 the purposes of this Act.

11 PART B—OTHER GENERAL REQUIREMENTS AND

12 PROVISIONS

13 APPLICATIONS

14 SEC. 621. (a) No grant may be made under this Act to
15 the State Agency of or any entity in any State unless an
16 application (meeting the requirements of this Act and of the
17 State plan of that State approved under this Act) for the
18 grant has been approved by the Secretary.

19 (b) To be approved under this Act, an application for a
20 grant for any project must contain or be accompanied by—

21 (1) a budget covering the year for which the grant
22 is sought (and such additional period as the Secretary
23 may require) showing the sources of funding for the
24 project and allocating the funds available for the proj-
25 ect among the various types of services to be provided

1 or assisted or the various types of activities to be con-
2 ducted or assisted and among the various population
3 groups to which the project is directed;

4 (2) a statement of the objectives of the project,
5 which objectives must be in accord with criteria estab-
6 lished by the Secretary and must include at least those
7 objectives which the Secretary may specify;

8 (3) any statistics or other information which the
9 Secretary and, where applicable, the State Agency
10 may request in order to determine compliance of the
11 project with the requirements of this Act;

12 (4) in the case of any project under which services
13 are to be provided, the schedule of fees to be charged
14 therefor and the discounts to be allowed (to those
15 unable to pay in full) on the basis of relative inability
16 to pay for the services, along with satisfactory assur-
17 ances that the applicant will make every reasonable
18 effort to collect for the services from all available
19 sources;

20 (5) information on the organization and operation
21 of the applicant and the measures taken to provide rea-
22 sonable opportunities for interested agencies, organiza-
23 tions, and members of the public to comment thereon
24 and on the proposed project;

1 (6) satisfactory assurances that the applicant will
2 submit such reports, at such times and containing such
3 information, as the Secretary may request and main-
4 tain such records as the Secretary may find necessary
5 for purposes of this Act, and afford the Secretary and
6 the Comptroller General of the United States such
7 access to such records and other documents as may be
8 necessary for an effective audit of the project or
9 activity;

10 (7) satisfactory assurances that funds made availa-
11 ble under this Act will be used to supplement and, to
12 the extent practical, increase the level of non-Federal
13 funds that would, in the absence of those Federal
14 funds, be made available for the purpose, and will in
15 no event supplant such non-Federal funds;

16 (8) in the case of a grant under title IV (except
17 section 402) to any entity in a State, certification that
18 the State Agency of that State has approved the appli-
19 cation as being in accord with the State plan approved
20 under this Act;

21 (9) in the case of any project for provision of any
22 services (A) a description of the steps the applicant has
23 taken and will take in an effort (which the Secretary
24 determines to be reasonable) to coordinate the services
25 it provides with other mental health services and sup-

1 port services in the same area or areas, and (B) satis-
2 factory assurances that the applicant will, in the provi-
3 sion of such services under the project, as a minimum
4 meet the standards of quality of care prescribed by the
5 Secretary; and

6 (10) such other information and material and such
7 other assurances as the Secretary may prescribe in
8 order to carry out the purposes of this Act.

9 The requirements under this section for assurances, state-
10 ments, descriptions, and other information and materials with
11 respect to an application for a grant for a project apply also
12 to the activities of any Core Service Agency with respect to
13 which payments are to be made from such grant.

14 DURATION OF GRANTS

15 SEC. 622. Any grant under this Act is for such period of
16 time, not exceeding one year, as the Secretary may
17 determine.

18 PERFORMANCE STANDARDS

19 SEC. 623. (a) In determining whether or not to approve
20 an application for a grant under this Act, the Secretary shall
21 consider the extent to which performance by the applicant
22 under any prior grant under this Act or the Community
23 Mental Health Centers Act complied with applicable require-
24 ments, standards, and criteria.

1 (b) The Secretary shall prescribe standard measures of
2 performance designed to test the quality and extent of per-
3 formance by applicants under any such prior grants and the
4 extent to which such performance has helped to achieve the
5 National or other objectives for which the prior grants were
6 made.

7 EVALUATION AND MONITORING

8 SEC. 624. (a) With the approval of the Secretary, any
9 recipient of a grant under this Act may use a portion of that
10 grant for evaluation of the project or activity involved and of
11 the recipient's program of which the project or activity is a
12 part.

13 (b) Appropriations for grants under title I, II, III, or IV
14 may also be used by the Secretary for reviewing performance
15 by recipients of grants thereunder to determine the extent to
16 which they have complied with the requirements applicable
17 to such grants, and the extent to which they have advanced
18 the National or other objectives for which the grants were
19 made.

20 INDIRECT PROVISION OF SERVICES

21 SEC. 625. Any mental health services for the provision
22 of which an entity is responsible for purposes of a grant
23 under this Act may be provided by it directly at its primary
24 or satellite facilities or through arrangements with other enti-

1 ties or health professionals and others in, or serving residents
2 of, the same mental health services area.

3 STANDARDS OF CARE

4 SEC. 626. The Secretary shall prescribe standards relat-
5 ing to the quality of care in the provision of mental health
6 services by any recipient of a grant under this Act.

7 TECHNICAL ASSISTANCE

8 SEC. 627. Such portion as the Secretary may deter-
9 mine, but not more than 2 per centum, of any appropriation
10 for grants under title I, II, III, or IV for any fiscal year is
11 available for technical assistance, including short-term train-
12 ing, by the Secretary to any State Agency or other entity
13 which is or has been a recipient of a grant under any of such
14 titles, to assist it in developing, or in better administering,
15 the mental health services program or programs for which it
16 is responsible.

17 PAYMENT PROCEDURES

18 SEC. 628. (a) Except as provided in subsection (b), the
19 amount of payments under any grant for any year under this
20 Act, other than section 401, may be reduced to the extent—

21 (1)(A) the sums paid to the grantee under any
22 prior grant under the same section of this Act, or (B)
23 in case such amount is to be paid under section 403 or
24 406, the sums paid to it under section 406 or under

1 section 203 (a) or (e) or 211 of the Community Mental
2 Health Centers Act, plus

3 (2) the funds available for the project or activity,
4 for which the prior grant was made, from State, local,
5 or other sources (including collections),
6 exceed the total cost of the project or activity for which the
7 prior grant was made, instead of such excess being repaid to
8 the United States.

9 (b) In the case of any such excess—

10 (1) a reduction under subsection (a) shall not be
11 made to the extent adjustments were previously made,
12 or excused under clause (2) of this subsection, on ac-
13 count of such excess, and

14 (2) such portion of that excess for any year for
15 any project under title IV of this Act or for any project
16 or activity under the Community Mental Health Cen-
17 ters Act as the Secretary may determine, but not ex-
18 ceeding 5 per centum of the cost of operation of the
19 recipient's mental health program, may be retained by
20 the recipient for deposit in a reserve fund maintained
21 for purposes approved by the Secretary, and shall not
22 be counted as available funds for purposes of any sub-
23 sequent grant under this Act.

CONFORMING AMENDMENTS

1

2 SEC. 629. (a) Section 507 of the Public Health Service
3 Act (relating to grants to Federal institutions) is amended by
4 inserting “, and appropriations under title IV of the Mental
5 Health Systems Act,” before “shall also be available”.

6 (b) Section 513 of such Act (relating to evaluation of
7 programs by the Secretary) is amended by inserting “Mental
8 Health Systems Act,” after “Community Mental Health
9 Centers Act,”.

10 (c) Section 1513(e)(1)(A)(i) of such Act (relating to func-
11 tions of health systems agencies) is amended by inserting
12 “Mental Health Systems Act,” after “Community Mental
13 Health Centers Act,”.

14

GRANTS FOR MEMBERS OF INDIAN TRIBES

15 SEC. 630. (a) At the request of any Indian tribe or
16 tribes (as defined in the Indian Health Care Improvement
17 Act) or any urban Indian organization (as so defined), a grant
18 may be made under title IV of this Act to the Indian Health
19 Service or any institution, clinic, or other unit thereof, on the
20 same terms and conditions as apply to non-Federal entities,
21 for any project (for which such a grant is available) to serve
22 members of, respectively, such tribe, tribes, and organization.

23 (b) Any grant under subsection (a) may be made for a
24 project serving members of an Indian tribe or tribes (as so
25 defined) or an urban Indian organization (as so defined) even

1 though the area in which those members reside is included in
2 two or more mental health services areas of a State.

3 GOVERNING BODIES OF LOCAL AGENCIES

4 SEC. 631. No entity is eligible for a grant under title
5 IV, other than section 401, unless it meets the requirements
6 applicable to a community mental health center under sub-
7 paragraph (A) or (B) of section 201(c)(1) of the Community
8 Mental Health Centers Act, whichever is applicable, and, in
9 case such subparagraph (A) is applicable, it provides satisfac-
10 tory assurances that it will meet the requirements applicable
11 to such a center under clause (ii) of such subparagraph (A).

12 COOPERATIVE AGREEMENTS AUTHORIZED

13 SEC. 632. In any case in which a grant is authorized to
14 be made under this Act by the Secretary to the State Agency
15 of or any entity in a State for any project or activity, the
16 Secretary may, if he deems it appropriate, instead enter into
17 a cooperative agreement with such Agency or entity under
18 which the Secretary will make the same payments, on the
19 same terms, for such project or activity as he would under a
20 grant therefor, but only on condition that such Agency or
21 entity complies with the requirements of this Act, including
22 those relating to an application, to the same extent as would
23 be required of an applicant for or recipient of a grant for the
24 same purpose.

1 OBLIGATED SERVICE FOR MENTAL HEALTH TRAINEESHIPS

2 SEC. 633. (a) Section 303 of the Public Health Service
3 Act is amended by adding at the end thereof the following
4 new subsection:

5 “(d)(1) Any individual who has received a clinical train-
6 eeship, in psychology, psychiatry, nursing, or social work,
7 under subsection (a)(1) that was not of a limited duration or
8 experimental nature (as determined by the Secretary) is obli-
9 gated to serve, in service determined by the Secretary to be
10 appropriate in the light of his training and experience, at the
11 rate of one year for each year (or academic year, whichever
12 the Secretary determines to be appropriate) of the trainee-
13 ship.

14 “(2) The service required under paragraph (1) shall be
15 in a State mental (inpatient care) institution, or for any entity
16 eligible for a grant under title IV of the Mental Health Sys-
17 tems Act, or in a health manpower shortage area (as deter-
18 mined under subpart II of part D of this title), or in any other
19 area or for any other entity designated by the Secretary, and
20 shall begin within such period after the termination of the
21 traineeship as the Secretary may determine. In developing
22 criteria for determining for which institutions or entities or in
23 which areas, referred to in the preceding sentence, individ-
24 uals must perform service under this paragraph, the Secre-
25 tary shall give preference to institutions, entities, or areas

1 which in his judgment have the greatest need for personnel to
2 perform that service unless, for good cause shown to the Sec-
3 retary, the individual requests performance of other service
4 under this paragraph.

5 “(3) Any individual who fails to perform the service re-
6 quired of him under this subsection within the period pre-
7 scribed by the Secretary is obligated to repay to the United
8 States an amount equal to three times the cost of the trainee-
9 ship (including stipends and allowances) plus interest at the
10 maximum legal rate at the time of payment of the trainee-
11 ship, multiplied, in any case in which the service so required
12 has been performed in part, by the percentage which the
13 length of the service so performed is of the length of the
14 service so required to be performed.

15 “(4)(A) In the case of any individual any part of whose
16 obligation to perform service under this subsection exists at
17 the same time as any part of his obligation to perform service
18 under section 752 or 753 (because of receipt of a scholarship
19 under subpart IV of part C of title VII) or his obligation to
20 perform service under section 472 (because of receipt of a
21 National Research Service Award thereunder), or both, the
22 same service may not be used to any extent to meet more
23 than one of those obligations.

24 “(B) In any case to which subparagraph (A) is applica-
25 ble and in which one of the obligations is to perform service

1 under section 752 or 753, the obligation to perform service
2 under that section must be met (by performance of the re-
3 quired service or payment of damages) before the obligation
4 to perform service under this subsection or under section
5 472.

6 “(C) In any case to which subparagraph (A) is applica-
7 ble, if any part of the obligation to perform service under
8 section 472 exists at the same time as any part of the obliga-
9 tion to perform service under this subsection, the manner and
10 time of meeting each obligation shall be prescribed by the
11 Secretary.”.

12 (b) The amendment made by subsection (a) applies in
13 the case of any academic year (of any traineeship awarded
14 under section 303(a)(1) of the Public Health Service Act) be-
15 ginning after the enactment of this Act if the award for such
16 academic year is made after such enactment.

17 PART C—AUTHORIZATIONS

18 AUTHORIZATION OF APPROPRIATIONS

19 SEC. 641. (a) There are authorized to be appropriated,
20 for grants under title I, for grants under title II, and for
21 grants under title III, \$45,600,000 for the fiscal year ending
22 September 30, 1980, and such sums as the Congress may
23 determine for each of the next three fiscal years.

24 (b)(1) There are authorized to be appropriated, for
25 grants under title IV, \$302,155,000 for the fiscal year

1 ending September 30, 1980, and such sums as the Congress
2 may determine for each of the next three fiscal years.

3 (2) For each fiscal year which is subsequent to the fiscal
4 year ending September 30, 1983, and which is specified
5 below, there are authorized to be appropriated such sums as
6 may be necessary to make continuation grants for projects for
7 which an initial grant was made under title IV (other than
8 section 401) in or before the fiscal year ending September 30,
9 1983, and which are eligible for such a continuation grant in
10 that subsequent fiscal year—

11 (A) in the case of projects under section 402 or
12 405, the subsequent years are the fiscal years ending
13 September 30, 1984, and the next three fiscal years;

14 (B) in the case of projects under section 403, the
15 subsequent years are the fiscal years ending September
16 30, 1984, and the next six fiscal years;

17 (C) in the case of projects under section 404, the
18 subsequent years are the fiscal years ending September
19 30, 1984, and the next fiscal year;

20 (D) in the case of projects under section 406, the
21 subsequent years are the years for which such projects
22 continue to be eligible for grants under that section.

1 TITLE VII—MISCELLANEOUS
2 COMMUNITY MENTAL HEALTH CENTERS ACT
3 APPROPRIATIONS

4 SEC. 701. No funds may be appropriated under the
5 Community Mental Health Centers Act, other than section
6 231 thereof, for any year period after September 30, 1979.

Senator KENNEDY. In summary, I believe we have begun to develop a useful and responsive mental health care system in this country. The 16 years since the first act was proposed have been fought with trial and error, starts and stops, successes and failure. We have gained considerable experience in the meantime, and millions of patients and families have been helped in this process. This bill substantially moves us forward and, with appropriate amendments, I feel that we can make important improvements in our mental health care systems.

Senator Schweiker?

**STATEMENT OF HON. RICHARD S. SCHWEIKER, A U.S. SENATOR
FROM THE STATE OF PENNSYLVANIA**

Senator SCHWEIKER. Thank you, Mr. Chairman.

In February, I joined with the other members of the Health Subcommittee in welcoming Mrs. Rosalynn Carter, Honorary Chairperson of the President's Commission on Mental Health. In testimony, Mrs. Carter gave us the benefit of her expertise, developed through her work in Georgia and on the Commission, and highlighted some of the serious, unmet mental health needs of Americans.

Today, we begin to get down to the nuts and bolts of what Congress must do in terms of new legislation to meet those needs and move toward the goal of making a flexible, comprehensive system of mental health services available and accessible to all who need them. It will not be an easy task. It cuts across Federal, State, and local government jurisdictions, and we must look for ways to make our partnership with State and local governments work better. It cuts across congressional jurisdictions, since so many issues are tied to financing mechanisms which must also be reviewed by our colleagues on the Senate Finance Committee.

Two key areas I intend to focus on closely are the problems faced by formerly institutionalized mental patients as they move into the community and involvement of the private sector in providing better mental health coverage, for example, through employee mental health packages.

Nowhere are the failures of our current mental health system more glaring, the needs more acute, or the problems more complex and intractable than in the area of care for the chronically mentally ill. Congress, with the best of intentions, encouraged the phasing-down of mental institutions and required community mental health centers to provide aftercare and transitional living arrangements for chronic patients. The sad fact is that in too many cases, the care has simply not been provided. We must work to see that our good intentions are implemented and certain minimum standards of care are provided, while allowing some flexibility. I would list the following as key elements that must be required: Preparation of individual treatment plans, implemented through a system of careful case management; accessibility of needed health and mental health services in the community; appropriate placement of former patients, with attention to problems of oversaturation, so that so-called psychiatric ghettos are not created; accessibility of social services, recreational opportunities and transportation; and, for those patients who are not ready for independent living, careful

monitoring of placement facilities to avoid the horrors of malnutrition, unsanitary conditions, and actual physical abuse that have marked the lives of so many former inmates of State hospitals. To the maximum extent, we should build on existing resources and community programs to achieve these goals. Above all, we must avoid establishing another Federal grant program with requirements that are not enforced.

I believe that the Carter administration's proposal, the Mental Health Systems Act, introduced last week by Senator Kennedy shares these goals and represents a starting place for our subcommittee's work. At first glance, I am concerned about certain elements of the bill, which would lead to fragmentation of services. One of the problems of the existing CMHC program is that the centers have not proven able to provide all mandated services. It would be unfortunate indeed if, in an attempt to be flexible, we sacrifice the goal of comprehensiveness, one of the core concepts of the CMHC program, on the theory that something is better than nothing.

We must also be cautious in targeting services to specific groups—another concept which, while good in theory can in practice go awry. Providing services to specific underserved groups is desirable, but not as a substitute for providing comprehensive services accessible to all in need, and not if it leads to a dual system of community mental health care: One for priority populations, and another for other Americans.

I am sure today's witnesses have much to contribute to our consideration of these difficult issues, and I look forward to your testimony.

Thank you, Mr. Chairman.

Senator KENNEDY. Mr. Secretary, we welcome you.

STATEMENT OF JOSEPH A. CALIFANO, JR., SECRETARY OF HEALTH, EDUCATION, AND WELFARE

Secretary CALIFANO. Thank you.

Mr. Chairman and Senator Schweiker, it is a pleasure to be here to testify on the proposed Mental Health Systems Act.

Your sponsorship of this legislation, Mr. Chairman, is a reflection of the longstanding commitment you have demonstrated to addressing the problems of the mentally disabled.

The proposed Mental Health Systems Act is an outgrowth of this administration's concern for the mental health needs of all Americans. The proposed legislation is the culmination of an extraordinary process which began when the President appointed his Commission on Mental Health less than 1 month after his inauguration.

The Commission spent a year consulting with a broad cross-section of mental health professionals, citizens, State and local officials, community groups, and mental patients to assess the most pressing mental health needs in this country and to determine the most appropriate ways of meeting those needs. Rosalynn Carter, as honorary Chairperson of that Commission, played a major role. She attended most of the meetings of the Commission, attended many meetings of the different Commission Task Groups and was present at the public hearings the Commission held throughout the coun-

try. As the Commission noted in its final report, "Her dedication to improving care for those in need has given us forceful leadership and sparked a spirit of excitement and hope around the country."

One year ago, the Commission presented its report to the President. The report noted that great progress has been made in reaching and treating the mentally ill, but it also pointed out serious deficiencies in our current efforts. I would like to take a few moments to describe some of the Commission's major findings and recommendations which have helped shape our legislative proposal.

The Commission reported on a dramatic shift in the patterns and locus of care for persons suffering chronic mental illness and reported on new problems posed by this shift.

Between 1955 and the present, the population of large mental institutions declined from approximately 600,000 to about 160,000. In 1955, three out of four persons receiving mental health care were treated as inpatients whereas now three out of four persons receiving mental health care are treated as outpatients.

For many long-time residents of mental institutions, the deinstitutionalization has meant being dumped into communities to live in poorly maintained boarding homes or single room occupancy hotels—often without adequate food, clothing, recreational, or social services.

Stable community living is possible for the 1.5 million adults with chronic mental disabilities only if they have access to both mental health care and to a range of support services such as income maintenance, housing, vocational rehabilitation, training in community living skills, day care, and medical care.

Planning for and managing mental health services has become far more complex with the shift from institutional care to widely scattered community-based services. States differ substantially in their current capacities to effectively manage community-based services.

In its report, the Commission noted that our current efforts to prevent mental illness and promote mental health are "unstructured, unfocused, and uncoordinated." It recommended increased resources for research directed to the prevention programs targeted to groups at high risk of developing mental illness.

Senator KENNEDY. What has been done administratively to coordinate those programs?

Secretary CALIFANO. Mr. Chairman, when I first became Secretary, I tried to consolidate several of those programs including some of the commissions, and met with enormous resistance from various interest groups interested in specific pieces of these programs. Legislative attempts to consolidate committees have been unsuccessful and basically, shortly after Mr. Klerman became the Director of the Administration on Alcohol and Drug Abuse and Mental Health, we tried to accomplish the whole situation and peer review process and met with substantial legislative resistance, so there has not been much done. I don't think the difficulty rests in this area with the Department; as you mentioned in your opening statement, something needs to be done to deal separately with the various and overlapping jurisdictions.

Senator KENNEDY. You mean from an administrative point of view? Have you got the authority? It is just the interest groups and power groups who are against it?

Secretary CALIFANO. We ended up in terms of "adamant to the whole peer review process." We ended up in a legal argument over whether I had authority or not. Because of the strong feeling of the chairman of the Human Resources Committee and counsel that we did not have that authority, we decided to do it on a more limited basis. I should, I guess, note two other things that we had just in the past month. We had just brought in a new head of the National Institute of Alcohol Abuse and Drug Abuse, both related closely to mental health. We have top to bottom review of the personnel, coordination, and what have you.

Senator KENNEDY. You have a complete report by the Deputy Assistant Secretary for Planning where they made a number of recommendations on titles XVIII, XIX, and XX programs?

Secretary CALIFANO. I may have, Mr. Chairman.

Senator KENNEDY. I was just wondering about the coordination between reimbursement, financing, and quality in the nursing home. What kind of coordination do you get? Do you get many complaints? I'm interested in how those branches work together. What is the interrelation?

Secretary CALIFANO. In medicare and medicaid they are closer together with respect to financing and 2 months ago I totally reorganized both of those programs. They will operate in a common functional way.

In terms of title XX, we have not yet got the kind of coordination we should have. Title XX is the wide-open program as you know. It is virtually revenue sharing as far as the States are concerned and we have a relatively modest amount of control over how those funds are spent. But I would like, to the extent to which we could, get title XX better coordinated in XVIII and XIX.

The Commission recognized the significant role which the Community Mental Health Centers Act has played in providing needed care to millions of Americans:

To date, 726 community mental health centers have been funded. In 1979, an estimated 2.7 million people will receive care in a community health center.

The community mental health centers program has been successful in attracting other dollars—each community mental health center Federal dollar is estimated to generate \$3 from non-Federal sources.

Despite the successes of the community mental health centers program, the Commission documented certain problems.

Many communities do not have the resources for initial support of a comprehensive community mental health center with the 12 services as required by the current law. There is a need for greater flexibility to suit the needs of each community.

Certain populations such as the aged, racial and ethnic minorities, poor persons, residents of rural areas, and children and youth have not been adequately served by the existing program, and there is a need to focus services to these groups.

The Commission also described the lack of coordination between the mental health and general health care sectors which has great

significance in light of the number of persons with a mental health problem who are treated in the general health care sector.

It is estimated that 15 percent of the U.S. population is in need of mental health services. Of that 15 percent, approximately 18 million or 54 percent receive mental health care from primary care physicians, many of whom lack adequate mental health training.

Cooperative working relationships between mental health and general health care settings are rare.

Finally, the Commission noted that our current distribution of mental health personnel leaves certain areas and groups unserved.

Rural areas, small towns, poor urban areas, and public mental institutions have only some of the mental health personnel they need.

There are insufficient numbers of mental health professionals trained to treat children, adolescents, and the elderly and there are inadequate numbers of minority professionals.

Senator KENNEDY. Yet HEW cut the money for the training program, did it not, from \$93 million to \$89 million?

Secretary CALIFANO. We had to make some difficult budgetary decisions this year, as you know, in the health area and other areas. In that area where there were reductions in training funds, it was our feeling that other Federal programs like BOEG's could provide money for students and hopefully the States would also provide money in these areas.

Senator KENNEDY. In this area we take particular note of the problem of the lack of adequate trained personnel among the minorities. I guess it is less than 2 percent of all the psychiatrists in the United States that are black. For Hispanics, the percentage is even lower. There are only three psychiatrists in the country that are American Indian. And the statistics go on.

I'm wondering, with the reduction in the training program, whether you have special programs to try to increase the percentage of minorities providing services related to mental health?

Secretary CALIFANO. Mr. Chairman, we do. The biggest money we place in the area of training of minorities is probably the funding and support that we have for places like the Howard Medical School and they still produce a number of black doctors and health professionals. In terms of professional health programs for minorities, we—

Senator KENNEDY. Besides the general funding program, are there special programs at HEW—for example, in the field of psychiatry—to boost the percentage of minorities involved with the problems of mental health?

Secretary CALIFANO. I don't think there are programs there above and beyond what you would find in the other medical schools. But I can submit for the record what we have.

Senator KENNEDY. If you could submit in detail what HEW is doing in terms of minority personnel, it would be helpful. Also, what you intend to do about it, if anything, would be helpful.

Secretary CALIFANO. To respond to these and other problems, the Commission developed a series of recommendations to improve the Nation's mental health services. Many of these recommendations have formed the blueprint for the administration's mental health legislation—the Mental Health Systems Act. The proposed act pro-

vides a flexible approach by which States and communities can plan, develop, and implement programs to begin systematically to meet the mental health needs of their citizens, emphasizing services for those groups underserved by the current system.

Title I of the bill would authorize funds to be used by the States to support State and local development of a system of mental health and support services for chronically mentally ill adults and children to help them live in noninstitutional settings.

Since persons suffering from chronic mental disabilities are incapable of moving from agency to agency in search of various services, fragmented services must be coordinated for them to prevent those persons from being hospitalized unnecessarily or from being neglected in the community. States may apply for funds to coordinate existing services for these adults and children, to establish services where none exist, to improve the competency of personnel providing services, and to provide retraining and job placement help for former institutional employees who are adversely affected by the transition to community care.

Senator KENNEDY. In title I, you have, I guess it was, \$48 million? I think that was the figure for title I.

Secretary CALIFANO. \$46 million.

Senator KENNEDY. St. Elizabeths alone is going to take, what, about \$50 million?

Secretary CALIFANO. \$55 million, Mr. Chairman. But St. Elizabeths is a major capital construction program.

Senator KENNEDY. I'm just wondering how far we go in trying to provide funds for use by States to support local systems. I'm trying to put in some kind of perspective how far the moneys will go?

Secretary CALIFANO. You have to view that money essentially as linking money, linking other pieces of the system, whether it is nursing homes or medicaid, which will be supported in large measure by the medicaid program; other services as you indicated supported by title XX linking community health centers. We regard this money as—

Senator KENNEDY. The mental health centers. What is the problem of getting them to be more active? It appears they have many patients going from the institutions right into the nursing homes without being able to utilize the mental health centers. What has been the problem here, do you think? Reimbursement?

Secretary CALIFANO. I think for elderly people and for many poor people with a mental health problem, the reality of financing medicaid, the fact that medicaid is available and decent nursing homes provide encouragement for people to live in that kind of environment. Whereas medicaid will not pay for an apartment, medicaid will pay for the nursing home. We created a multibillion-dollar industry. I guess it is up to about 41 cents of every medicaid dollar goes to long-term care which, by and large, means nursing homes. So \$2 to \$5 billion in an industry that hardly existed 15 years ago is now a \$10 billion industry just with Federal support. It is reimbursement that has created a lot of that. We do not think that the community mental health centers have been well enough linked to the move of people out of the institutions, nor do we think the general health care system—we would very much like to

have more mental health people accorded patients institutionalized in the general health care system.

Senator SCHWEIKER. What has HEW done in terms of outreach efforts for the deinstitutionalized patient? What kind of structure is there now? What more do we need to do in this area?

Secretary CALIFANO. Senator Schweiker, there are limits to what HEW can do. This legislation provides money to give some linkage to the existing social services system including mental health care system to the deinstitutionalized person. Whether HEW should get into the business of establishing fire and safety codes for every boardinghouse in the community is something I have questions about. There are some obligations of local government and some obligations of State governments in these areas that should be followed. But wherever Federal funds are going to move, there is inevitably going to be a desire to make sure that those funds are spent in places that are safe and that are healthy.

Senator JAVITS. Mr. Secretary, would you give me 1 minute, because I've got to go elsewhere. I just wanted to put my statement in the record and say that I have decided to join as a key sponsor of S. 1177. I know that it needs amendment and I will do my utmost to bring amendments into it.

I think we will have in New York an extraordinary pattern. We are working now on a State system in close cooperation with AFSCME, the government workers federation which is going to testify here today, so I am hopeful that some of the lessons we learned will be incorporated in the Federal bill and I will, for my part from this point of view, work from within the bill as one of its cosponsors.

Thank you.

Secretary CALIFANO. Senator, may I just say on behalf of the administration how deeply we appreciate your cosponsorship. I think that is a very good signal for this legislation. We are open to amendments on the bill and hope to work with the committee on it.

Senator JAVITS. Thank you.

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

Senator JAVITS. Mr. Chairman, the United States has long been recognized as a world leader in terms of its health care system and biomedical research program. Never before in the history of mankind have such facilities and equipment for the prevention and cure of diseases been available; never before has the prognosis for recovery from diseases and physical disabilities been so promising.

While we can point with pride to the many accomplishments of medicine in this country, regretfully we must feel less sanguine about the system that is responsible for providing mental health care.

Sixteen years ago the Federal Government began a major effort to establish a network of community mental health centers. That effort, small in comparison to the investment in State psychiatric institutions, has made mental health services available to millions of Americans in one-half of this Nation's communities. Neverthe-

less, the program for many reasons has failed to achieve its potential.

In my judgment, and in the judgment of the President's Commission on Mental Health and others, the Federal role in mental health must be revised and strengthened. This is the principal goal of S. 1177.

However, it is my hope that during the consideration of this bill, the committee will ask whether this legislation will effect permanent change in the mental health system, whether it will lead to permanent alternatives to institutionalization, and whether it will protect the basic rights of the mentally ill.

New York is pursuing a very interesting and important effort to improve the whole mental health effort and I will try to bring the lessons learned in this State effort to bear on the Federal bill. I intend to try to make the bill responsive to these basic questions as we move forward in our consideration of S. 1177.

Thank you, Mr. Chairman.

[The prepared statement of Senator Javits follows:]

PREPARED STATEMENT OF SENATOR JACOB K. JAVITS

Mr Chairman, as a cosponsor of the legislation which the subcommittee is now considering, I strongly support the need for such legislation and will work closely with you to win its swift passage in both this committee and in the Senate. There is no question that a tremendous need for mental health services exists throughout our population. Such needs cannot be ignored, particularly when effective treatments are available. The legislation now before us offers an opportunity to provide much needed services to people who thus far have had inadequate access to mental health services and to make vital changes in the organization and delivery of mental health services throughout the country.

Many of the provisions in this version of the bill will permit the achievement of these objectives. For example, the bill specifically focuses on population groups who are unserved or underserved and on projects which will improve the availability of comprehensive mental health services and promote mental health and prevent mental illness. Furthermore, the bill contains provisions which will do much to improve the coordination of mental health service within each State thereby moving us closer to a truly integrated mental health system.

I support in principle these important provisions. However, I have several serious concerns which I would like to bring to the attention of the committee at this time. Specifically, I am concerned about the provisions which relate to the chronically mentally ill and the deinstitutionalized person. With respect to this particular population group, I believe this health subcommittee is in a unique position to approach their health needs in a fashion which many of us have advocated for a number of years—that is, to approach the needs of this defined group of people from a total point of view. We all recognize that "health" is a function of a broad range of factors—factors which include, among others, housing, nutrition, education, and physical and mental health care. For a number of chronically mentally ill persons, too many of these needs are neglected. While I recognize that the authority for providing funding assistance to accomplish such an objective will come from a variety of sources—from State and local resources and various Federal programs—I believe that the bill which this committee produces should reflect a sensitivity to such a wholistic philosophy.

Second, I believe the bill should look more closely at the status of the deinstitutionalization movement, make recognition of the fact that public policy has failed adequately to address the needs of the deinstitutionalized chronic mental patient since the deinstitutionalization movement began roughly 15 years ago, and do whatever possible to remedy this situation in line with available resources. I am concerned, for example, that there are actually some people who are living in streets and subways as a consequence of being discharged from state psychiatric institutions. Not only are these people not receiving needed mental health services, but their most basic living needs are not being addressed.

Unfortunately, we do not have an appropriate strategy for dealing with this range of problems. Not only do we not have enough housing units in many parts of the

country for chronic mental patients, but we do not even know what kinds of housing arrangements are most appropriate. Furthermore, we do not have sufficient numbers of people trained to assist the chronically mentally ill nor do we even have sufficient personnel to perform many of the necessary coordinating functions called for in the bill.

We cannot make up for public policy failures overnight. Therefore, while I firmly support in principle each of the requirements currently contained in the bill, I believe that many of the requirements should be framed as goals—not as minimum requirements. Given the availability of limited resources at both the Federal and State levels, I believe first that these requirements should be phased in over time and second that our policy be consistent with the total approach to health care such that we assure that basic living needs as well as physical, mental, social and other support services are addressed.

Between now and full committee markup, I will draft amendments which I believe will address these concerns. I ask the cooperation of the chairman, the other members of the committee and particularly Senator Schweiker who I know has a great interest in these provisions in working with me satisfactorily to resolve these differences.

Senator KENNEDY. Thank you.

Secretary CALIFANO. Under title II of the proposed Mental Health Systems Act, States and localities would be encouraged to develop innovative programs for the prevention and early detection of mental disorders and for the promotion of mental health. Funds would be available, for example, to sensitize a broad range of social service providers and educational personnel to the potential mental health problems which could be avoided or minimized for the persons they serve.

Support for more effective State management of mental health services is provided under title III. States could apply for funds to enhance State data systems, improve planning and resource allocation, increase State capacity to set performance standards and increase State ability to evaluate existing services.

Title IV of the act provides increased flexibility in the development of community mental health services while at the same time encouraging comprehensive services for those communities which can support them. Public or private nonprofit community groups may apply for funds for the following purposes:

- To conduct an assessment of a community's mental health needs and develop a plan for services based on the assessment;

- To provide one or more services to a group which is presently unserved or underserved by the mental health system;

- To develop comprehensive mental health services for all residents of a designated area within a time frame which is tailored to the needs and resources of each community;

- To link general health care and mental health services by placing mental health professionals with access to the mental health care system in ambulatory health care centers. These professionals will enhance the general health care sector's ability to identify, treat, and refer persons who suffer from mental disorders;

- To provide funds for mental health activities which do not generate revenues such as preventive services, coordination of services, consultation and education services, outreach and evaluation; and

- To continue funding for existing community mental health centers for their remaining years of eligibility.

Senator KENNEDY. Mr. Secretary, before moving on to that, there is extremely modest funding available for all of those services indicated on your page 10 and 11. HEW goes from \$308 million to

\$302 million on this figure. I mean you have got some phasing down of support for the mental health centers, and we know that there have been very few that have had to terminate because of it. There is no doubt of the enormous kinds of pressures that exist upon those centers. So the actual difference between 1979 and 1980 is really minus \$6 million. You have some difference in research programs and some difference in terms of the training program. That brings it up \$32 million for new services?

Secretary CALIFANO. Mr. Chairman, under this overall, for the investment in mental health of the Department, I think we have to put it in context. We spend, we estimate, about \$2 billion in medicare and medicaid to provide mental health services. About half a billion dollars is medicare and the rest is medicaid.

In the NIHM, in terms of direct grant services in 1959, Congress appropriated \$542 million. In fiscal 1980 we will have \$612 million, an increase of somewhere between 10 and 15 percent. In the community mental health centers themselves, the funding goes down from the \$308 million.

The reason for that is that these community mental health centers are on an 8-year cycle. They are supposed to be phased out in 8 years and become self-sufficient. That accounts for the decline.

Senator KENNEDY. That is right. Have you made an evaluation if they can survive? If there is going to be a reduction of services? What kind of economic pressures will they be under? What is your evaluation?

Secretary CALIFANO. Our people think the proposals we make make sense. No community mental health services should go out of business. We have cut off funds from six. That was because of financial mismanagement. Some have been suspended. By and large, with the funds we have, we would keep the community mental health services going, the good ones. Of 117 of these graduate centers, only one has failed so far. We have done pretty well. When I said "graduate," I mean the ones that have come off of the plan.

Senator KENNEDY. Do you also provide what services have been reduced as well in those centers?

Secretary CALIFANO. I would hope not, Mr. Chairman. By and large, one of the tough things to measure in the health care system is productivity and I think that if services have been reduced, I don't think it is attributable to any change in Federal funding. I hope it is not attributable to any change in Federal funding.

Senator KENNEDY. I think we will probably get testimony later this morning from the mental health centers that they believe there has been a reduction. I am trying to get some empirical information from your shop as to what the facts are they way you see them.

Secretary CALIFANO. After their 8-year period, 117 community mental health centers will be totally phased out; only 1 has failed. I will submit for the record the extent to which there has been any reduction in services in the Mental Health Centers. But like the rest of the health care system, my own judgment is that there is plenty of room for increased productivity. We have not moved with productivity standards in the community mental health service, but we are beginning to test out productivity standards, encounters

per week that ought to be done per week. It will be a couple of years before we can measure that. This system, like other systems, can be held stable for a year or two if it is accompanied by increases in productivity. It is difficult to make those judgments.

Senator KENNEDY. You and I are in very substantial agreement that more does not mean better in terms of overuse of drugs, medical procedures and a wide variety of things. Yet millions of Americans are in need of these services and are not getting them.

What then is the bottom line? What new funds will be available to local communities in this country under this budget?

Secretary CALIFANO. The funding for the Mental Health Systems Act for the first year is proposed at \$99,100,000. In terms of cut-back, it is about \$60 million; that is net funding from NIH which will be available to communities.

Senator KENNEDY. Half of that is research?

Secretary CALIFANO. \$27 million is research, but part of all research—

Senator KENNEDY. So we are talking about \$32 million to local communities in this country?

Secretary CALIFANO. Any good research program will have a training component and people get trained in the course of that. In terms of money that then goes out in service areas under the Mental Health Systems Act—

Senator KENNEDY. I get \$32 million that will go out to the communities in new money. I'm not far off.

Secretary CALIFANO. You are not far off.

I would note, and I think it is important to note, that this is a beginning; that in 1966 the model cities started with \$10 million in the first year and was up to half a billion in the second year, so the potential is there for enormous growth. I hope the OMB is not over me.

Title V of the proposed legislation gives the Secretary of HEW authority to provide, on a pilot basis, that all the funds under the act in a particular State should be funneled through the State mental health agency. That agency would distribute the funds to the community groups and would be charged with the responsibility of monitoring the federally supported community mental health services.

To meet the needs of many areas which are currently in need of mental health professionals, under title VI of the proposed legislation persons who receive mental health stipends will be required to work in an underserved area for a period equal to the length of their Federal support.

Title VI also provides that in order for a State to receive any funds under the act it must develop a mental health plan for the State which identifies the mental health needs and available services in each area. The plan must also include a description of how the rights of the mentally disabled will be protected and must provide protection for institutional employees who are adversely affected by the emphasis on community-based care in lieu of institutional care.

Mr. Chairman, the administration believes that this legislation is an important step toward establishing adequate mental health services for the citizens of this country. We recognize that any

advances in the provision of mental health services must be made in partnership with the States and with the local communities. States provide the vast bulk of the money to support mental health services. The funds provided through this legislation will be used to encourage the States to use their mental health funds in a manner which is consistent with our national priorities.

I might just note in terms of the shares of mental health services, by estimate in fiscal 1979 the country will spend about \$17.3 billion on mental health; \$3 billion will be Federal, \$5.5 billion will be State and local and the balance will be private insurance and self-paid.

There are many areas of the Commission recommendations, Mr. Chairman, which are not addressed in this legislative proposal. Some of them are being addressed in other legislative proposals. You indicated the importance of moving into this area. For example, we have proposed to increase the availability of mental health services for the elderly. We will be proposing changes in the medicare reimbursement ceiling for outpatient services to \$750 from \$250. We will also propose changes in the copayment required for beneficiaries so that they pay only the 20 percent currently required for general health services instead of the 50 percent copayment currently required for mental health services.

Our recently introduced child health assurance program, CHAP, will mandate that States provide mental health services for medicaid eligible children.

Administratively we have taken several steps to address other Commission recommendations:

To assist the chronically mentally ill to function effectively outside of institutions, HEW and the Department of Housing and Urban Development have initiated a joint demonstration project which provides housing and support services for mentally disabled persons.

To promote protection of the rights of mentally disabled persons, the Department is providing \$700,000 for demonstration projects to provide advocacy services to the mentally ill. We are also conducting a study of existing advocacy programs to determine the appropriate Federal role in this area.

To examine the feasibility, desirability and cost of changes in financing of mental health services, we are exploring ways of making medicaid, SSI, title XX, and medicare programs better able to serve the needs of the mentally handicapped. We will also be conducting demonstrations of cost-related reimbursement for free-standing mental health clinics.

Also, in response to the recommendations of the President's Commission, the President's 1980 budget provides for increased funding for research into the causes of mental illness and for ways to improve the delivery of mental health services.

Obviously, Mr. Chairman, no one piece of legislation can provide for all the mental health needs of our Nation. Especially for those who suffer from chronic mental disabilities, issues relating, as you have noted, to medicaid, title II, and SSI must be explored as we seek to find ways to provide truly adequate services for all those who need them. But the need to examine those programs must not

stop us from acting now to meet those needs which clearly can be met with the Mental Health Systems Act.

Two weeks ago, the Washington Post told the story of one homeless patient who had been released from a mental hospital. He spent his nights in a rock quarry and his days trying to escape being beaten and robbed. For this homeless man, deinstitutionalization has led from life in a snakepit—to near death in a gravel pit.

We have the capacity with this legislation to work with the States and local communities to prevent such tragedies. We urge you to enact the Mental Health Systems Act to provide the basis for a Federal, State, and local partnership for the provision of mental health services to those in this country who are most in need of those services.

Thank you, Mr. Chairman.

Senator KENNEDY. Thank you very much, Mr. Secretary, for a fine statement.

I would like to cover three areas: One is about the advocacy program. The Commission made a strong statement in support of advocacy. I am wondering what we really expect? I can imagine we will have an amendment to the legislation in this area and I want to get your reaction. Obviously you have not had a chance to look at the amendment. What is the importance, in your view, of developing an advocacy program?

Secretary CALIFANO. I think it makes sense to develop an advocacy program for the mentally ill. The question is who should develop it and how should it be developed. We decided HEW should develop that after this legislation to do two things. One is to get a better sense as to what works: A community-based advocacy system which the States fund, and that is in part what we are doing with the \$700,000 demonstration fund, to have some advocacy centers demonstrate which ones work best. We have a long record.

Senator KENNEDY. There are 17 advocacy programs now sponsored by the ABA. We have got them in the Older Americans Act and a number of States have good programs. Do we really have to have a demonstration program on this or can't we build upon the existing programs we have and use those as a basis for greater action?

Secretary CALIFANO. I think, Mr. Chairman, our judgment was that it made more sense. When I asked whether we had an assessment of the advocacy centers in the mental health area when we were getting into this area, I found we had never done an assessment of what they achieved. That in part is why it was not included in the legislation. We are doing the assessment. The legal services corps should be placed where you fund that kind of activity instead of at HEW. Those kinds of questions we felt we didn't have a solid basis to answer.

Senator KENNEDY. Let me ask you just on the planning provisions whether we will bet a reaction from States about redtape and additional regulations—doesn't that sound familiar, Senator Schweiker? And we are not giving them any money to move ahead on this? How do you react and respond to this? We have been trying to experiment with a number of different ways and means to deal with that. The LEAA, we have extended it to 3 years for

LEAA grants. Obviously you are aware of the concern that we have. We are not providing any resources and we are going to hear, I am sure, from the States some complaints about this. What could you tell us?

Secretary CALIFANO. Well, Mr. Chairman, I think the States would like the provisions of this legislation which provide flexible grants to them to set up community mental health activities with more flexibility than the Community Health Centers Act. We rely on the States for providing training, advocacy, providing a bill of rights for mentally ill in the State and for providing other linkages. We have to lift some requirements on the States and give them money. There is not enough money in this legislation to provide them all the funds that they will need to do that planning. I think there is enough money in this legislation as it begins to get restarted.

You mentioned LEAA. When you get to a substantial grant program like that, or what I have done with the Elementary and Secondary Education Act, we have the States coming in every third year with plans instead of every year in order to ease their burden. You can't have no planning and give the money out free.

Senator KENNEDY. With the very modest amount of money that will be available for the States, do you know whether they will feel it is worthwhile to make the effort?

Let me ask one final question about employee protection. There has been a good deal of concern that, with the termination and closing down of some of these institutions, both HEW and the Government generally have been really quite indifferent to the problems of employees. Many of them are well trained, they are dedicated. They have worked in this field and yet their interests have not been adequately protected. They have mentioned that regional offices in HEW have been insensitive.

Now, what is the word from the top, what do you expect? How are you going to make sure that your expectation is going to be realized in these regional areas?

Secretary CALIFANO. Well, we try in this legislation to be sensitive to the needs of the employees, to the need for retraining. There are funds for retraining. One can argue about the adequacy of the funds. But the principle of the obligation to retrain the employees would be established by this legislation.

Senator KENNEDY. That is part of the \$46 million, the retraining program? I believe so.

Secretary CALIFANO. Yes, that is right. The important point is that we recognize the obligation of the Government to provide assistance for retraining of these employees. I think if there is a desire to strengthen those provisions of the legislation, then in some way or another we certainly would be open to doing that. It is important to recognize that these people are dedicated. They have given their lives and careers to taking some of the most vulnerable people among us and we have an obligation to them to train them in continuing work and to do other things.

Senator SCHWEIKER. Secretary Califano, you and I both mentioned the problem of "dumping" in our statements, and I referred to it again a while ago in my question regarding outreach. What is the Federal responsibility, and are we fulfilling it? As I read the

law, the law says: As soon as a community mental health center is established, one of the first things that it must set up is the provision of follow-up care to residents discharged from inpatient treatment at a mental health facility. That is a prime requisite as soon as a center is set up. Then, after expiration of a 3-year period, they also have to provide a program of transitional halfway house services for mentally ill individuals, who have been discharged and would, without such services, require inpatient treatment in such a facility.

It seems to me the law is quite explicit about the responsibilities that the community mental health centers have, with respect to this dumping problem.

What I am getting at is, we give grants for 8 years. Have we ever refused a grant? Have we ever stopped a grant because the CMHC wasn't taking care of the dumping in a catchment area?

Secretary CALIFANO. Not to my knowledge. The centers we have turned off have been six centers. The problem was financial mismanagement. Others have been suspended. I will have to check to see if I am correct.

Senator SCHWEIKER. Your figures pointed out that we are going from three out of four patients who are hospitalized to three out of four who are now treated as outpatients. If we acknowledge that dumping is a big problem that is occurring in the deinstitutionalization process today, isn't there some kind of leverage we ought to use in our assessment of whether a mental health center is meeting its responsibilities to its area, since we are providing Federal funds to it?

Secretary CALIFANO. I think the responsibility is both on the mental health center and also on the States and cities. I think that by and large the people who are institutionalized are in State institutions and when they are being deinstitutionalized, they are deinstitutionalized by the States who run those institutions. We should not in any way supplant the responsibility of the States in this area, even where the States have not done an adequate job, which is true in many States, and in the cities which have not done an adequate job, which is true of Washington, D.C., in many respects.

I don't think we should move in and take over responsibilities. We can help. A community health service which does not have control over the number of people and the time people will be put into the community, shouldn't be penalized for not being able to serve the people they put in the community. These grants are not made to the States, to the community health services directly.

Senator KENNEDY. There is joint responsibility. I agree.

We have been arguing about a hospital in Pittsburgh because of safety codes. The Federal arm of HEW says you don't have a safety code for this hospital. We are going to shut it down or cut it off. We have some responsibility to see things are carried out.

I would agree with you about the States. Your point is well taken. They have a large responsibility in this area. That is part of our job to see that they exercise it.

Secretary CALIFANO. I think there is a responsibility as well. I am just saying to develop a system that would be free of either insensitivity or penalties because they don't have control over who

comes into the community. There is an increase in chronic health patients community health centers are seeing.

Senator SCHWEIKER. Do you know what the cost of institutionalizing a patient is, as opposed to the cost of providing day care in the centers? What is the financial impact of the shift from three out of four patients being in hospitals to be treated as outpatients?

Secretary CALIFANO. I would have to submit that for the record. But it undoubtedly has reduced the costs.

Senator SCHWEIKER. Well, I don't know. You may be right. It seems to me that is the big question. If we are suddenly unlatching the gates and putting patients out in the community and providing outpatient services, direct institution costs will certainly decrease—yes, I concur. But haven't we created as much or more total community cost? What is the Federal responsibility for that? How much are the States picking up?

Secretary CALIFANO. We'll have to do an analysis and submit that for the record. There is in addition, as you know, in addition to the poor financial aspect, the human aspect in terms of having an individual as capable of living in his or her home or community or on an out basis during the daytime, a tremendous human value.

Senator SCHWEIKER. Part of the problem, too, as you well know, is that many of the institutions that are unloading patients don't close, so the overhead and fixed costs continue. Instead of lowering costs, we are multiplying costs. We are keeping fixed overhead costs, and adding new ones in the community.

Secretary CALIFANO. I hope you are willing to deal with the problem of hospital beds as well as closing some of these mental institutions.

Senator SCHWEIKER. We talked about St. Elizabeths. My next question relates to the agreement that was reached regarding St. Elizabeths. What does this tell us about our national problem? Is this a model for what we ought to be doing nationally? What kind of lessons have we learned about St. Elizabeths that ought to be applied in a national policy?

Secretary CALIFANO. I think St. Elizabeth is *sui generis* in many respects. When I became Secretary, I made a major objective to get St. Elizabeths accredited again. It badly deteriorated over the last decade. We have been able to get its outpatient section accredited. I hope we'll get an accreditation for the hospital.

One of the major problems was the physical plant and facility. It needed \$53 or \$55 million in capital investment, buildings which will have to go in in the next few years. There are a whole host of problems. It is not an example for the country. I would like to make it one. It has problems in recordkeeping. It has problems in attracting personnel, so I don't think I would hold it up as an example, and I don't think that our \$55 million investment is something you can consider necessary or typical for the rest of the country.

Senator SCHWEIKER. I can see you are not holding it up as an example. It is obsolete in equipment and services, lacking in personal commitments to patients—I agree with what you say—but I think there is a lesson here, too, that can be applied on a national scale.

Secretary CALIFANO. I think there may be, but I would underline the fact that most of the facilities like that around the country are accredited. St. Elizabeths is not accredited. Its records are more severe in terms of recordkeeping and following up patients who are institutionalized. We can provide the States with incentives to have better data systems than they now have and following the patients once they get into the community.

Senator KENNEDY. Does the administration have any proposals aimed at fostering more private sector effort in providing more mental health services—for example, company paid employee health plans? What have we done or what can we do?

Secretary CALIFANO. A couple of weeks ago the President had the insurance companies in to the White House. I talked to him about one part of the mental health problem, alcoholism, and asked them if they would look at their policies and change them to cover treatment for alcoholism outside of the acute care bed. Presently they will cover detoxification in an acute health care facility, \$300 or \$400 a day. We don't need that. One company has already done it. Another company has agreed to do it.

We also agreed to establish a mechanism whereby we would periodically meet with an executive group of these insurance companies to try to move in the private sector in these areas and when I meet with them I will raise the mental health problem. I found them by and large quite willing to listen and respond.

Senator SCHWEIKER. Thank you, Mr. Secretary. I look forward to hearing the results of those talks.

Senator KENNEDY. Thank you very much, Mr. Secretary. We welcome you here. This legislation provides a large mandate. It talks about many of the things that all of us are concerned about. I'm concerned, as you could tell from the earlier questioning, about the rather limited resources. These are the things that are of concern to you as well. On the one hand, we want to make the progress that this legislative offers. Yet we don't want, by failing to provide the necessary resources, to fail to realize what is the real promise of the legislation. So we are glad to have you here. We have areas in which we will work with you and your staff. We are proud to have you here. I am proud to sponsor this legislation. We are enormously grateful to Mrs. Carter's leadership as you pointed out earlier. Thank you very much.

Secretary CALIFANO. Thank you, Mr. Chairman.

It is always a pleasure to be here.

Senator KENNEDY. Always. See how nicely we get along with the administration these days? [Laughter.]

Senator KENNEDY. Hilda Robbins, national president of the Mental Health Association.

Senator SCHWEIKER. Mrs. Robbins is one of my constituents and has been very active in the mental health field since I first came to Congress in 1960. She has been a leader in local mental health efforts, the State effort, and the national effort.

I don't know anyone who has been more devoted, more interested, or more motivated to serve than Hilda Robbins. She has done an outstanding job. I am delighted that a person of her ability has been willing to make a life-long commitment to mental health. We welcome you.

Senator KENNEDY. That is a very nice introduction, Ms. Robbins. We welcome you to the committee to hear your testimony.

STATEMENT OF HILDA ROBBINS, NATIONAL PRESIDENT OF THE MENTAL HEALTH ASSOCIATION, ACCOMPANIED BY ROBERT VANDIVIER, ACTING PROGRAM DIRECTOR, NATIONAL MENTAL HEALTH ASSOCIATION

Ms. ROBBINS. Thank you very much.

I have been working as a volunteer in the mental health field for 23 years.

From the time in 1908 when one man, Clifford Beers, a mental patient, started a movement among citizens to secure better treatment for the mentally ill until now, when upward of 1 million of our Mental Health Association volunteers are joined in the same effort, our basic purpose and goals have not wavered. When the Congress passed landmark legislation in 1963 there was a new inspired determination among our members, because now there was a national goal, a national plan, and funds from the Federal Government. That national goal and commitment was the creation of a system to make accessible to all persons an appropriate array of coordinated mental health services. The 1963 legislation incorporated a commitment to the concept of comprehensiveness, coordination, continuity of care, geographical responsibility and accountability, a multiple disciplinary approach and control by local governance with a majority of consumers. That concept embodied in legislation has survived several major amendments and two Presidential vetoes. We were pleased that the concept was vigorously restated in the PCMH report. The country may have fallen behind the original schedule for the completion of this plan, but we are convinced that we are still on the right track. Therefore, we encourage a strong reaffirmation of the intent of Congress and urge that it be stated unequivocally in the first section of this bill. To the extent that this bill, as finally amended, will advance that national goal and concept, we will enthusiastically support its passage. To the extent that it would endanger that commitment, we would be obliged to oppose its adoption.

I will comment briefly in three areas: (1) Those parts of S. 1177 which we believe should be favorably considered for building into what can become a better and more responsive mental health system; (2) those related issues we would support which were enumerated by Senator Kennedy when he introduced S. 1177 and also those read in the record this morning by Senator Schweiker; and (3) those ideas and parts of the bill which would require major alteration to be compatible with the national goal for a mental health delivery system and with the position of the Mental Health Association.

We endorse and support the following concepts in the bill:

First, we support stronger partnership arrangements between the Federal, State, and local governments.

Second, we support better identification and greater availability of services to all underserved populations.

Third, we support more emphasis on prevention efforts.

Fourth, we support better linkages with the general health care system.

Fifth, we support governance by fully representative local boards with a majority of consumers.

Sixth, we support the emphasis that is placed on providing services for the chronically mentally ill, or the long-term mentally disabled.

Seventh, we support continued funding of those services which do not ordinarily produce revenue.

Senator Kennedy made a number of noteworthy observations when this bill was introduced. With these we concur:

First, we strongly support the inclusion of an advocacy system title in this legislation.

The time for demonstration projects has passed. It is time to get on and develop a system.

Second, we have long recognized the need for and endorse changes in titles XVIII, XIX, and XX of the Social Security Act which were referred to by the Secretary.

Third, we support the idea of providing specific funds for training of non-clinical personnel including members of local governance boards.

Fourth, we commend the special consideration given in Senator Kennedy's introductory remarks to the needs of minority populations, aggressive adolescents, and rape victims.

Fifth, we commend and support Senator Kennedy's remarks regarding the need to intensify our efforts both in training more minority professionals and expanding our knowledge base on the special issues confronting those communities.

The third part of my testimony will deal primarily with elements of title IV of S. 1177 since that is where the major changes are recommended. First, it is important to say, we do not encourage blind support of the present Federal community mental health center system. We have suggested modifications and amendments of the CMHC law through the years. We are dealing with a dynamic, evolving social process and S. 1177 can be a significant part of that process. The beauty and the genius of the developing community mental health system lies in its responsiveness to human needs and consumer input. The evolving community mental health system should not be seen as it has by some as just another piece of poverty legislation. It is to become a system of service available to all who choose it. It is controlled by local citizens with responsibility for planning, developing and evaluating services. It is not a sprawling Government bureaucracy. It includes nonprofit agencies with multiple funding sources. Certainly, it is not an experimental untested system but is operating in over 700 communities. It has grown and changed and now provides unavailable services to millions of people. It is not inflexible or unchangeable. It has been amended to be consistent with experience.

I was surprised and puzzled when Secretary Califano said the centers cannot be held responsible for default in taking care of the deinstitutionalized patient and it seems much blame has been placed on the centers for these things. There is blame on both sides. Many things are responsible for the deinstitutionalized system. The centers have their share of the responsibility, but you cannot have all of the blame laid there. It is not a system without weaknesses, because it is still a developing system. But it is infi-

nately better than the old State hospital and infinitely better than a spotty, limited, fragmented patchwork of services operating in a laissez faire fashion as many of the early, unsystematized, local clinics operated.

There are two important elements underlying the community concept as originally conceived which we find to be threatened by the language of title IV. We are eager that the legislation be viewed very carefully to avoid the dangers which we find to be present.

First is the concept of planning accountability for a defined geographical area. Second is the need for coordination of all services into a system. Those who drafted this legislation expressed grave concern for certain identified unserved populations. However, rushing services from one group to another depending upon which group may have the public sympathy at a particular point in time simply guarantees that neglect will be shifted around from one group to another group. New initiatives to provide single services in communities not yet ready for a full dimension community system seems commendable, but without short- and long-range geographic planning, responsibility established in those communities will be left with huge gaps where no services exist for those not a part of the favored group.

There is a need for language changes and a few substantive changes, mostly calling for more precise and specific details. If the intent of the bill is to create a coordinated system, and an accountable network of services, clear language to assure that this indeed will happen should be written into the legislation. This is the position we want most urgently to support.

An assumption has been made by some that the present process of applying for Federal funding is too complex. The solution which seems to be suggested is the provision of a specific service to a single population group requiring a minimum of standards and linkages. We submit that this would be the wrong solution and would not solve the identified problems. The chronically mentally ill, children and adolescents, ethnic minorities, and the elderly and the poor do not need their own treatment facilities, but they need attention as a part of community planning, coordinated services, and a well-designed care system.

Undoubtedly the most obvious reason for a lack of services for any group is the inadequate funding for community systems all ready and waiting to be born. If the Federal funding envisioned in the original legislation had been up to pace and if 1,500 CMHC's were to be in place by 1980, we would not be discussing this particular issue today. Maybe we would be talking about getting better quality services through those. But we certainly would not have that fear which could lead to the burial of the CMHC's without the publication of an obituary.

All social change is hard to effect. Perseverance is essential. It took hundreds of years to get mentally ill inmates out of prisons so that they could become patients in State hospitals—frequently for life. It took another hundred years to start moving inpatients from behind locked doors in State hospitals into outpatient services and short-term care in the community. The 15 years of emphasis on developing a comprehensive community mental health system has

shown us some weaknesses and many strengths, as you say, some rewards, some disappointments. We believe that those weaknesses highlighted by the PCMH report are very real and very important, but particularized segments of the population identified as underserved must not be used to short circuit the existing design. The existing plan can be adapted to special needs, but the language of this bill as presently written suggests the abandonment of a larger good for an immediate objective. It is therefore unrealistic to assume that the Mental Health Systems Act will be in place for fiscal year 1980; the appropriations recommended in fiscal year 1980 budget of \$99.1 million provide an opportunity to proceed further with the development of the present system, while at the same time providing for those shifts in emphasis properly called for in the new legislation.

In closing, let me emphasize that as the bold new approach embodied in the community mental health system program has grown in public acceptance, the major national provider and consumer organizations in the mental health field have also grown into a community of understanding and supporting collaborators dedicated to resolving differences in ways to maximize service to patients. We are certain that this same spirit will prevail as those of us committed to improving mental health service continue to discuss this important legislation. We are grateful to Senator Kennedy and the members of this subcommittee for helping to assure continuing thought and discussion, and certainly to Rosalynn Carter for her dedicated and effective leadership of the President's Commission on Mental Health, which has done so much to raise urgent, unmet mental health needs to the awareness of the public.

Thank you.

It is most encouraging and gratifying that both Senator Kennedy and Senator Schweiker have been so thoroughly involved in mental health legislation for so long a period of time. We would like to thank your staff and Dr. Shapiro's staff for the excellent assistance they give us and the way they listen when we give them consumer input. My staff tells me they work together very nicely. We thank you for that. It is always nice when people are willing to receive consumer input.

Senator KENNEDY. Fine. That is a very nice comment. I want to say how much we appreciate your help and assistance. You are on the firing line, and represent organizations that are on the firing line, and have in so many instances a different perception about how these programs work. It is of enormous value to us to get that input.

I have a question as to the nature of the funding of this program. Now whether we can even begin to scratch the surface for improving quality of life of institutionalized patients and the mentally ill with this kind of bill, I don't know. We reviewed very briefly with the Secretary how much in new resources will be available. How would you describe it? Is this bare bones?

Ms. ROBBINS. Bare bones minus a certain percentage. It would be a mistake to think, by writing new legislation and not appropriating more money to think you will solve the problem. You are spreading the problem over more agencies. The whole concept of treating the individuals in the community is beginning to be sup-

ported and accepted; not supported financially, but by the investment in the system that will serve all the people. It would be a shame not to give it adequate funding so that it can continue to grow. One of the frustrations that we have not quite brought out and said in the opening today, when we started talking about these programs in 1963 we envisioned that there would be national health insurance on board by now and that some of these funding problems we are trying to deal with in grant mechanisms and other ways would not exist and there would be no need for those considerations. I would hope we don't have to wait too much longer for that health insurance, whether it be through a national program or something that Senator Schweiker has discussed which I think has a lot of merit when employees really get involved in this, but that is one of our problems.

Senator KENNEDY. The reimbursement mechanism, no matter how you deal with it, is really the key in terms of the delivery system. This is something which we, the Congress, have not really understood as an institution. We have the Finance Committee dealing with the financing aspects, this committee dealing with the delivery system. Until we look at it in a systems way, we will still be trying to put the pieces together.

Ms. ROBBINS. We are particularly aware, because of the kind of national health insurance position we have taken, that is the mental health position, and I think this is reflected in pieces of legislation with which you are familiar, which would give preference to treatment in an organized setting, and which would include a multiple disciplinary situation, a variety of services offered and a number of other things. I hope we don't set up a lot of services in the country to which people would be going and then they would not be eligible for preferential reimbursement for some kind of insurance program. That would be a tragedy.

Senator KENNEDY. You have been enormously successful in getting volunteers. You have some 1 million volunteers. How can you see that that program can be expanded and nurtured?

Ms. ROBBINS. We have very aggressive membership programs in the association. The growth has been because things moved into the community and mental health is more accepted. There was a time when people didn't really want to be associated with mental health programs. There is too much stigma attached to it. The value of having a good membership and big membership and informed membership is I didn't dream up this paper all on my own. We have members who have been on other boards; they have worked with patients as volunteers and worked in liaison with innumerable mental health organizations including State and Government organizations, and we find that kind of feedback that comes back to us is most helpful in helping us determine what is working and what isn't working and what needs changes. We have defined a program and guidelines to be used in community mental health centers and it helped us highlight the weaknesses and the strengths.

Senator KENNEDY. What is your own view today about the most important priorities in the areas of mental health?

Ms. ROBBINS. I think it is that thing which Dick has highlighted and most of the others who have spoken, and that is the long-term

mentally disabled, the deinstitutionalized patient. It is most difficult to deal with because it cuts across so many areas and there are a number of reasons. These people aren't very demanding. They don't come in and say: I am going to jump out the window if you don't do something for me immediately. I need help.

They are very retiring. They are very happy, in their own sense, to sit and not make any demands. Providers aren't so keen about giving service to these people because they know again they are going to be ill for the rest of their life and, as a general population, we don't like to think about people who are chronically ill. That word sticks in people's throats sometimes.

It does not mean we don't have a responsibility for people that we recognize as needing services and the very nature of their illness makes them so open to abuse and neglect and misuse. That is the biggest problem we have. There are other underserved populations which need service—children's services and minorities and an area that is not dealt with in this bill, but something we are concerned about is seeing escalation of funds put into mental health research. That is way behind other researches. It is not dealt with here. But it is a problem.

Senator KENNEDY. It is an excellent response. It is a reflection of the quality of our own society, too. It was an excellent answer.

Senator SCHWEIKER?

Senator SCHWEIKER. Thank you, Mr. Chairman.

Ms. Robbins, following up on the problem of deinstitutionalization, which you also alluded to earlier in your statement, what advice can you give this committee? How should the committee or the Federal Government deal with this problem? It is multifaceted. It is a State and city responsibility if you are in an urban area, obviously the mental health centers and other providers have a role, too. Have you any specific suggestion as to what we in the Federal Government ought to be doing or looking at that maybe we are not, to help solve this problem?

Ms. ROBBINS. I think that if there could be some, one responsible entity that could see, for instance, that there were changes made in SSI. Did you know that when a person leaves the hospital and goes to their family, returns to their family, their SSI payments are reduced by one-third? That discourages patients from going back to their families and discourages their families from taking them. That is one change that can be made.

We have talked about changes in medicaid and medicare and social services. We have not discussed the area of housing. That is one of the real big stumbling blocks. All are in different departments of the Government. No one is pulling them together or seeing that they are really coordinated. That would be a big step.

Senator SCHWEIKER. We need a lead agency.

Ms. ROBBINS. We really do. This business of so many patients and former patients being in the psychiatric ghettos which you have mentioned, I often wondered if there couldn't be a funding for an impacted area. There is funding for schools when there are additional Federal employees in an area. This is a much more needful thing than that. Not that I am passing judgment on that. It is just so desperately needed because of the zoning laws in most of the States and counties and, unfortunately, zoning laws are not just

counties but townships and municipalities, so it is difficult to get hold of them. They are keeping out the former patients from vast areas and they are all getting concentrated in a very narrow area. I can understand why the residents of that area would not find that a very desirable situation.

On the other hand, if those residences in which they are concentrated could be improved some and made more habitable, it would not mean that the community was deteriorating such as is frequently the case now. Funds in impacted areas around large State hospitals might help. That is a possibility for you to consider, Senator SCHWEIKER.

Senator SCHWEIKER. You mentioned housing a moment ago, and you have obviously elaborated on it now. In addition to what you just mentioned, are there other problems with housing that you see?

Ms. Robbins. Well, the zoning is one matter, but just making the funds available to HUD, to community development funds, to the mentally ill; that is still on a demonstration progress basis, even though the Senate said the mentally ill shall be treated equitably and have equal access, HUD in the second year said: "We will make them available only on a demonstration process and see how it will work out." That could be changed.

Some areas of blatant discrimination in which the Federal Government is the one who is doing the discriminating, I think is one of the things that could be helped by having a good advocacy program. When you think about the fact that there are at least 10 areas in which the mentally ill are legally discriminated against and most of that is by the Federal Government, I should think you would find that kind of hard to live with.

Senator SCHWEIKER. Very good point. Do you have any suggestions or reactions to NIMH's oversight of this situation? How can we improve it?

Ms. ROBBINS. I think that there have been a number of times when technical assistance from NIMH, at a critical point in the development or crisis situation in the center, would be most helpful. I understand the reason it was not available is that there were not enough funds for a good technical assistance staff. Those areas, particularly poverty areas that have not been able to make applications for funding, could be helped along the road a lot by technical assistance. I think the monitoring has been somewhat lax and inadequate because, again, there has not been enough staff available for NIMH in regional offices to do that kind of monitoring and you seem to be suggesting the possibility of sanctions even. That might be considered.

Senator SCHWEIKER. I'm not sure that I was suggesting sanctions, but it struck me we have not said anything to anybody. I've got to believe somebody is not doing their job.

Ms. ROBBINS. If you look at an area where there was a State hospital emptying patients out, and if that center did not have one of its priorities to take care of the patients, I think the Feds would have good reason to ask about it and give them 10 months to come into compliance and to meet the priorities.

Senator SCHWEIKER. If we don't ask about it, everybody gets the impression we don't care. If we don't even ask people we fund for a

year "What are you doing for chronic patients?" we have a serious problem. No wonder everyone says, "Let someone else do it".

Ms. ROBBINS. The States say, "The Feds don't care, they are not monitoring. It is not our job, because they bypassed us." You know the arguments there. So I think the presence of the Feds in monitoring and setting standards is very important because the standards set by the Feds in my experience have always been higher than the others, but they have not always been followed up and monitored as well.

Senator SCHWEIKER. Maybe a mental health center would come back and say, "Wait a minute, we don't have the funds to do it. We are not getting enough money." When they say that, we have the opportunity to put the responsibility where it belongs and say, to the State, "You you are not doing your share." When no one cares about it, no one accepts responsibility. We have nothing to work with.

Ms. ROBBINS. The problem of fixing responsibility and accountability is something that concerns us. Without a geographic responsibility that is there, and without one agency that is responsible for all these services being pulled together, it is just hard to place that kind of accountability. It is terribly important. Just the idea of linkages, which are very good and very necessary, does not necessarily solve that problem and does not particularly provide necessary services. If you link together two very very weak agencies, you don't have a strong service agency or service thing. You have just got two weak ones that have a weak link.

Senator SCHWEIKER. One final question. We are talking here about some kind of minimum standards of care and services for the chronic and deinstitutionalized patients. My question is, How can we develop such standards? You heard me discuss this with Secretary Califano. Is it feasible to make it a Federal responsibility? Is it something we should, instead, insist that the State invoke if they are going to qualify for funds? What is your view of who should set a minimum standard?

Ms. ROBBINS. I think that title I needs more specificity. Certainly some of the standard setting would be there. I also think there is kind of a backing away from identifying community command in title I because it really sort of focuses it all on the State. If you really looked at that with the idea of being more specific and more concrete and bringing the performance contracts into a more specifically defined way of serving the State and Feds, it would help. There was a lot of talk about performance contracts in the early part of the legislation, 6 or 8 months ago. It seems they have changed their name and got shifted to a less important part. We think they are a good way for the Feds to keep their responsibility defined and the States understanding as to what it is. I hope those can be tightened up.

Senator SCHWEIKER. Thank you very much. You have been very helpful to us.

Ms. ROBBINS. Thank you.

Senator KENNEDY. As you are aware, the proposals, even in the program I support, are extremely limited in terms of dealing with the problems you have identified here. We have found many that have pointed out the costs of health insurance, from the way that

we have proposed it, but when you are talking about long-term care, and the mentally ill need this, we are talking about a major commitment of resources in our society that we have not really begun to fathom. Whether we will or ever will, is something we have got to continue to evaluate. I don't know what your sense about this is.

Ms. ROBBINS. I think there will have to be a careful differential between those services for the long-term mentally ill that would logically be reimbursed and the payments should come from health insurance, and those that should not. I don't think that housing and board and some of the reeducation programs should come from that health insurance.

Senator KENNEDY. Just the medical aspect?

Ms. ROBBINS. The medical aspect would be logical. The important thing would be the mentally ill, whether it be the long-term or acutely seriously ill, be not discriminated out on the basis of diagnosis. I think that would be unconstitutional.

[The prepared statement of Ms. Robbins follows:]



mental health association

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EXTENDED TESTIMONY BEFORE THE SENATE SUBCOMMITTEE
 ON HEALTH AND SCIENTIFIC RESEARCH,
 COMMITTEE ON LABOR AND HUMAN RESOURCES

ON S. 1177, THE "MENTAL HEALTH SYSTEMS ACT"

BY HILDA ROBBINS, NATIONAL PRESIDENT

MAY 24, 1979

NATIONAL OFFICERS 1979

<i>President</i> HILDA H. ROBBINS	<i>President-Elect</i> BEVERLY BENSON LONG	<i>Vice President, Fund Raising</i> PHILIP EMILE, JR.	<i>Vice President, Organization & Development</i> THOMAS C. BINKLEY	<i>Vice President, Program</i> JULIA J. OLIVER
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<i>1979 National Mental Health Chairperson</i> BETTY HAMILTON	<i>Acting Executive Director & Assistant Secretary</i> RICHARD C. HUNTER	<i>Board Member Emeritus</i> ROSALYNN CARTER		



From the time in 1908, when one man, Clifford Beers, a mental patient, started a movement among citizens to secure better treatment for the mentally ill, until now, when upward of one million of our Mental Health Association volunteers are joined in the same effort, our basic purpose and goals have not wavered. When the Congress passed landmark legislation in 1966 there was renewed determination among our members because now there was a national goal and furthermore a national plan and funds from the federal government. The national goal and commitment were to the creation of a system to make accessible to all citizens an appropriate array of coordinated mental health services. The 1966 legislation incorporated a commitment to the concept of comprehensiveness, coordination, continuity of care, geographical responsibility and accountability, a multi-disciplinary approach and control by local governance with a majority of consumers. (Please see Attachment #1 for further background information on this national goal.)

That concept embodied in legislation has survived several major amendments, and two Presidential vetoes, and we are pleased that the concept was vigorously restated in the report of the President's Commission on Mental Health. The country may have fallen behind the original schedule for the completion of this plan, but we are convinced that we are still on the right track. Therefore, we encourage a strong reaffirmation of the intent of Congress and that it be stated unequivocally in the first section of this bill. To the extent that this bill, as finally amended, will advance that national goal and concept, we will enthusiastically

support its passage. To the extent that it would endanger that commitment, we would be obliged to oppose its passage.

It seems appropriate to examine the issues before us in three areas: (1) those parts of S. 1177 which we believe should be favorably considered for building into a better and more responsive mental health system; (2) those related issues we would support which were enumerated by Senator Kennedy when he introduced S. 1177, and (3) those ideas and parts of the bill which would require major alteration to be compatible with the national goal for a comprehensive community-based mental health delivery system, and with the position of the Mental Health Association.

Area 1. We endorse and support the following concepts in the bill:

1. Stronger partnership arrangements between federal, state and local governments. Performance contracts should be used with very specific standards, conditions and sanctions spelled out.
2. Emphasis on providing services for the chronically mentally ill, or the long term mentally disabled. States need federal assistance in developing the multiple services required by the long term mentally disabled. A plan for gradual sharing of this responsibility by federal, state and local governments would be important and desirable.
3. Better identification and availability of services to all underserved populations. The PCMH, the Congress, the MHA, and the Centers themselves have identified inadequacies in this area. We are committed to correcting these problems.
4. Emphasis on prevention efforts. An administrative unit for prevention within NIMH would generate federal leadership

which must include connections with, and more direction and monitoring of, local activities. We also want the most careful and complete data collection. The collection and dissemination of information about reliable and proven successful prevention programs which can be replicated should be a high priority as well as new prevention projects which are potentially effective and need research.

5. We support better linkages with the general health care system. We also would see advantages to requiring certain linkages between the mental health system and the social service, transportation, education, rehabilitation, and other systems.
6. Governance by fully representative local boards with a majority of consumers, as presently required under the CMHC Act.
7. Continued funding of services, such as consultation and education, which do not normally produce revenue. This will be an increasingly important aspect of mental health funding when national health insurance is in effect. (See attachment #2 for more detailed comments on each Title.)

Area 2: Senator Kennedy made a number of noteworthy observations when this bill was introduced. He invited comment, and I would offer the following (Please see attachment #3 for additional comments and recommendations.)

1. We strongly support the inclusion of an advocacy system title. There is sufficient experience to support the growing belief that federal legislation for mental health advocacy is needed now.

The advocacy system must be totally independent of mental health service providers and mental health funding agencies, and must be adequately financed on its own. It must include access to legal remedies. The neediest and most numerous of the mentally disabled among us must not be further denied a much needed means of assuring their basic rights.

2. We have long recognized and supported the need for changes in Titles XVIII, XIX, and XX of the Social Security Act. Specific changes we have recommended are enumerated in lengthy testimony by this Association. Some of these recommendations are summarized in Attachment #3. We commend both the President and Senator Kennedy for taking first steps to correct the unconscionable discrimination which has been and continues to be perpetrated in these federally supported programs.
3. We support the idea of providing specific funds for training of non-clinical personnel. There is additionally a need for funds for special training of all of the members of local governance boards. Local governance boards really work but they cannot work on just good intentions and ignorance. They need help with issues and skills.
4. We commend the special consideration given in Senator Kennedy's introductory remarks to the needs of minority populations and children. They have been consistently unserved or underserved and need comprehensive community-based services to meet their specialized needs.

5. We commend and support Senator Kennedy's interest in training more minority professionals and expanding our knowledge base regarding the special issues confronting these communities. We appreciate his support for expanding the role and scope of influence of the Minority Center located within NIMH.

Area 3: The third part of my testimony will deal primarily with specific issues related to Title IV of S. 1177 since that is where the major changes are recommended. First, it is important to say we do not encourage blind support of the present system. We have suggested modifications and amendments of the CMHC law through the years. We are dealing with a dynamic, evolving social process, and S. 1177 can be a significant part of that process. The beauty and genius of the developing community mental health process lies in its responsiveness to human needs, consumer input and governance. The evolving community mental health system should not be seen, as it has been by some, as just another piece of poverty legislation. It is to become a system of service available to all who need and choose it. It is controlled by local citizens with responsibility for planning, developing and evaluating services. It is not a sprawling government bureaucracy. It includes non-profit agencies with multiple funding sources. It is not an experimental, untested system, but is operating in over 700 communities. It has grown and changed and now provides previously unavailable services to millions of people. It is not inflexible nor unchangeable. It has been amended to be consistent with experience. It is not a system without weaknesses, because it is still a developing system. It is infinitely better than

only the old state hospital system, and infinitely better than a spotty, limited, fragmented patchwork of services operating in a laissez-faire fashion.

There are two elements underlying the community concept as originally conceived which we find to be threatened by the language of Title IV. We are eager that the legislation be viewed carefully to avoid the dangers which we find to be present.

First is the concept of planning accountability for a defined geographical area. Second is the need for coordination of all services into a system. Those who drafted this legislation expressed grave concern for certain identified unserved populations. However, rushing services from one group to another, depending upon which group may have more public sympathy at a particular point in time simply guarantees that neglect will be shifted around from group to group. New initiatives to provide single services in communities not yet ready for a full dimension community system seems commendable as far as it goes in the bill, but the language needs to be changed to assure that those very populations most in need of services are not deprived of their right to a fully comprehensive system of services developed in a planful and accountable way. In a later section of these comments, we propose specific changes needed in Title IV which we strongly believe will better serve to provide an appropriate array of services to those most in need, while at the same time continuing to honor the national commitment to providing community mental health services to all who need and choose them. The present language will, we believe, lead ultimately to huge

gaps both in geographical distribution and in the array of services made available to people.

There is a need for language changes and several substantive changes mostly calling for more precise and specific details in most of the Titles. The general looseness of language, especially in Title IV, concerning partnerships, relationships to health planning, monitoring and evaluation, consumer participation, definitions, timetables, sanctions, etc., calls for more than careful editing, in as much as these words either are or are not consistent with the meaning of a community mental health system, depending upon how they are intended. If the intent of the bill is to create a coordinated system, and an accountable network of services, clear language to assure that this indeed will happen should be written into the legislation. This is the position we want most urgently to support.

An assumption has been made by some that the present process of applying for federal funding is too complex for rapid action. The solution which seems to be suggested is the provision of a specific service to single population groups requiring a minimum of standards and linkages. We submit that this would be the wrong solution and would not solve the identified problems. The chronically mentally ill, children and adolescents, ethnic minorities and the elderly don't so much need their own treatment facilities but they do need attention as a part of community planning, coordinated services, and a well-designed system of care.

Undoubtedly the most obvious reason for a lack of services for any group is the inadequate funding for community mental health service

systems ready and waiting to be born. If the federal funding envisioned in the original legislation had been up to pace, and if 1500 CMHCs were to be in place in fact by 1980, we would not be discussing this particular issue today, even though we might well be discussing how to provide better quality services. We would not be discussing provisions in proposed legislation which we fear could lead to the burial of the CMHC program without the publication of an obituary.

We are concerned that children's needs have been de-emphasized from earlier drafts of the legislation, particularly for the two million seriously mentally ill children. There was previously a separate section describing the "Most In Need" (MIN) program for this population, but it is now almost impossible to identify. We understand the MIN program is intended in Title I, Services to the Chronically Mentally Ill, and is described by the addition of the words "and children" to "chronically mentally ill adults." This title should have a new section more fully describing the important MIN program.

All social change is hard to effect. Perseverance is essential. It took hundreds of years to get mentally ill "inmates" out of prisons so that they could become "patients" in state hospitals, frequently for life. It took another hundred years to start moving "inpatients" from behind locked doors in state hospitals into outpatient services and short term care in the community. The fifteen years of emphasis on developing a comprehensive community mental health system has shown us some weaknesses and many strengths, some rewards and some disappointments. We believe that those weaknesses highlighted by the PCMH report

are real and important, but particularized segments of the population identified as underserved must not be used (and ultimately shortchanged) to short circuit the existing basic design. The existing national goal of comprehensive services and the plan for achieving them can and should be adapted to special needs, but the language of this bill as presently written suggests the abandonment of a larger good for an immediate objective.

It will require time to integrate all the desirable elements of change that are recommended in S. 1177 with all the desirable elements to be retained from the present system and the new ideas that have been contributed by Senator Kennedy and others. Because it is therefore unrealistic to assume that the Mental Health Systems Act will be in place for FY1980, the appropriations recommended in the FY1980 budget of \$99.1 million provides an opportunity to proceed further with the development of the present system of services, while at the same time providing for those shifts in emphasis properly called for by the PCMH and in the new legislation.

When work was beginning on the implementation of the final PCMH report, we transmitted to Secretary Califano specific legislative recommendations (Attachment #4). We recognize that it is not possible to incorporate all of our recommendations nor even a major proportion of the 117 recommendations of the PCMH. We therefore would underline Senator Kennedy's introductory comments regarding the importance of careful review and amendment of this important legislation, and of the importance of additional legislative improvements that will be needed.

In closing, let me emphasize that as the bold new approach embodied in the community mental health systems approach has grown in public acceptance, major national provider and consumer organizations in the mental health field have grown into a community of understanding and supporting collaborators dedicated to resolving differences in ways to maximize service to patients. We are certain that this same spirit will prevail as those of us committed to improving mental health services continue to discuss this important legislation. We are grateful to Senator Kennedy and the members of this Subcommittee for helping to assure continuing thought and discussion, and we are most grateful to Rosalynn Carter for her dedicated and effective leadership of the PCMH, which has done so much to raise urgent, unmet mental health needs to the awareness of the public.



mental health association

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national headquarters

The Association bases its response to any proposed legislation on our best understanding, as consumer advocates, of the needs of persons suffering from mental illness or persons potentially in need of mental health care.

The Association continues to support the basic purpose and concept, established and reaffirmed by Congress since 1963, of coordinated and accessible community mental health services, available to all citizens. This is an appropriate and essential ongoing national goal.

Central to the concept of community mental health care, as established by Congress, is a system which is comprehensive in scope and coordinated in delivery. President Kennedy in his February 3, 1963, message to Congress calling for the development of CMHCs, cited the need for "early diagnosis and continuous and comprehensive care, in the community." Congress, in its 1975 override of the President's veto of the CMHC Act, stated:

"The Congress finds that --

- (1) community mental health care is the most effective and humane form of care for a majority of mentally ill individuals;
- (2) the federally funded community mental health centers have had a major impact on the improvement of mental health care by --

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- (A) fostering coordination and cooperation between various agencies responsible for mental health care which, in turn, has resulted in a decrease in overlapping services and more efficient utilization of available resources.
- (B) bringing comprehensive community mental health care to all in need within a specific geographic area regardless of ability to pay, and
- (C) developing a system of care which insures continuity of care for all patients.

and thus a national resource to which all Americans should enjoy access; ..."

The Association, working with volunteer members throughout the country, has maintained close contact with the emerging community mental health system which has been facilitated by the present community mental health center law. While there have been obvious weaknesses in these developments, continuing reports from our membership confirm our conviction that the essential elements of the concept of community mental health care are sound and must be strengthened in any new federal legislation. We were pleased that this concept was reaffirmed by the final report of the President's Commission on Mental Health, which stated:

"Our long-range goal for mental health services must be a comprehensive and integrated system of care that draws on the strengths of both the public and the private sector....The services offered should be coordinated, and continuity of care assured, within the mental health sector and among mental health systems and the health, social service, education, and income support systems. Because we can no longer afford a fragmented system that leaves many people unserved, there must be effective planning and accountability procedures."

In reference to the Community Mental Health Centers program, it is important to note that in 1974 (latest available data) the Federally supported CMHCs represented only 4.2% of the \$14.5 billion expended for mental health care in the U.S., but provided almost 30% of the episodes of mental health care given in that year. The PCMH report has also reminded us that about one-half of those served by CMHCs were below poverty income levels,



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Comments on Titles and Selected Sections of S. 1177.

Section 2. Findings and Purpose.

The points made in this section are generally appropriate but insufficient.

Section 2(a). Findings omit mention of the significant progress made to date in developing community mental health service delivery systems occasioned by the community mental health center legislation.

Regarding Section 2(b). Both in the Statement of Purpose and Objectives of the Act, there is omission of what has been a national mental health policy, reflected in numerous statements of Congressional intent and law, and reaffirmed by the President's Commission on Mental Health. That is the purpose of providing an appropriate, coordinated, and accountable range of community based mental health services for all citizens in need of such services. This central purpose must be reaffirmed in any legislation proposed to replace the current Community Mental Health Centers Act.

Regarding Section 2(a) (4) on prevention, the statement should be revised to read: "present efforts to prevent mental disability through (add: utilization of existing knowledge), discovery and elimination of the causes"

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Section 3(6). Definition of "area mental health authority," is unclear in relation to Section 3(7) "Core Service Agency." Questions of boundaries and function in both definitions, should be clarified. Further, we question whether an area mental health authority, when adequately defined, should relate to more than one mental health service area.

Section 3(8). "Support services" should include educational as well as social and other services.

Section 3(10). "Mental health services area" as defined is too broad, and should include indication of relationship to presently established CMHC catchment areas or similar concept specifying limited numbers of people served. Here and elsewhere, the concept of defined services for specific and limited geographical areas, with appropriate flexibility, must be strengthened. Relationship to Health Service Areas should be clarified.

Section 3(11). "Comprehensive mental health services" is appropriately defined here by allusion to current law, but the definition is changed subsequently in the draft by giving the Secretary authority to exclude any of the comprehensive services from the definition. (Section 401(c)).

We note that there is no definition of ambulatory health care center.

TITLE I. MEETING THE NEEDS OF THE CHRONICALLY MENTALLY ILL.

We support the inclusion of a separate Title for meeting the needs of the chronically mentally ill.

The confusion of role and function between area mental health authorities and core service agencies, mentioned above, is reflected in this Title.

This should be clarified.

The concept of performance contracts among levels of government should be better reflected in this Title and elsewhere. Specific standards, the rights and duties of the parties, and sanctions for non-performance, should be spelled out. There should, perhaps, be a separate section under this Title to describe components of services for chronically mentally ill children and adolescents. This should include description of the required relationship between Title I services and, for example, services provided under P1 94-142, Education for All Handicapped Children Act.

Section 101(5) may be strengthened by naming the described individual as a "case manager."

The relationship between Title IV and Title I should be clarified, e.g., can a Title IV agency be a Core Service Agency? The relationships between performance contracts, once defined, services for the chronically ill, and Title IV agencies should be clarified.

TITLE II. PREVENTION OF MENTAL ILLNESS.

We support the inclusion of prevention as a separate Title. The content of this Title should be enlarged, however.

There is no focus for coordination and leadership at the national level, nor is there any indicated process or structure for setting national goals. The President's Commission on Mental Health spoke clearly to this need. An administrative unit for prevention within NIMH is needed.

There is no mention of the importance of utilization of existing knowledge about prevention nor indication of need for improving the process of applying research findings in prevention programs.

Finally, there is no indication of methods for monitoring and evaluating prevention programs.

TITLE III. STATE MENTAL HEALTH SYSTEMS IMPROVEMENT.

We are supportive of the thrust of this Title.

Question has been raised about the advisability of providing federal funds "for what the states should be doing anyway." There is, however, need for improved capacities within the states to facilitate planning, developing, evaluating and monitoring integrated systems of service. A federal program of assistance should be considered in conjunction with national goals for deinstitutionalization, and incentives for states to move toward integrated, community-based, systems of care.

Implementing this important national goal will be facilitated both by improving state mental health programs and by improving the ability of the federal government to utilize information, including uniform statistics, generated within the states.

TITLE IV. COMMUNITY MENTAL HEALTH SERVICES.

- A. The weaknesses of Title IV stem directly from the failure in Section 400 to reaffirm the fact that since 1963 the overarching concern of the Congress, vigorously restated by the President's Commission on Mental Health, has been to provide all persons in need a full array of community mental health services accessible in defined geographic areas, and to make it possible for all such persons to secure coordinated care by providing a known entry point into the system.

Section 400 should be amended to make this the first purpose of Title IV.

The basic weakness of Title IV is reflected in Sections 402 and 403.

- B. As drafted Section 402 would make it possible for one mental health service entity to provide one service to one population group with no effective

means provided to secure all necessary services for that group, let alone other persons in need. Instead of progress toward the goal of comprehensive and coordinated mental health services, Section 402 as drafted could signal a return to the day of fragmented and inadequate services, at the expense of those most in need.

At a time when dollars are in short supply it ignores the cost-effective concept of coordinated provision of services and could encourage the proliferation of many separate cost-increasing entities. It also puts a premium on applicants with effective grant writers seeking to provide the services that are easiest to provide, more success-oriented or more apt to secure third-party funding. Once again those most in need of the least attractive services could be discriminated against.

We recommend the following changes in Section 402:

1. Amend Section 402(a) to provide that preference would be given to Section 402 grant applications from mental health service areas containing no community mental health center or other entity applying for or receiving a Section 403 grant.
2. Amend Section 402(b) to provide that a grant may be made under Section 402(a) only if:
 - (a) the entity will provide all of the comprehensive mental health services determined to be most immediately required for one or more population groups in the area by a culturally relevant needs assessment made by the area mental health authority and approved by the HSA and the state agency.
 - (b) the entity undertakes to supply all the comprehensive mental health services not immediately required by such needs

assessment when and as determined to be necessary by the area mental health authority.

(c) The entity demonstrates that it will meet the needs of at least one priority population group as determined under the state plan.

(d) The entity undertakes either:

- (i) to supply comprehensive mental health services to all residents of the area on a time schedule approved by the area mental health authority; or,
- (ii) to affiliate with the CMHC or Section 403 entity in the area, if any, or if none to affiliate with other Section 402 entities in the area, or other mental health entity included in the state mental health plan.

In case of failure within a reasonable time to comply with either Subsection (i) or (ii) above, the Secretary, after seeking and considering the comments and recommendations of the entities involved, the area mental health authority (and the state agency), shall attempt to secure such compliance. If such efforts fail the Secretary shall terminate the grant of the entity or entities he determines to have unreasonably failed or refused to comply.

3. Add Section 402(e) providing that there may be no more than two Section 402 entities in any mental health service area.

C. Although Section 403 is entitled "Development of Comprehensive Mental Health Services" it does not adequately achieve its goal. Therefore it should be changed as follows:

1. Section 403(b)(2) should be amended to require that within 90

days after receipt of its initial grant under Section 403(a), the entity must commence and thereafter continuously provide the following comprehensive mental health services: outpatient; emergency; consultation and education; screening; planning and evaluation; and that it will commence and thereafter continuously provide all the remaining comprehensive mental health services in accordance with a plan and time schedule approved by the Secretary; provided, however, that the Secretary may waive the requirement as to one or more of such remaining services if he finds that such service is neither necessary nor feasible in the area.

2. Section 403(b)(3) should be amended to require such entity, in providing such services to the general population of the area, to give special emphasis to priority population groups as determined by a needs assessment made by the area mental health authority and in conformity with the state plan.
3. Section 403(b)(4) should be amended to require that the entity will comply with and be subject to comparable provisions to those of Section 402(b) relating to affiliation agreements.

D. We agree with what we understand to be the purpose of Section 404: to provide a linkage between the physical and mental health care systems. However, for purposes of clarity Section 3 should contain a definition of ambulatory health care centers. Consideration should be given to special needs of unserved and underserved populations including children and adolescents, the long term mentally disabled and ethnic minorities as well as the poor.

- E. Section 406(b) relating to continued support for CMHCs should be amended to require each CMHC to comply with and be subject to provisions similar to those of Section 402(b) relating to affiliation agreements.
- F. We do not understand the reason for Section 406(c) and do not see why special discriminatory provisions should apply to CMHCs receiving initial grants in fiscal year 1979.
- G. If Section 402 entities are freed from the requirement of state approval the dangers of fragmented services and inflated costs are greatly increased. Therefore, in Section 621(b)(8) all Title IV grants should be subject to approval by the state agency.
- H. The intent of Section 405 is laudable, but the imposition of a five year limit 405(d) should be eliminated. This would represent an unwarranted step backward from present law.
- I. The present draft ignores PL 93-641 and the proposed amendments relating to mental health planning. Title IV should contain provisions making certain that the substantive and procedural planning requirements of PL 93-641 shall be complied with.
- J. The following are important changes or additions to the draft Systems Act, which are essential to an effective Title IV.
 - 1. Each section of Title IV should have separate authorizations and appropriations, or proportions should be indicated. Of total funds made available for grants to Section 402 and Section 403 entities, for example, a proportion of 15% for 402 and 85% for 403 would be appropriate.
 - 2. Provision should be included in the Mental Health Systems Act for

CMHC and Title IV entities to become certified providers of care for Medicare and Medicaid.

TITLE V. PILOT PROJECTS FOR STATE ADMINISTRATION OF GRANTS.

This Title should be combined with Section 632 on "cooperative agreements." It should not be titled "Pilot projects," but should be described as providing for carefully defined performance contracts among federal, state and local governments, on an ongoing basis. The standards for a given state qualifying for such performance contracts should be high, and require planful movement toward an integrated, community-based system of mental health care. These standards may appropriately include effective state community mental health legislation. Incentives for such movement by the states should be provided.

The phrase "willing and able" is used to describe states eligible for Title V grants. The law should spell out clearly what this means. For example, a state should be required to have an operative plan which includes at least the following:

1. redirection of institutional care dollars to community services;
2. assurance of adequate manpower and systems to monitor and assess community mental health service providers;
3. meeting the mental health needs of underserved populations;
4. coordination of relevant service agencies;
5. evaluating effects of treatment programs;
6. including an effective timetable for implementation of the plan; and,
7. assuring active, consumer-oriented, citizen participation throughout the system.

TITLE VI. REQUIREMENTS FOR PARTICIPATION: AUTHORIZATION

Section 601. Requirements for State Mental Health Services plans should include assurance of effective citizen participation, including local community planning, in this and other sections.

Section 602(1). Mental Health Service Areas are inadequately defined here as elsewhere. There should be some indication of population limits, and/or specification of relationship to CMHC catchment area definitions.

Section 602(2). The concept of modular planning, as described in the PCMH Task Force Report on mental health planning should be included in this section on plan content. For example, the relationship of the mental health plan to the state plan for PL 94-142, Education for All Handicapped Children, should be described, among other mandated state plans related to mental health.

Section 602(4). The Area Mental Health Authority should be better defined here and elsewhere. Its parallel relationship to the health systems agency planning process should be defined.

Section 602(8). Description of training here and other places should include training for mental health planning as well as for providers.

Section 621(b)(5). Requirement for public comment is not enough. Active citizen participation should be required.

Section 621(b)(8). Section 402 entities should not be excluded from the general requirement for Title IV entities to be certified by the state agency in accordance with the state plan.

Section 624(b). The permissive language here should be changed to mandatory, so that the Secretary shall use funds for reviewing performance by recipients.

Section 625. The provision for indirect services is too loose. While flexibility is needed, this much flexibility could destroy accessibility. Not all services described in Title IV would be amenable, for example, to being provided from a base outside a given mental health services area or catchment area, as indicated here. Certain highly specialized services, given a finding of need, may be appropriately contracted with providers outside a catchment area. The basic community services, such as outpatient, should not. Use of contracts and satellite facilities is appropriate and useful, given adequate standards.

Section 631. MHA strongly concurs with this provision that all Title IV entities must have governing boards meeting CMHC board requirements under Section 201(c)(1) of the CMHC act.

Section 632. Cooperative agreements have apparently replaced performance contracts in this draft. Performance contracts should be reinstated, and more carefully defined. Such contracts should reflect "partnerships" and should be governed by the following principles:

1. There must be a federal, state and local partnership, with all levels being mutually responsible for the performance of specific agreements spelling out mutually agreed upon standards and conditions.

Federal funds should not be made available merely for the purpose of improving the capacity and the efficiency of the state but only on a showing of a plan to emphasize community treatment in the least restrictive setting.

2. The partnership must fit the pattern of the Health Planning Act (PL 93-641).
3. There must be emphasis on the identification of need, planning

and service delivery at the local level. There must be a clear and enforceable agreement as to how the money is to get to the local level, recognizing that some must remain at the state level.

Part of the funding must be for competent and adequately funded local planning staff.

4. There must be majority consumer participation in governance at all levels. It is particularly important to have a broad citizen input at the local level.

Special attention must be given in the performance contract to the needs of the underserved population.

5. Planning and service delivery must be so coordinated as to eliminate gaps. There must be mechanisms provided in the contracts to ensure a continuum of care, from the most restrictive medical model to the community support services, for each patient, with emphasis on the least restrictive setting.
6. There must be adequate monitoring and evaluation procedures at each level with a clear requirement that the consumer be a part of these procedures.
7. There must be a specific timetable for performance of the contracts.
8. There must be clearly spelled out sanctions for non-performance.



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Additional Comments on Mr. Kennedy's Introductory Remarks on 5/17/79

The Mental Health Association (MHA) wishes to reinforce Senator Kennedy's statement that "both Medicare and Medicaid must be re-examined in relation to their support of mental health services to the poor and elderly."

The MHA concurs with the President's Commission on Mental Health that mental health services under Medicaid are extremely limited and that services are restricted in ways that services for the physically ill are not. Many states limit the amount, duration, and scope of Medicaid services and Medicaid favors institutional care with almost 70 percent of the mental health care reimbursements under Medicaid in FY 1977 being for institutional services. We, therefore, believe that there are many necessary changes that must be made to eliminate the discrimination in Medicaid.

The MHA is focusing its current efforts in Medicaid on the Child Health Assurance Program (CHAP) legislation which was introduced to improve and expand the Medicaid program - Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT). The MHA is seeking to obtain in CHAP provisions for mentally ill children equal to those provided for children with physical illness. We are urging that CHAP mandate all mental health services including inpatient

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care with no provisions that would allow states to limit the amount, duration, and scope of mental health services for potentially 1,950,000 mentally ill children who could be eligible.

Medicare discriminates against the mentally ill both directly and indirectly. It discriminates directly as follows: In Part A, hospital insurance, which is provided automatically to all Medicare eligibles, Section 1812(b)(3) sets a lifetime limit of 190 benefit days in a psychiatric hospital. There is no lifetime limit on time in other hospitals regardless of the diagnosis. In Part B, the supplemental medical insurance available on payment of monthly premiums, Section 1833(c) limits reimbursement for treatment of "mental, psycho-neurotic, and personality disorders" to 50 percent of the doctor bills and other reasonable costs after the deductible. Reimbursement for other covered illness is at the rate of 80 percent. In addition, Section 1833(c) places an annual ceiling of \$250 on reimbursement for outpatient treatment of mental illness (\$202 if the deductible is also for mental illness). No annual ceiling is placed on reimbursement for treatment of any other illness.

The indirect discrimination lies in the fact that the Medicare Act does not recognize Community Mental Health Centers as primary providers of health care. Although Medicare subscribers who are treated by physicians in Mental Health Centers may be reimbursed, treatment by other mental health professionals and other services offered by the Center, in fact, the Centers themselves, are usually not recognized under Medicare.

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To overcome this discrimination against our older Americans who become mentally ill, the Mental Health Association recommends the following amendments to Title XVIII of the Social Security Act:

1. Grant provider status to qualified Community Mental Health Centers for outpatient and partial hospitalization services.
2. Decrease the copayment for mentally ill patients from the present 50 percent down to 20 percent, the same as for any other covered illness.
3. Raise the annual ceiling on reimbursement for treatment of mental illness from the present \$250 up to \$750. There is no annual ceiling for other covered illness.
4. Eliminate the 190-day lifetime limit of coverage on patients in psychiatric hospitals, making the benefits and benefit periods the same as for patients in other hospitals.

The Mental Health Association has taken no stand on National Health Insurance as such, but we feel that any plan of national health insurance that is adopted must include adequate mental health coverage which includes:

1. Treatment for mental illness must be made as accessible as treatment for other covered illnesses, and that this treatment should be available in the least restrictive setting.
2. Reimbursement mechanisms should encourage the development of a comprehensive mental health system with an emphasis on outpatient care provided in organized settings.
3. Mental Health coverage must be designed so that appropriate treatment is available to every individual who needs it.

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The MHA concurs with Senator Kennedy that in reauthorizing Community Mental Health Centers the issue of "financing of certain programs such as consultation and education and prevention that have not been traditionally reimbursed as a medical service" needs to be re-examined. The MHA continues to strongly emphasize the need for continuing governmental funding for these non-reimbursable services as experience has shown that existing mechanisms for reimbursement are inadequate to insure that they will continue after the Federal support ends.

As stated in our testimony, the MHA shares concern for the underserved populations and appreciates Senator Kennedy's highlighting, in his remarks of May 17, 1979, his concerns that legislation impact especially on the deinstitutionalized patient, minorities, and children.



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August 8, 1978

Honorable Joseph A. Califano, Jr.
Secretary of Health, Education
and Welfare

Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Mr. Califano:

On June 5, 1978, the Mental Health Association wrote to you making certain broad recommendations regarding the proposed Mental Health Services Act to implement the recommendations of the President's Commission on Mental Health (PCMH). The purpose of that letter was to offer assistance to your Task Force in suggesting "a plan for a plan" to implement the PCMH Report.

We now submit more specific proposals relating to a comprehensive approach to mental health services as a part of human services. These proposals reflect the reactions to the PCMH Report of the mental health volunteers who deal regularly with legislative issues.

Our major premise is that the ultimate goal is the well being of all human beings; that the structure and the system should be made to fit those human beings instead of trying to force them to fit the structure.

In brief, there must be a rational, cost effective system. Such a system must be adequately financed, staffed and accessible to all persons. Those portions of the population presently served inadequately, ineffectively or not at all must be given special attention. This includes children, adolescents, elderly, racial and ethnic minorities, and the chronically mentally ill.

We agree that federal mental health legislation must cover each of the eight areas identified by the PCMH Report, i.e., community supports, a responsive service system, insurance for the future, new directions for personnel, protecting basic rights, expanding the base of knowledge, a strategy for prevention, and improving public understanding. These are integral parts of the whole, and no one area can be said to be of greater or lesser importance than the others. This gives particular importance

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to the following recommendation: There must be created at the federal level a consumer-oriented entity to develop an overview of all mental health issues without regard to jurisdictional compartments, since not all mental health problems can be dealt with by one Congressional sub-committee or one executive agency. ADAMHA would be an appropriate place for such an entity.

A system must be developed incorporating the following processes:

1. A process for identifying and defining the problems.
2. A process for ensuring that prevention is emphasized.
3. A process for continuous planning and evaluation of the service delivery system.
4. A process for protecting the rights of all persons who are the justification for the very existence of the system, with due regard for the effectiveness of the system itself and the rights of those who serve it.
5. A process for the actual delivery of services to those in need, with particular reference to populations with special needs such as children, adolescents, elderly, racial and ethnic minorities and the chronically mentally ill.
6. A process for funding.
7. A process for research of all types: to prevent mental illness, to cure or ameliorate it, and to plan for and provide services more effectively.

Again, these processes cannot be prioritized. They are mutually dependent upon and supportive of each other.

Before dealing in detail with specific legislation to implement the recommendations of the PCMH, we will indicate general areas of immediate and special concern that must be considered in even the most limited Mental Health Services Act.

(1) First and predominant is the recognition that mental health and physical health are indivisible aspects of the whole person, not separate conditions. Therefore mental health problems must be recognized as of equal status with physical health problems; and funding and other resources must be provided commensurate with their importance.

(2) There must be at all levels of government a data retrieval system capable of developing and disseminating uniform, comprehensive statistical and other data relating to mental health. Without such a system there can be no effective mental health delivery system.

(3) There must be sufficient qualified personnel, properly trained and adequately representing populations with special needs, to meet the needs of mental health research, planning, service delivery, evaluation and prevention.

Honorable Joseph A. Califano, Jr.
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(4) There must be an integrated mental health service delivery system capable of providing comprehensive and coordinated mental health care. Legislation incorporating the so-called new initiative proposal would encourage the proliferation of free-standing, limited service centers with no obligation to provide comprehensive, coordinated care as quickly as feasible and necessary. This would be seriously defective, and we would actively oppose it.

(5) The time has come to make certain that deinstitutionalization does not lead to reinstitutionalization; that adequate local facilities and support systems are immediately made available to the chronically mentally ill. These special efforts must be made within the overall system, not as part of a separate, fragmented program.

(6) There is a clear and urgent need for much more effective coordination between the state and community programs. To provide this coordination a variety of incentives must be initiated, such as performance contracts, linkage grants, etc.

(7) We must always remember that in every area of mental health programming there are seriously underserved populations, specifically children, adolescents, elderly, racial and ethnic minorities and the chronically mentally ill. Therefore every program and every piece of legislation must be carefully scrutinized and amended where necessary to insure that it does not discriminate against any of such populations.

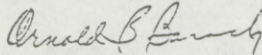
(8) NIMH must immediately focus its technical assistance efforts on developing proposals for unserved and underserved areas. We support PCMH Recommendation 7.

(9) Prevention is as important as a good service delivery system. Therefore programs must be developed to meet that need.

Finally, we attach a list of recommended specific legislation, being mindful that what we suggest and what the PCMH Report recommends cover areas and issues outside the scope of past NIMH consideration. What we envisage is a legislative program covering many of the areas identified in the PCMH Report, recognizing that not all areas may be covered by a single bill. Nevertheless, the Task Force recommendations should not be made without awareness and consideration of the system as a whole. We make no attempt to impose a priority structure on our recommendations.

The list is long and the need is great. We recognize that not all items will fit in a single bill and that not all items may be immediately financially feasible. Nevertheless we are convinced that the mandate of the PCMH Report cannot be carried out unless and until all of these recommendations are adopted. We recognize and appreciate your commitment to mental health, and we intend to give our active support to that commitment and these recommendations.

Yours very truly,



Arnold B. Barach
National President

/bf

Enclosures

MENTAL HEALTH ASSOCIATION LEGISLATIVE RECOMMENDATIONS FOR
A COMPREHENSIVE MENTAL HEALTH SYSTEM

A. Community Supports

1. Demonstration programs should be identified or developed and evaluated so as to identify and improve effective linkage mechanisms between community mental health services and community support systems.

B. A Responsive Service System

1. The community mental health service system must be continued and strengthened by emphasizing the need for coordinated and comprehensive delivery of services, not weakened by fragmented, free-standing, limited scope facilities. We generally support the pending Rogers legislation calling for a three-year extension of the Community Mental Health Centers Act. Specifically we urge that:

(a) the catchment area concept be strengthened to assure responsibility for a defined population, at the same time allowing appropriate cross-catchment area sharing of services.

(b) centers be permitted to phase in the required services gradually on the basis of a community needs assessment.

(c) centers be allowed to provide specific services by contracts with third-party providers.

(d) the development and funding of new centers be prioritized so that underserved populations would be given special consideration.

(e) continued federal funding be authorized after the eighth year for services not customarily funded by other sources.

(f) significant consumer involvement comparable to that required under the Health Planning Act (P.L. 93-641) be mandated on all governing boards.

We enclose a copy of the revised position paper developed by our Committee on Legislation and Services (attachment #1) which more completely states our views on this topic.

2. Planning

(a) Mental health must be an integral but identifiable component of all health planning at all levels, national, state and local.

(b) There must be an adequate number of qualified mental health consumers and providers on all governing boards and of mental health qualified staff at all levels. We support recommendations 47 and 48 of the PCMH Report.

(c) The designated planning agencies must consult with and consider the recommendations of mental health planning agencies at all levels. We support recommendation 43 of the PCMH Report.

(d) Responsibility for aggregating mental health plans and preparing the mental health component of the state health plan should be delegated

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to the state mental health authority, subject to review and approval by the state health planning authority and the Governor.

(e) Funds for mental health planning should be specifically designated in the budget of each health systems agency and the state mental health authority.

3. The needs of the chronically mentally ill must be met by:

(a) upgrading the quality and quantity of community mental health service systems as they replace state mental hospitals. We specifically recommend adoption of the concepts of case management and performance contracts, with the caution that the mere adoption of these concepts will not be productive and that means must be devised for constant evaluation of the system.

(b) eliminating discrimination against the chronically mentally ill in H.U.D. housing legislation, S.S.I. legislation and Medicaid and Medicare.

C. Financing and Insurance for the Future

1. Medicare

(a) CMHC's and other organized mental health care systems should be given provider status.

(b) The allowable reimbursement for outpatient treatment of mental conditions should be increased to at least \$750 in any calendar year.

(c) Beneficiary co-insurance should be reduced from 50% to 20% to conform to requirements for physical illness.

(d) Coverage for inpatient psychiatric disorders in acute care settings should be extended to be equivalent to that provided for physical illness.

(e) Two days of partial hospitalization should be allowed for each day of inpatient care.

2. National Health Insurance

Any national health insurance program must contain, from the beginning, a mental health component of equivalent status with the physical health component, so that the side effects of mental illness will cease to be a major contributor to the high cost of physical illness. We enclose (attachment #2) a copy of the Mental Health Association position paper on national health insurance.

D. New Directions for Personnel

1 The maldistribution of mental health personnel must be remedied by incentive programs designed to encourage service in designated geographic or population areas or facilities where there is a shortage of qualified personnel.

2. Incentive programs should be set up to encourage minority and

Page Three

other professional personnel particularly qualified to treat populations with special needs.

3. Incentive programs must be set up for the training of personnel qualified for research and planning as well as treatment.

E. Protecting Basic Rights

1. We recommend creation of an entity to identify and propose amendments to specific legislation discriminating against the mentally ill or particular groups of the mentally ill. We note particularly the discriminatory provision in the Medicare legislation, CHAP, H.U.D. housing legislation and the provisions regarding presumptive disability under Supplemental Security Income.

2. All data retrieval systems must contain mechanisms to protect the confidentiality of individual patient data.

3. Immediate attention should be given to legislation improving the mental health services in federal prisons, with particular reference to incarcerated minorities.

4. An advocacy system must be established to represent mentally disabled persons as recommended by the PCMH. We recommend the development of advocacy projects and a program of assistance to support existing federal, state and local advocacy groups.

F. Expanding the Base of Knowledge

1. It is a national disgrace that although about 33% of all hospital beds are occupied by persons diagnosed as mentally ill, only 3.5% of the Federal health research dollars go to mental health research.

We must find a stable funding mechanism capable of providing funding commensurate with the problem. In this connection we recommend:

(a) consideration of means of obtaining Congressional support of such mechanisms as forward funding and full funding of appropriate research projects.

(b) that an Administration target of 5% of total public expenditure for mental health services be established for the NIMH research and training budget.

(c) that the NIMH research budget for FY 1980 be \$165.4 million.

2. We must review our research manpower program and must appropriate funds to rebuild our research capacity, which has been sadly neglected over the last 15 years, by training research personnel, particularly minority researchers and others specially able to appreciate the needs of underserved populations.

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3. We must provide federal incentives to expand and improve state research capacity, specifically in the area of mental health service delivery.

4. We must significantly increase consumer involvement in determination of research directions and related public policy issues.

5. Legislation similar to S. 2579 should be passed to establish a Presidential Commission on the Participation of Human Subjects in Biomedical and Behavioral Research modifying and expanding the currently expiring National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research.

G. Prevention

1. We support the establishment of a Center for Prevention, with particular emphasis on primary prevention. We also support an appropriation of \$10 million for the first year and 10% of the NIMH budget within ten years.

H. Populations with Special Needs

In addition to the above recommendations we have the following special recommendations relating directly to specific underserved groups, including ethnic minorities and the poor, children and adolescents, the elderly and the chronically mentally ill:

1. The importance of encouraging research of minority mental health problems and of encouraging the increase in minority personnel engaged in research should be recognized in considering budget appropriations and research awards.

2. Priority should be given to residential programs where a minority concentration exists, with funding for linkages to community support systems.

3. The present NIMH Center for Minority Services should be upgraded to become a Division of Minority Mental Health Programs.

4. HSA's should utilize culturally relevant needs assessments with special attention to ascertaining the needs of children, adolescents, elderly, racial and ethnic minorities, and chronically mentally ill. These needs assessments should be utilized in grant reviews for community mental health services.

5. EPSDT legislation should be revised to mandate services for mentally ill, developmentally disabled, and mentally retarded children.

6. Increased appropriations to full authorization levels should be made for Education to All Handicapped Children (P. L. 94-142) and the legislation should be implemented to meet mental health needs.

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7. We support the development of Child Care legislation that includes sound mental health provisions.

8. Head Start should be retained in HEW and its appropriation should be increased.

9. An interagency linkage mechanism must be set up to secure coordination and cooperation among the approximately 106 federal programs for child and maternal health.

10. There should be increased expenditures for research into primary prevention and the needs and problems of children and adolescents.

11. Federal support of comprehensive prenatal and early infant care services should be expanded.

12. Foster Care and adoption programs should be improved.

13. We should support innovative programs for children and adolescents such as the NIMH Most In Need Program.

Senator KENNEDY. Thank you very much.

Excellent statement. Excellent statement. Thank you.

Our next witness will be Dr. John Wolfe, executive director, National Council of Community Mental Health Centers.

STATEMENT OF JOHN C. WOLFE, PH. D., EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS; ACCOMPANIED BY CHRIS KOYANAGI, SPECIAL CONSULTANT FOR GOVERNMENT AFFAIRS, NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS; AND DAVID SANDLER, ATTORNEY AT LAW, DIRECTOR, GOVERNMENT RELATIONS, NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS

Dr. WOLFE. Thank you, Senator Kennedy.

I am John Wolfe. By training I am a psychologist. I previously ran a community mental health center and currently I am the executive director of the National Council of Community Mental Health Centers.

First of all, community health centers have been studied by the General Accounting Office, Ralph Nader and internally. One of the interesting things is that each time there are problems found concerning the mental health centers, it does seem to hold that the bottom line is that they provide quality services and they indeed have brought about many of the changes that were first articulated by President John Kennedy in 1963 when he called for bold new approach.

We find a great deal to support in the proposed legislation, of course, and we support the need and the efforts to strengthen the current system. However, we have some areas of concern that we must articulate so that we don't throw out the things that are within the current system that are good, but capitalize on those things in the new legislation.

For example, we are concerned that the new initiatives, if they are implemented as written in the Mental Health Systems Act, will cause a fragmentation of service and the poor and underserved will really have a second-class type of care because there would be no backup services for these people. If, for example, we provide only a consultation-education service, where are those other services going to come from under the proposed legislation?

So we feel that there should be a base of core services that would be available to all these people from the very beginning. We are also concerned that the proposed legislation does not show how these various pieces would be pulled together managerially within the community; in other words, if there are several such agencies that apply for these funds, how indeed do they come together into a working relationship?

We have no indication that the initiation of these services would result in a move toward comprehensive care in that community. Now the new bill, as it is written, has many gaps in the proposed Federal-State partnership also. In fact, we do not read the act as developing a partnership, but rather as a gradual step-by-step phenomena turning the total responsibility from the Federal Government over to the State agencies.

We believe in a partnership. If that is really the intent, we would support the intent of a real partnership between the State people, Federal people, and local people.

Senator SCHWEIKER. You are concerned that they are bailing out? Is that correct?

Dr. WOLFE. I think that is the implication in terms of the long-range effect. We think that if there is really a partnership, we talk about such things as how do the Federal people and the State people, at the very beginning when the community applies for a grant, work together?

Do they work together with the grant people? Do they work together providing technical assistance?

Do they work together in terms of providing funds?

I think that is a really important issue in terms of funding in the sense that—I have to disagree with Secretary Califano when he said that the lack of Federal funds, or the termination of Federal funds, has not resulted in any adverse effects on those centers. As a matter of fact, a study from the administration, the Abt Study, coming out of Boston 2 or 3 years ago indicated that, and this was a study of something like 27 centers that were ending their regular funding, that those centers did indeed suffer cutbacks in services, cutbacks in staff.

The main things that were lost were such things as the indirect services that make a community mental health service unique; namely, consultation and education, outreach and aftercare and also management services which were cut.

Senator KENNEDY. What is the reason for this cutback in service?

Dr. WOLFE. States were not picking up the declining Federal funds. As a matter of fact, in the State of Massachusetts, at the Franklin Hampshire Community Mental Health Center, currently there is a problem that they are struggling with because they are at the end of their 8-year funding and the State is not picking up the programs that that center has had in the past. I think this goes to the root of something we all need to address and that is the concept of seed money.

I think for a long time that we have passed legislation that we were providing seed money with the expectation that the States would pick these programs up at a later date. I think the history of the mental health centers has shown that that has not been the case. Again, if we are going to talk about a partnership, I would like to see legislation designed so that from the very beginning funds were in common between the States, Federal people, and the local communities so that the funding base for those programs that were doing quality work would be able to continue.

Instead what we do is piecemeal legislation. Year after year we come down here and lobby on behalf of the centers to add on some legislation so they can continue their existence. It leaves communities in the place where they cannot plan, do long-term planning, and deliver the kinds of services that they need to deliver on behalf of patient care.

We also feel that there is a need in this proposed legislation for national standards. We talk about how do we insure that agencies are indeed delivering the kind of services they are supposed to do and what is the attitude if they are not doing that? At the current

time, community programs have experienced multiple-site visits from the various funding agencies, Federal, State, and local, and there is no partnership in this effort to reduce the amount of administrative time it requires, the amount of money that is spent on these multiple-site visits and sets of standards.

Again, it seems very logical to assume if we are talking about a partnership between the Federal agencies and the State agencies that this is another place that a true partnership can be implemented.

Finally, I would just like to conclude by stating that we certainly want to thank Mrs. Carter for her efforts, Thomas Bryant of the staff, the President's Commission on Mental Health, and all the people who have brought us to this point in our history to better our mental health care for all people. However, this proposed legislation needs careful study. It will need some revision if our goals are to be met. I look forward to working with you and your subcommittee to develop a comprehensive mental health system in this country.

Thank you.

Senator KENNEDY. Fine.

Do I understand you correctly that in the history of the existing law, the moneys went to the mental health centers and that now it is going to be going to the States and your concern is that the States will set different types of priorities or take a cut out of whatever comes through there?

Dr. WOLFE. Both.

Senator KENNEDY. Rather than having it go directly to the centers themselves?

Dr. WOLFE. Yes.

Senator KENNEDY. You are satisfied with the current arrangement in terms of the relationship between the centers and the funding agency?

Dr. WOLFE. We are not satisfied from the point of view that the States historically have been ignored. There is a greater need for collaboration and partnership of the States and Federal agencies together with the communities. Merely shifting the focus of the responsibility from the Federal agency to fund the States and to pass it through the States, doesn't make good management sense.

Senator KENNEDY. Will you make some suggestions as to how you think that can be done?

Dr. WOLFE. Yes.

Senator KENNEDY. If you understand what the recommendations were and what they are driving at, give us some alternatives, some suggestions.

Dr. WOLFE. Certainly. I think there can be defined in the legislation the percentage of moneys that the Federal Government and State government should contribute in the beginning. Waiting until the end of the period of time and assuming that the States will pick it up has been disastrous. The data indicates that through the Abt study.

Senator KENNEDY. The centers have been under some criticism that they are not providing services to minorities, the elderly, and deinstitutionalized patients. What is your reaction to those allegations?

Dr. WOLFE. I think the facts are true. The issue is a complex one. There are many things which contribute to the failure to provide services to many of these populations, not the least of which is finances. There has been a lack of resources. There have been two Presidential vetoes that have killed the program. There is a fight for survival. There have been turf fights among the agencies and professions in the last 16 years. The centers are caught in the middle. It is unique. CMHC's employ a variety of disciplines with all the problems inherent in that. There has been lack of cooperation between the various components. There has been an expectation that the centers could indeed do all these things for people. These expectations were too high.

For example, housing and vocational rehabilitation are problems in every city. Neither of these are the mainstream of what a mental health center can do. They were charged to set up halfway houses in the last legislation. At the community level, it has been very tough to crack zoning regulations. People didn't want them to live next door. The centers were responsible to deliver that kind of service. It is a complex answer. There are many factors involved.

Senator SCHWEIKER. On the turf fight, you obviously know that these are jurisdictional splits even between our Senate Health Subcommittee and the Finance Committee.

Would you define how this problem of jurisdiction affects Government agencies, so we would have a clearer idea of the problem?

Dr. WOLFE. I can give you a personal experience. When you work on behalf of a patient to get vocational rehabilitation for him and you are told it is too high a risk to spend their money and then you have a fight between two agencies, the mental health agency and the vocational rehabilitation agency. The resolution is a very tough, long-term, drawnout process to get the moneys that are legitimately there for that patient.

We see the same thing between titles XVIII and XIX. We have the inability of the Federal agencies themselves to coordinate their efforts. We have that problem within HEW. There is a lack of coordination between HUD, HEW, and Labor. All these play a part on the patients' life. There is no mechanism to bring those agencies together either among agencies or between agencies.

Senator KENNEDY. What is your assessment of the regional offices of HEW in terms of technical assistance and the kind of training they make available?

Dr. WOLFE. One of our past presidents, President Nixon, created a monster which has resulted in a lessening of the effectiveness of the regional offices and also a real problem for both the central office and the regional office. In the regional office they are responding to two masters, one is the regional health administrator and the other is the central office. That creates a problem for bureaucrats and community centers that receive or do not receive the technical assistance. There has been a loss of some very fine people in the regional offices. I think it is a function of that reorganization a few years ago.

The quality of staffs in regional offices has certainly decreased in the last 5 or 6 years. It leaves a lot to be desired but, at the same time, I think that the regional offices are functioning as well as

they can, given the circumstances and management systems they have to work under.

Senator KENNEDY. They are doing better?

Dr. WOLFE. They are doing better, but not what we would like to see them do. This is the creation of the design of the system.

Senator KENNEDY. If you have some suggestions, let us have them.

Dr. WOLFE. We could submit them for the record.

[The material referred to follows:]

PROPER STAFFING OF REGIONAL OFFICES

The regional offices must be properly staffed if they are to be effective. Unfortunately, they have been forced to cut down on personnel even though their responsibilities have grown. Moreover, there is a lack of personnel who have jurisdiction over CMHC's who actually have expertise in the mental health area. There are too many individuals who qualify as "health generalists" involved with mental health programs. Also, there is a lack of individuals who have some expertise in business management. With new legislation creating mental health entities for priority groups and making the CMHC standards more flexible, more people are going to be needed at the regional level for consultation and technical assistance. For these new programs to get started and survive, expertise must be made available.

Senator KENNEDY. Finally, questions concerning regulations, guidelines, paperwork, and other matters of concern. If you have some suggestions about how to deal with those as well, please submit them. We need a degree of accountability. Maybe there are ways of making it simpler. I personally think we have to take it program by program, agency by agency. Maybe you have some suggestions about the way we can assure accountability, but also see a significant reduction in regulations, and so forth. If you could give us a recommendation in that area, we would appreciate it.

Dr. WOLFE. We will do that.

[The following was received for the record:]

ASSURANCE OF ACCOUNTABILITY

Accountability can be improved by a variety of methods. Standards can be developed by the Secretary such as the JCAH standards. Some States have already developed their own standards for the physical plant as well as the program and more should be encouraged to do so. Furthermore, the individual centers themselves could establish PSRO's and quality assurance programs.

Senator KENNEDY. Do you have any further questions?

Senator SCHWEIKER. Dr. Wolfe, going back to the problem of deinstitutionalization, what suggestions can you give the committee about what we ought to be doing to improve this situation?

Dr. WOLFE. It seems the various agencies and people that come into contact with this population; the authority and responsibility need to be well defined as to what is it that a community health center should and can do for this population of people.

What are the things that a State hospital can and should do for this population?

What is it that housing should do?

In the legislation, we define the boundaries in various pieces and if there is an authority vested somewhere, and I am not sure where it is, to insure that these pieces are pulled together, then you will have a different set of service deliveries for the deinstitutionalized group. Piecemealing it by giving more money to any one agency won't help. There has to be authority to bring it together. The

pieces are lying out there, but they are not put into the picture to make it a whole.

Senator SCHWEIKER. Do you have any suggestions as to what we ought to be investigating at NIMH in terms of redefining the law or oversight responsibilities? Are there any suggestions for managerial, administrative, or policy, improvements that you might pass on to us?

Dr. WOLFE. I go back to HEW. This causes frustration for all of us in the field. The inability of HEW to coordinate itself creates a lot of problems. Certainly NIMH is part of that within HEW.

As Hilda Robbins has said, through increasing technical assistance to the centers, I am convinced we can improve some of the problems there. Certainly improving the quality of the staff within the regional offices would be another area which could be of great assistance to NIMH.

Senator SCHWEIKER. Do you have any specific proposals to pass on to us? In the position you occupy, you obviously see different kinds of programs, some successful and some not, which deal with the chronically, mentally ill, and the deinstitutionalized patient.

Are there any particular success stories that come to mind that might be applied in a national effort?

Are there more effective or responsive ways of dealing with the problem that we might incorporate in our legislative ideas?

Dr. WOLFE. Yes, in terms of community mental health, there are some things that are going on in the community support program which has not been evaluated, but which is an attempt to deal with the population in a new way. When the data comes back on that, we will have some ideas. Also there is at least some rethinking by the professionals that for this population of people, they are not going to change the personality of the individual and that support services such as social support services showing people how to shop and write a check, these are things a community health center can do. It cannot do all the things, but it can act as a reentry point back into the community and provide such things as partial hospitalization and some community mental health centers are doing that. They can provide an outpatient service for many chronically ill people who come out of the State hospitals and, at the same time, there has to be better coordination and working together between State hospitals and centers and rehabilitation housing and the various pieces.

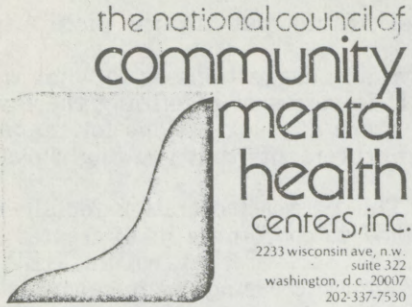
Senator SCHWEIKER. Thank you.

Senator KENNEDY. We look forward to working with you. You mentioned some of the areas where you have suggestions. There will be others as well, I am sure.

Your testimony has been very, very helpful, and I thank you.

Dr. WOLFE. Thank you.

[The prepared statement of Dr. Wolfe follows:]



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TESTIMONY

BEFORE THE

SENATE SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

MAY 24, 1979

BY

JOHN C. WOLFE, PH.D.
EXECUTIVE DIRECTOR
NCCMHC

representing community mental health centers in the united states

ON FEBRUARY 3, 1963, PRESIDENT JOHN KENNEDY REQUESTED CONGRESS' HELP IN PROVIDING HUMANE TREATMENT FOR THE MENTALLY AFFLICTED AND SET THIS NATION ON A COURSE TO REMEDY CENTURIES OF NEGLECT. AS A DIRECT RESULT OF PRESIDENT KENNEDY'S INITIATIVE, THE FEDERAL GOVERNMENT HAS ALREADY MADE AN INVESTMENT OF OVER \$1.5 BILLION IN CREATING OVER 700 COMMUNITY MENTAL HEALTH CENTERS (CMHCs) THROUGHOUT THE UNITED STATES AND ITS TERRITORIES. BASICALLY, ALL WE ARE ASKING THIS COMMITTEE TO DO IS TO CONTINUE THIS PROGRAM WHICH BEGAN 16 YEARS AGO AND EXPAND IT TO ENSURE GREATER ACCESS FOR THOSE THAT HAVE BEEN UNDERSERVED IN THE PAST -- THE AGED, THE CHRONICALLY MENTALLY ILL, MINORITY GROUPS, CHILDREN, POOR PERSONS AND THOSE LIVING IN RURAL AREAS. IT IS INDEED REFRESHING, AFTER YEARS OF IMPOUNDMENTS AND VETOES, TO HAVE A CONCERNED PRESIDENT AND ENERGETIC FIRST LADY WHO ARE WILLING TO CONFRONT THIS COMPLEX ISSUE AND HAVE RECOMMENDED INCREASING THE AMOUNT OF FEDERAL DOLLARS FOR MENTAL HEALTH.

THE MENTAL HEALTH SYSTEMS ACT FOCUSES ON PROVIDING MENTAL HEALTH SERVICES TO THOSE WHO HAVE BEEN UNDERSERVED IN THE PAST. WE STRONGLY BELIEVE THAT PROGRAMS ARE NEEDED TO DEAL WITH THESE PRIORITY GROUPS. ANY NEW PROGRAM, HOWEVER, SHOULD BE OF THE SAME QUALITY AND SHOULD PROVIDE THE SAME DEGREE OF COMPREHENSIVE SERVICES AS CURRENTLY PROVIDED BY CMHCs. WE CANNOT ALLOW THOSE GROUPS WHICH HAVE BEEN IGNORED IN THE PAST TO BE SHORT-CHANGED IN THE NEW SYSTEM OF MENTAL HEALTH SERVICES WHICH WE ARE CREATING. THE POOR AND UNDERSERVED DESERVE THE SAME

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QUALITY OF SERVICE ENJOYED BY EVERYONE ELSE. THE SYSTEMS ACT, HOWEVER, PROPOSES TWO SYSTEMS OF MENTAL HEALTH CARE -- A FRAGMENTED SCATTERING OF ONE-SERVICE ENTITIES FOR SPECIAL AND MINORITY GROUPS AND AN ESTABLISHED SYSTEM OF COMPREHENSIVE CMHCs FOR THE GENERAL POPULATION.

NCCMHC AGREES THAT THE CURRENT SYSTEM REQUIRES MODIFICATION, ESPECIALLY IF WE ARE TO SERVE THOSE GROUPS WHICH THE SYSTEM HAS NOT FULLY SERVED IN THE PAST. IN ORDER TO PROVIDE FOR UNDERSERVED GROUPS, WE RECOMMEND THAT A NEW INITIATIVE GRANT PROGRAM BE MADE AVAILABLE TO PUBLIC AGENCIES AND PRIVATE NONPROFIT ORGANIZATIONS WHICH ARE OPERATED BY GOVERNING BOARDS MEETING THE REQUIREMENTS OF THE COMMUNITY MENTAL HEALTH CENTERS ACT. THESE GRANTS SHOULD BE MADE FOR A PERIOD OF EIGHT YEARS TO PROVIDE SERVICES LISTED IN SECTION 201 OF THE CMHC ACT. TO QUALIFY FOR A GRANT, THESE AGENCIES MUST PROVIDE THE FOLLOWING THREE ELEMENTS OF SERVICE: EMERGENCY (24-HOUR) SERVICE, OUTPATIENT, AND CONSULTATION AND EDUCATION. AFTER FOUR YEARS, THEY SHOULD BE REQUIRED TO PROVIDE INPATIENT, SCREENING, AND FOLLOW-UP CARE; AND PARTIAL HOSPITALIZATION SHOULD BE REQUIRED BY THE END OF THE SEVENTH YEAR.

THE FOLLOWING LIMITATIONS SHOULD BE SET ON AWARDING THESE GRANTS:

- 1) APPLICANTS MUST HAVE A CONTRACTUAL AGREEMENT TO AFFILIATE WITH OTHER ENTITIES FUNDED UNDER THIS PROGRAM OR UNDER THE CMHC ACT AND SERVING THE SAME CATCHMENT AREA.

- 3 -

2) NO CATCHMENT AREA WOULD BE ELIGIBLE FOR MORE THAN TWO INITIATIVE GRANTS. THIS WILL NOT PRECLUDE A GRANT TO DEVELOP A COMPREHENSIVE CMHC IN A CATCHMENT AREA RECEIVING TWO INITIATION GRANTS.

AGENCIES FUNDED UNDER THIS PROGRAM WOULD BE ELIGIBLE FOR PLANNING GRANTS UNDER SECTION 401 OF THE SYSTEMS ACT TO DEVELOP A COMPREHENSIVE PROGRAM. THESE AGENCIES SHOULD BE GIVEN PRIORITY IN FUNDING UNDER THIS SECTION.

AS PROPOSED, SECTION 403 OF THE SYSTEMS ACT DOES NOT DEVELOP COMPREHENSIVE CMHCs. INSTEAD, IT RENEGES ON OUR COUNTRY'S COMMITMENT TO THE MENTALLY ILL AND WILL PUT AN END TO THE GOAL OF ESTABLISHING A CMHC IN EVERY CATCHMENT AREA OF THE COUNTRY. ALTHOUGH WE WOULD LIKE TO SEE THE FEDERAL REQUIREMENTS GOVERNING CMHCs MADE MORE FLEXIBLE, THE SYSTEMS ACT MAKES THINGS SO FLEXIBLE THAT WHAT WE ARE REALLY LEFT WITH IS NOTHING.

MR. CHAIRMAN, I AM SURE YOU ARE AWARE OF THE MOVEMENT IN CONGRESS TO LABEL CMHCs AS HEALTH CARE PROVIDERS UNDER MEDICARE. THIS WILL BE A TREMENDOUS BENEFIT FOR THE ELDERLY. IT HAS TAKEN MANY YEARS TO CONVINCE THE FINANCE COMMITTEE TO EVEN CONSIDER SUCH LEGISLATION, BUT WE ARE NOW APPROACHING THE POINT WHERE THIS PROPOSAL MAY WIN SENATE APPROVAL. IF WE NOW WEAKEN THE CMHC PROGRAM BY ESTABLISHING MENTAL HEALTH AGENCIES WHICH PROVIDE ONLY MINIMAL SERVICES, IT WILL GREATLY HINDER EFFORTS TO COVER CMHCs AND THE PROPOSED NEW COMPREHENSIVE PROGRAMS UNDER

THE SYSTEMS ACT UNDER THIRD-PARTY FINANCING ARRANGEMENTS SUCH AS MEDICARE.

THE SYSTEMS ACT PROPOSES DEVELOPMENT AWARDS TO CREATE COMPREHENSIVE MENTAL HEALTH ENTITIES SIMILAR TO CMHCs. WE AGREE WITH THE REPORT ISSUED BY THE PRESIDENT'S COMMISSION ON MENTAL HEALTH THAT THE CURRENT CMHC REQUIREMENTS ARE TOO RIGID AND DISCOURAGE DEVELOPMENT IN UNSERVED AREAS. IN ORDER TO MAKE THE PROGRAM MORE FLEXIBLE WHILE PRESERVING THE CONCEPT OF COMPREHENSIVENESS, WE PROPOSE THAT THE ENTITIES CREATED BY DEVELOPMENT AWARDS IN THE SYSTEMS ACT BE KNOWN AS COMMUNITY MENTAL HEALTH CENTERS AND BE REQUIRED TO PROVIDE THE FOLLOWING:

- 1) WITHIN THREE YEARS: INPATIENT, OUTPATIENT, PARTIAL HOSPITALIZATION, EMERGENCY SERVICES, SCREENING, FOLLOW-UP, AND CONSULTATION AND EDUCATION.
- 2) WITHIN FIVE YEARS: SPECIALIZED SERVICES FOR CHILDREN AND ELDERLY PERSONS, AND SERVICES FOR ALCOHOLICS AND DRUG ABUSERS IF THE NEED EXISTS.

CONSEQUENTLY, IN ORDER TO PROVIDE THE NEEDED FLEXIBILITY, WE RECOMMEND THAT SERVICES BE PHASED IN OVER AN ESTABLISHED PERIOD OF TIME. PRIORITY FOR FUNDING SHOULD BE GIVEN TO THOSE AREAS OF THE COUNTRY WHICH HAVE NO MENTAL HEALTH SERVICE WITHIN THE CATCHMENT AREA AND NONE READILY ACCESSIBLE AND TO AREAS WHERE THERE ARE ONLY MINIMAL SERVICES AVAILABLE TO RESIDENTS IF THEY HAVE SUFFICIENT POPULATION TO WARRANT ESTABLISHMENT OF A COMPREHENSIVE PROGRAM. IN ADDITION, SPECIAL PROVISIONS TO

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ENCOURAGE THESE AREAS TO INITIATE A PROGRAM ARE NEEDED. THUS, FOR THESE PRIORITY GEOGRAPHIC AREAS:

* A CMHC PROGRAM COULD BE INITIATED WITH THREE OR MORE OF THE SERVICES DEFINED IN SECTION 201(B)(1)(I)-(IV) OF THE CMHC ACT, AS AMENDED;

* BY THE END OF FOUR GRANT YEARS, ALL OF THE SERVICES IN SECTION 201(B)(1)(I)-(IV) OF THE CMHC ACT AS AMENDED MUST BE IN PLACE;

* BETWEEN THE 4TH AND 7TH GRANT YEARS, CMHCs MUST PHASE IN SPECIALIZED SERVICES FOR CHILDREN AND THE ELDERLY AND, WHERE THERE IS AN UNMET NEED, SERVICES FOR ALCOHOLICS AND DRUG ABUSERS.

FUNDING FORMULA

A SINGLE FUNDING FORMULA FOR ALL CMHCs (AND ALSO FOR ALL NEW INITIATIVE PROGRAMS) IS NEEDED. ALL SUCH PROGRAMS SHOULD BE FUNDED AT THE LESSER OF THE PROGRAM'S DEFICIT OR THE FOLLOWING PERCENTAGE OF ITS OPERATING BUDGET:

1ST GRANT YEAR	-- 90%
2ND GRANT YEAR	-- 80%
3RD GRANT YEAR	-- 70%
4TH GRANT YEAR	-- 60%
5TH GRANT YEAR	-- 50%
6TH GRANT YEAR	-- 40%
7TH GRANT YEAR	-- 30%
8TH GRANT YEAR	-- 20%

THESE PERCENTAGES WOULD NOT APPLY TO EXISTING CMHC PROGRAMS, WHICH WOULD CONTINUE TO BE FUNDED UNDER THE FORMULA NOW IN EFFECT.

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WE SUPPORT SECTION 405 OF THE SYSTEMS ACT WHICH ALLOWS SOME DEGREE OF FEDERAL FUNDING AFTER THE NORMAL EIGHT-YEAR CYCLE HAS RUN ITS COURSE. STATE GOVERNMENTS HAVE BEEN RELUCTANT TO REPLACE FEDERAL FUNDING AFTER THE EIGHTH YEAR. WE WOULD RECOMMEND THAT THESE GRANTS BE FUNDED ON A PER CAPITA BASIS OF \$1.50 PER PERSON IN THE CATCHMENT AREA WITH A MINIMUM GRANT OF \$75,000. EVERY FIVE YEARS, THE PER CAPITA PAYMENT SHOULD BE READJUSTED TO REFLECT THE INCREASES IN THE COST-OF-LIVING INDEX. GRANTS SHOULD BE MADE FOR A TWO-YEAR PERIOD, AND THERE SHOULD BE NO LIMIT ON THE NUMBER OF TWO-YEAR GRANTS TO WHICH A CMHC IS ENTITLED. ONLY IN THIS WAY WILL CMHCs BE ABLE TO MAINTAIN THE ESSENTIAL ELEMENTS OF THEIR PROGRAMS AND ENSURE THE CONTINUANCE OF CARE IN THE COMMUNITY.

THE NEW ROLE OF THE STATES AS PROJECTED IN THE MENTAL HEALTH SYSTEMS ACT NEEDS CAREFUL REVIEW AND REVISION. NCCMHC SUPPORTS AN INCREASED PARTICIPATION OF THE STATES IN THE PLANNING AND DELIVERY OF COMMUNITY MENTAL HEALTH SERVICES. THERE SHOULD BE AN EQUAL FEDERAL-STATE-LOCAL PARTNERSHIP WHICH HAS NOT EXISTED IN THE PAST. AS PROPOSED, HOWEVER, THE SYSTEMS ACT WILL GRANT THE STATES AN UNDUE AMOUNT OF AUTHORITY OVER CMHCs. SINCE MOST STATES STILL STRUGGLE WITH THE PROBLEMS OF DEINSTITUTIONALIZATION, IT IS UNWISE TO GIVE THEM UNLIMITED AND UNREGULATED AUTHORITY OVER CMHCs, ESPECIALLY IN REGARD TO FEDERAL FUNDING AND EVALUATION.

WE RECOGNIZE HOW EASY IT WOULD BE FOR THE FEDERAL

GOVERNMENT TO LEAVE EVERYTHING UP TO THE STATES AND GIVE THEM A CERTAIN AMOUNT OF MONEY EACH YEAR FOR MENTAL HEALTH. IN THIS WAY, THE FEDERAL GOVERNMENT WOULD ONLY HAVE TO MONITOR 50 STATE AGENCIES RATHER THAN HUNDREDS OF INDIVIDUAL COMMUNITY PROGRAMS. IF SUCH A SYSTEM, HOWEVER, WERE PUT INTO EFFECT, IT WOULD REVERSE THE CURRENT TREND TOWARD DEINSTITUTIONALIZATION AND WOULD LEAVE THE POOR AND THOSE LIVING IN RURAL AND UNSERVED AREAS WITH ONLY A VERY REMOTE CHANCE THAT A COMPREHENSIVE MENTAL HEALTH CENTER WOULD BE ESTABLISHED IN THEIR COMMUNITY. FOR THESE REASONS, DR. DAVID HARGROVE, PRESIDENT OF THE RURAL MENTAL HEALTH ASSOCIATION, VEHEMENTLY OBJECTS TO GRANTING THE STATES THE AUTHORITY WHICH THE SYSTEMS ACT PERMITS.

REACTION TO THE SYSTEMS ACT FROM OUR RURAL CENTERS HAS BEEN QUITE STRONG. ONE CENTER DIRECTOR WROTE TO US STATING: "ESPECIALLY IN RURAL AREAS, STATES HAVE NOT DEMONSTRATED THE INTEREST, LEADERSHIP AND ADMINISTRATIVE ABILITY TO DEVELOP COMPREHENSIVE COMMUNITY MENTAL HEALTH SERVICES." HE CLAIMS THAT FEW SERVICES WOULD EXIST AT ALL IF COMMUNITIES COULD NOT CONTRACT DIRECTLY WITH THE FEDERAL GOVERNMENT. HE CITES AS EVIDENCE \$12 MILLION IN UNUSED TITLE XX FUNDS WHICH ARIZONA SENT BACK TO THE FEDERAL GOVERNMENT.

POOR AND RURAL AREAS OF THE SOUTH WILL BE HIT THE HARDEST BY THIS INCREASED POWER OF THE STATES. OUR MEMBERSHIP IN THE SOUTH HAS INFORMED US THAT THEIR EXPERIENCE WITH FEDERAL FUNDING CHANNELLED THROUGH THE STATES IS THAT THE SINGLE STATE

AGENCIES ADMINISTERING THOSE FUNDS EVENTUALLY DIRECT THEM TO THEIR OWN PRIORITIES.

NEW MENTAL HEALTH LEGISLATION MUST NOT DESTROY THE EXCELLENT RELATIONSHIP THAT HAS DEVELOPED BETWEEN THE COMMUNITIES AND LOCAL GOVERNMENTS AROUND THE COUNTRY AND THE FEDERAL GOVERNMENT. LOCAL AUTONOMY IS THE CORNERSTONE OF THE COMMUNITY MENTAL HEALTH MOVEMENT, AND WE CANNOT ALLOW THIS TO BE CRUSHED BY STATE BUREAUCRACIES. OUR FEELINGS CAN BE SUMMED UP BY A STATEMENT MADE BY A COUNTY COMMISSIONER IN SHELBY, MONTANA:

WHY IS IT WHEN WE FINALLY, AFTER MANY YEARS OF STRUGGLE, HAVE A SUCCESSFUL MENTAL HEALTH PROGRAM FUNCTIONING AT THE GRASS ROOTS LEVEL, WITH THE LOCAL PEOPLE GOVERNING AND BEING RESPONSIBLE FOR IT, SOMEONE DECIDES THAT PUTTING THE CONTROL BACK INTO THE HANDS OF THE STATE BUREAUCRATS IS THE ANSWER. WHEN THE STATE OF MONTANA WAS IN CONTROL OF MENTAL HEALTH, THERE WAS AN INSTITUTION, OVERCROWDED, AND IN SAD NEED OF REPAIR. THE URBAN AREAS HAD A FEW PRIVATE PRACTITIONERS. A COUPLE OF UNDER-STAFFED MENTAL HEALTH CLINICS WERE AVAILABLE IN THE URBAN AREAS, AND VIRTUALLY NOTHING WAS AVAILABLE IN THE RURAL AREAS. IT WILL BE A SAD DAY FOR COMMUNITY MENTAL HEALTH IF WE TAKE A GIANT STEP BACKWARD AND IGNORE LOCAL INPUT AND CONTROL, AND ONCE AGAIN HAVE THE STATE BUREAUCRACY CONTROL THE SERVICE AND AVAILABILITY TO THE CITIZENS OF THE STATE OF MONTANA.

THE STATES HAVE NOT DEMONSTRATED A COMMITMENT TOWARDS COMMUNITY MENTAL HEALTH CARE. TO NOW GIVE THEM CONTROL OVER THE

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CMHC PROGRAM WOULD BE DEVASTATING. THIS CAN BE ILLUSTRATED BY THE PLIGHT OF THE FRANKLIN/HAMPSHIRE CMHC IN NORTHAMPTON, MASSACHUSETTS. THIS CENTER RECENTLY COMPLETED ITS EIGHT-YEAR FEDERAL FUNDING CYCLE AND HAS BEEN STRUGGLING WITH THE STATE IN ORDER TO MAINTAIN SOME FORM OF EXISTENCE. EFFORTS HAVE BEEN HINDERED BY THE FACT THAT THE STATE OF MASSACHUSETTS HAS NOT MADE AN OFFICIAL COMMITMENT TO SUPPORT CMHCs. FRANKLIN/HAMPSHIRE OFFICIALS MUST DEAL WITH THIS LACK OF RECOGNITION FROM THE STATE AS WELL AS FROM DEPARTMENT OF MENTAL HEALTH OFFICIALS WHO LACK GENERAL MANAGEMENT ABILITY TO DEAL WITH THE PROBLEMS THE CENTER NOW FACES.

OTHER THAN NOTICING A LIST OF THE CMHCs IN THE STATE, IF YOU READ THE STATE PLAN FOR MASSACHUSETTS, YOU WOULD NOT EVEN KNOW THAT CMHCs EXISTED. THE ISSUE OF WHAT THE STATE WILL DO AS CMHCs GRADUALLY LOSE THEIR FEDERAL FUNDING IS NOT ADDRESSED. FURTHERMORE, CHAPTER 735 OF THE LAWS OF THE COMMONWEALTH OF MASSACHUSETTS REQUIRES THE STATE TO ESTABLISH A COUNCIL OF ADVISORS CONSISTING OF CMHC REPRESENTATIVES TO ADVISE THE STATE COMMISSIONER OF MENTAL HEALTH. AS OF THIS DATE, THE STATE REMAINS IN VIOLATION OF THIS LAW.

THIS BEING THE SITUATION IN A PROGRESSIVE STATE LIKE MASSACHUSETTS, YOU CAN IMAGINE WHAT THINGS ARE LIKE IN OTHER PARTS OF THE COUNTRY. THE DANGER OF ROUTING FEDERAL MONEY THROUGH THE STATE IS RECOGNIZED BY DR. ROBERT RANKIN, COMMISSIONER OF MENTAL HEALTH SERVICES FOR THE STATE OF ARKANSAS, WHO STATES:

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BASICALLY, OUR PRIMARY CONCERN HERE IN ARKANSAS IS THAT THE INDEPENDENT COMMUNITY MENTAL HEALTH CENTERS CONTINUE TO BE ABLE TO RECEIVE FEDERAL FUNDING DIRECTLY RATHER THAN HAVING THE FUNDING ROUTED THROUGH THE OFFICE OF THE COMMISSIONER. THAT FLEXIBILITY HAS STOOD US IN GOOD STEAD HERE IN ARKANSAS AND I DON'T BELIEVE THAT IT WOULD IMPROVE THE SYSTEM IN ANY WAY TO HAVE THOSE DOLLARS ROUTED THROUGH MY OFFICE.

CONSEQUENTLY, TITLE V, WHICH GIVES THE POWER TO THE SECRETARY OF HEW TO ROUTE ALL CMHC FUNDS THROUGH AN UNLIMITED NUMBER OF STATES, MUST BE STRICKEN FROM THE BILL IN ITS ENTIRETY.

NATURALLY, THE INTEREST OF THE STATES IS WITH THEIR OWN INSTITUTIONS. STATE FUNDING FOR STATE INSTITUTIONS HAS NOT CORRESPONDED TO THE DECREASE IN PATIENTS ENTERING STATE HOSPITALS. SINCE THERE ARE ONLY VERY LIMITED AMOUNTS OF FEDERAL FUNDS AVAILABLE FOR MENTAL HEALTH SERVICES, IT DOES NOT MAKE GOOD MANAGEMENT SENSE TO HAVE THEM PASS THROUGH ANOTHER LEVEL OF BUREAUCRACY BEFORE THEY REACH THE PEOPLE FOR WHOM THE MONEY IS INTENDED. NOWHERE WILL THIS BE MORE TRAGIC THAN IN THE AREA OF PREVENTION, WHERE THE STATES LACK THE REQUISITE EXPERTISE AND COMMITMENT.

THE PRESIDENT'S COMMISSION GAVE A GREAT DEAL OF ATTENTION TO THE NEED FOR IMPROVED PROGRAMS TO PREVENT MENTAL ILLNESS, YET THE PROPOSED SYSTEMS ACT DOES NOT BEGIN TO MEET THE FOLLOWING RECOMMENDATIONS OF THE COMMISSION:

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- * THAT A CENTER FOR PREVENTION BE ESTABLISHED IN THE NATIONAL INSTITUTE OF MENTAL HEALTH;
- * THAT PRIMARY PREVENTION BE THE MAJOR PRIORITY OF THIS CENTER;
- * THAT \$10 MILLION BE ALLOCATED DURING THE FIRST YEAR WITH A FUNDING LEVEL OF NO LESS THAN 10% OF THE NIMH BUDGET WITHIN TEN YEARS TO SUPPORT EPIDEMIOLOGICAL, BIOMEDICAL, BEHAVIORAL AND CLINICAL RESEARCH AIMED AT PREVENTION; TO ASSESS AND EVALUATE EXISTING PROGRAMS OF PREVENTION; TO REPLICATE EFFECTIVE PREVENTIVE PROGRAMS INCLUDING THOSE RELATED TO COMMUNITY SUPPORT SYSTEMS AND TO ENGAGE IN OTHER APPROPRIATE ACTIVITIES.

NCCMHC BELIEVES IT IS TIME TO IMPLEMENT THESE RECOMMENDATIONS AND GIVE PRIMARY PREVENTION A FAR MORE PROMINENT POSITION IN MENTAL HEALTH SERVICES DELIVERY. THE NEW LEGISLATION SHOULD ESTABLISH THE PROPOSED CENTER FOR PREVENTION THROUGH WHICH HEW SHOULD MAKE GRANTS TO BOTH PUBLIC AND PRIVATE NONPROFIT AGENCIES TO ESTABLISH COMMUNITY CENTERS OF EXCELLENCE (AS RECOMMENDED BY THE COMMISSION'S TASK PANEL ON PREVENTION) WHICH WOULD PROVIDE PRIMARY PREVENTION MENTAL HEALTH SERVICES. GRANTS SHOULD BE FOR UP TO FIVE YEARS, NOT TO EXCEED 75 PERCENT OF COSTS. AGENCIES APPLYING FOR SUCH FUNDING SHOULD PROVIDE PREVENTION SERVICES AND INCLUDE AN EVALUATION AND TECHNICAL ASSISTANCE COMPONENT. THE SERVICES COMPONENT MIGHT INCLUDE SERVICES FOR SPECIAL GROUPS WITHIN THE AREA SUCH AS RECENTLY BEREAVED, NEW PARENTS, TERMINALLY ILL, ETC., OR CONTRACTS WITH EXISTING COMMUNITY SELF-HELP

GROUPS, OR INITIATION OF SUCH GROUPS. UNDER THESE CONTRACTS, THE MENTAL HEALTH AGENCY WOULD PROVIDE PROFESSIONAL EXPERTISE AND CLINICAL SERVICES WHEN NEEDED. THROUGH THE EVALUATION AND TECHNICAL ASSISTANCE COMPONENT, THESE CENTERS OF EXCELLENCE COULD DISSEMINATE INFORMATION AND PROVIDE INSERVICE TRAINING. THE CENTER FOR PREVENTION IN NIMH SHOULD ALSO CARRY OUT THE OTHER FUNCTIONS RECOMMENDED BY THE COMMISSION AND LISTED ABOVE. FUNDING FOR SUCH A PREVENTION PROGRAM MUST BE ADEQUATE -- NCCMHC RECOMMENDS \$10 MILLION FOR THE FIRST YEAR, \$15 MILLION AND \$20 MILLION FOR THE FOLLOWING TWO YEARS.

TITLE I OF THE BILL IS INTENDED TO SET UP A NEW PROGRAM ENCOURAGING STATES TO CHANGE THE EMPHASIS OF THEIR PROGRAMS FROM INSTITUTIONAL TO COMMUNITY SERVICES. AS DRAFTED, HOWEVER, THE SYSTEMS ACT FAILS TO TAKE ANY FAR-REACHING STEPS IN THIS DIRECTION. THE EXISTING COMMUNITY SUPPORT PROGRAM PROVIDES FEDERAL FUNDING FOR INDIVIDUAL STATES TO INITIATE NEW COMMUNITY PROGRAMS, OR TO EMPLOY CASE MANAGERS OR MAKE OTHER MINOR CHANGES TO THE STATE MENTAL HEALTH SYSTEM. THE PROPOSED ACT APPEARS DESIGNED TO CONTINUE THIS EXTREMELY MODEST EFFORT.

UNLESS THE PROGRAM UNDER TITLE I HAS CONSIDERABLY MORE INCENTIVES TO REALLY CHANGE THE EMPHASIS AT THE STATE LEVEL, COUPLED WITH SUBSTANTIAL INCENTIVE FUNDING FOR STATES, IT IS HARD TO SEE HOW THIS PROGRAM CAN ACHIEVE THE OBJECTIVES SET FOR IT OR MEET THE COMMISSION'S RECOMMENDATIONS.

STATES PARTICIPATING IN SUCH A PROGRAM FOR THE CHRONICALLY

ILL MUST BEGIN TO SHIFT EMPHASIS FROM LONG-TERM INSTITUTIONAL CARE TO AFTER-CARE AND OTHER COMMUNITY PROGRAMS. STATES SHOULD SHOW A WILLINGNESS TO COORDINATE VARIOUS SERVICES FOR THIS POPULATION GROUP -- INCLUDING HOUSING, JOBS, SOCIAL SERVICES AND MENTAL HEALTH. THIS REQUIRES COOPERATION AMONG STATE AGENCIES, AND THAT REQUIRES A REAL COMMITMENT TOWARDS DEINSTITUTIONALIZATION BY GOVERNORS AND LEGISLATURES. MENTAL HEALTH BUDGETS NEED TO BE SHIFTED TO GIVE GREATER SUPPORT TO COMMUNITY SERVICES THAN IS NOW THE CASE. WE MUST REVERSE THE TREND WHERE, AS PATIENT POPULATIONS DECLINE, INSTITUTIONAL BUDGETS REMAIN THE SAME OR EVEN INCREASE AT THE EXPENSE OF NEEDED COMMUNITY PROGRAMS. FEDERAL FUNDS UNDER TITLE I SHOULD BE GIVEN AS INCENTIVES. A LIMITED AMOUNT OF FUNDING SHOULD BE MADE AVAILABLE TO STATES SUBMITTING PLANS WHICH HAVE THE POTENTIAL TO MEET DEINSTITUTIONALIZATION GOALS IN A MEANINGFUL WAY, WITH SUBSTANTIAL FEDERAL AID BEING AVAILABLE OVER THE NEXT FEW YEARS TO ASSIST IN ACHIEVING THESE GOALS.

THIS, AS WE UNDERSTAND IT, WAS THE PURPOSE OF THE COMMISSION RECOMMENDATIONS FOR PERFORMANCE CONTRACTS TO THE STATES FOR THE CHRONICALLY ILL POPULATION. THE DRAFT ACT APPEARS TO US TO AUTHORIZE A CONTINUATION OF THE COMMUNITY SUPPORT PROGRAM WHICH, WHILE IT HAS BEEN HELPFUL, HAS BEEN A PIECEMEAL APPROACH HELPING ONLY A FEW COMMUNITIES AND CLIENTS AND IN NO WAY TURNING AROUND THE STATE SYSTEM TO PROVIDE THE ENTIRE RANGE OF SERVICES NEEDED TO HELP THE CHRONICALLY MENTALLY ILL.

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WE SUPPORT THE PROGRAM OF LINKAGE GRANTS WHICH THE SYSTEMS ACT WILL CREATE. THESE GRANTS WILL SERVE TO BETTER INTEGRATE THE DELIVERY OF HEALTH AND MENTAL HEALTH SERVICES. IT IS IMPORTANT THAT HEALTH CARE CENTERS BE ABLE TO PROVIDE APPROPRIATE MENTAL HEALTH SERVICES AND MAKE PROPER REFERRALS.

SINCE CONGRESS HAS ALREADY BEGUN THE APPROPRIATIONS PROCESS, IT DOES NOT MAKE SENSE TO ATTEMPT TO ESTABLISH A NEW MENTAL HEALTH SYSTEM FOR THE NATION FOR FY 1980. SINCE THE PRESENT CMHC PROGRAM IS AUTHORIZED THROUGH NEXT YEAR, THERE IS NO NEED TO RUSH INTO A NEW PROGRAM WHICH MAY NOT BE APPROPRIATED FUNDING. FURTHERMORE, SOME PERIOD OF TIME IS NEEDED TO EFFECTUATE A SMOOTH TRANSITION AND TO PREPARE THE ADMINISTRATION TO EXECUTE THE NEW PROGRAM.

IN CONCLUSION, WE BELIEVE THAT THE SYSTEMS ACT PROVIDES A SOUND BASIS TO BEGIN TO IMPROVE ON OUR PRESENT MENTAL HEALTH SYSTEM. IT NEEDS, HOWEVER, CAREFUL STUDY AND SERIOUS REVISIONS IF THE GOALS OF THE ACT ARE TO BE MET. WE LOOK FORWARD TO WORKING TOGETHER WITH YOUR SUBCOMMITTEE TO DEVELOP AN IMPROVED MENTAL HEALTH SYSTEM FOR THE NATION.

* * *

Senator KENNEDY. Our next witness is Robert E. McGarrah, Jr., assistant director for public policy, American Federation of State, County, and Municipal Employees.

STATEMENT OF ROBERT E. MCGARRAH, JR., ASSISTANT DIRECTOR FOR PUBLIC POLICY, AMERICAN FEDERATION OF STATE, COUNTY, AND MUNICIPAL EMPLOYEES

Mr. MCGARRAH. Thank you, Mr. Chairman.

I am here to present this statement for Jerry Wurf, President of the American Federation of State, County, and Municipal Employees. He was unable to be here today. He wanted me to express his greetings to you.

Senator KENNEDY. I was with him on Sunday with some very fine employees at a regional meeting up in Boston.

Mr. MCGARRAH. Thank you. We appreciate it very much.

Mr. Chairman, our union represents over a million employees and is the largest union in the AFL-CIO. More than 250,000 of our members work in mental health institutions throughout the country.

It takes strong, eloquent and compassionate leadership to awaken the people to our obligation to care for our less fortunate fellow citizens, Mr. Chairman.

President Kennedy was such a leader. As early as 1957, he called the Nation's attention to the plight of the mentally ill confined in large institutions and to the plight of those in need of mental health care but unable to find this care. President Kennedy called for the creation of 2,500 community mental health centers—but today scarcely more than 700 such facilities are in operation around the country.

Today, 20 years later, Rosalynn Carter has raised her voice in support of a new standard of compassion for the mentally ill. Our union disagrees with some of the recommendations that Mrs. Carter has offered, but we applaud and admire her determination to serve as an advocate for people who have all too often been ignored.

Mr. Chairman, you have been an eloquent advocate for programs to make all forms of health care accessible and affordable to the American people.

Senator KENNEDY. We will include your statement in its entirety in the record. You have special issues and problems that you want to bring to the committee, so why don't you summarize them.

Mr. MCGARRAH. Thank you. We share many of the concerns you raised in your floor statement and also in your opening statement today, especially the issues you have raised with regard to entitlement programs such as medicare, medicaid, and supplemental security income. We think these problems have to be addressed if there is to be any solution to the deinstitutionalization problem that plagues patients throughout the country. Well over 300,000 mentally ill people today are confined to nursing homes today while there are only 146,000 in State hospitals.

These people do not belong in nursing homes. They are inappropriately cared for. Something has to be done.

Another serious problem we have noted throughout the country is that State mental hospitals and community mental centers have

been operated on two different tracks. Community mental health centers were developed independent of State mental hospitals and independent of State mental health systems. They have been funded directly out of Washington, D.C., and it has not been of any real significant service to chronically ill deinstitutionalized mental patients.

The Civil Rights Commission, the U.S. General Accounting Office, Ralph Nader, and currently the National Council of Senior Citizens and the American Association of Retired Persons have made major criticism of the community mental health centers because they are discriminating against the poor, the elderly and the chronically ill. We think there are major changes that need to be made in these programs. The current legislation that the administration has proposed underfunds and doesn't do an adequate job on the State level.

As you pointed out, \$46 million will hardly make a dent in the services for the chronically ill in this country.

Some of the recommendations that we made in our testimony which I think are important for you to consider: First of all, we must provide additional funding to maintain adequate public facilities for mentally ill people who need constant care.

State and local governments must adopt a policy of refusing to discharge patients unless there is clear evidence that equal or better community facilities exist.

On community mental health, Mr. Chairman, in New York State, as Senator Javits pointed out, AFSCME has taken a leadership role with Governor Carey in developing a single system of care, a continuum of care from the institutions into the community with State-operated community health centers. That is a major change and it gives assistance to chronically ill patients.

All States must be required to specifically account for each patient who has been deinstitutionalized. There is no hard data anywhere of the number of people, where they are and where they have gone. It is a serious problem.

We believe you can amend this legislation to require that community mental health centers, once they receive the data from the States as to where patients have been discharged, to followup with those patients in the community. They have got to locate them and be sure they receive the proper followup and after care and support services. This is a responsibility that the community health centers have to undertake if there is to be any decent service to these patients.

Furthermore, the same kind of changes can be made with the supplemental Security income program which provides almost \$2 billion a year to the mentally disabled who are in boarding homes such as the one that burned down recently on Lamont Street here in Washington, D.C., and others in Pennsylvania and Missouri.

Community mental health centers can be obligated to go out and see whether these patients are living in adequate facilities and not the substandard facilities that we have so often found them in. We think that there ought to be changes in the inequities in the medicaid program that only permit institutionalization for patients under 21 and people over 65. This results for example in New York instituting diversion programs where they send patients into nurs-

ing homes rather than admitting them into institutions when they know they need institutional care.

There are other changes that ought to be made. They would relate to establishing intermediate care facilities for the mentally ill.

The President's Commission on Mental Health called for this kind of change. There have got to be standards in nursing homes that have predominantly mentally ill patients in them. This should be included in this legislation. Provisions in medicare which discriminate against the aging and mentally ill must also be eliminated. In States where deinstitutionalization is being carried out, employees must receive guarantees that they will have access to new job opportunities in community-based facilities.

I have already mentioned the New York State example. That is one that ought to be followed in this legislation.

Currently, since 1975, in fact, Mr. Chairman, legislation has been on the books which you sponsored and you fostered in the Senate to provide protections for nonsupervisory employees, institutional employees. HEW has done absolutely nothing to implement that legislation. They have not issued regulations or guidelines. They have not bothered to recommend anything to the regional offices.

Our President, Jerry Wurf, has been in constant contact with HEW on this issue. We understand that an investigation is underway. Still, nothing has been done. We think this is a terrible situation. We think that the Secretary of Labor ought to have signoff authority and any deinstitutionalization plans that are devised by the States and that the money under this legislation which is tied to those plans ought to not be released from Washington until the Secretary of Labor signed off that that money is going to be adequately spent and appropriately spent to protect employees as well.

This should not impose an excessive fiscal burden on the taxpayer.

It costs no more to care for patients than to abuse them; no more to treat the mentally ill than to enrich profiteers; no more to build quality facilities that will last than to support inadequate boarding homes which must be closed down.

The cost to our Nation in money spent and lives wasted—this is incalculable.

Fundamentally, we are not talking about dollars and cents. We are talking about men, women and children—human beings. The mentally ill are the most helpless people in our society, and a society is judged by how it treats its most helpless citizens.

Thank you, sir.

Senator KENNEDY. OK. Very fine.

I wonder if you could tell us a little bit about the employee protections, if we could go back through this a little bit.

Do you have data supporting your claim about the failure to provide those employees protection?

Mr. McGARRAH. Yes.

Senator KENNEDY. Could you summarize it now and provide it for the record?

Mr. McGARRAH. Yes. I have some materials which I would like to submit for the record which begin with the statute which was

enacted in 1975. As I mentioned, you were instrumental in getting it on the books. It was part of the special help revenue-sharing legislation. It would be affected by this legislation. We have repeatedly been in constant contact with HEW and asked them to issue regulations to implement this. Nothing has been done.

I have a whole series of letters that go back to 1975 on this issue.

Just to give you some idea of the impact it has had on our people, in Massachusetts, more than 800 of our members have been affected. Some 500 have been affected in the State of Washington. In Ohio, almost 400 people have lost their jobs in State hospitals; Michigan, approximately 300; Minnesota, another 350. The problem is very serious in the State of Pennsylvania as well. We have over 20,000 people working in institutions in that State. There has been a very serious problem of communication in the State.

When States are making their plans for deinstitutionalization, they refuse to or, in many cases, they are unwilling to be in touch or consult with the employees affected.

Our people are not as well-equipped as other professionals are to move to any other job around the country. It is imperative that the Federal Government protect employees and implement legislation on the books. It ought to be implemented. HEW has an abysmal track record in protecting employees. S. 544, the health planning amendments, have good provisions and the Secretary of Labor has a signoff. I think that is the best kind of approach to take in this case.

I want to add, Mr. Chairman, that we appreciate your assistance in the past as well as Dr. Shapiro's help because the kind of effort we are making with HEW needs such assistance as yours. We won't be able to do it on our own. We have to make an impact on the Department. This is the only way we will be able to do it if the Labor Department has this kind of signoff authority.

Senator KENNEDY. Will you provide that for the record?

Mr. McGARRAH. Yes, I will, sir.

Senator KENNEDY. Given the track record on some of the State programs in the mental health system, how do you guarantee that the money that you urge will not be ineffectively used as it has been in the past?

Mr. McGARRAH. I would agree with you. Our union constantly criticized State and local governments in the past for inadequate management and poor funding and poor appropriation processes, but the problem here is that we have two systems. We have one system of community facilities catering to neurotic and family situational problems and the public system, State institutions, which are serving chronically ill patients. These systems are operating separately. We need a single delivery system, a publicly financed delivery system operated by State governments. State governments have the best tax base. Local governments do not. Nonprofit health centers cannot have adequate funding bases as stated over and over again this morning. The kind of accountability you can build into this legislation, I think the States should be required to operate this single system as they are doing in New York State right now.

Senator KENNEDY. Thank you very much.

Senator SCHWEIKER. Thank you very much for your testimony.

Mr. McGARRAH. Thank you.

[The prepared statement of Mr. McGarrah follows:]



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TESTIMONY OF ROBERT MCGARRAH

ASSISTANT DIRECTOR OF PUBLIC POLICY ANALYSIS

of the

AMERICAN FEDERATION OF STATE, COUNTY

AND MUNICIPAL EMPLOYEES, AFL-CIO

to the

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

of the

SENATE LABOR AND HUMAN RESOURCES COMMITTEE

May 24, 1979

in the public service

Mr. Chairman, my name is Rob McGarrah, and I am Assistant Director of Public Policy Analysis of the American Federation of State, County and Municipal Employees. AFSCE is the largest union in the AFL-CIO.

More than 250,000 mental health care workers throughout the nation are represented by AFSCE. I'm here today to testify on behalf of all of the more than one million members of AFSCE. Like all other Americans, AFSCE members are consumers of health care -- and potential consumers of mental health care. Like all other Americans, AFSCE members live in communities that are affected by the decisions that the state, local and federal governments make concerning mental health care policies.

A quarter million AFSCE members care for mentally disabled individuals. These workers haven't learned only about the mentally ill -- they have learned a painful truth about the American people.

Mental health care workers have been forced to reach the distressing conclusion that our society might prefer to ignore the mentally ill and their plight. We cannot accept this grim verdict upon our society.

It takes strong, eloquent, and compassionate leadership to awaken the people to our obligation to care for our less fortunate fellow citizens.

President Kennedy was such a leader. As early as 1957, he called the nation's attention to the plight of the mentally ill confined in large institutions -- and to the plight of those in need of mental health care but unable to obtain this care. President Kennedy called for the creation of 2,500 community mental health centers -- but today scarcely more than 700 such facilities are in operation.

Twenty years later, Rosalynn Carter raised her voice in support of a new standard of compassion for the mentally ill. Our union disagrees with

some of the recommendations that Mrs. Carter has offered, but we applaud and admire her determination to serve as an advocate for people who have all too often been ignored.

Mr. Chairman, you have been an eloquent advocate for programs to make all forms of health care accessible and affordable to the American people.

No form of health care has been less accessible and less affordable to most people than mental health care.

The private psychiatric profession has catered to a small sliver of the population -- a group known to social critics as the YAVIS the young affluent, verbal, intelligent, and sophisticated.¹

The psychiatric profession -- and its extensions in private facilities for the mentally ill -- have failed to care for the low-paid workers and the unemployed, the poor and the elderly, the residents of poverty-stricken rural areas and the inner city neighborhoods.

Those who have been denied decent treatment from the private mental health care establishment have been consigned to the public institutions where AFSCME members strive to do the best jobs they can under terribly trying circumstances.

Mr. Chairman, AFSCME was among the earliest critics of the large public facilities. Our members always knew that these facilities traditionally have been overcrowded, understaffed, and underfunded. Our union called for more modern facilities, better sanitary conditions, improved medical and nursing care, additional staffing, and better treatment, therapeutic, recreational, and occupation training programs. We were a lonely voice, but we were a loud voice.

Initially, AFSCME was sympathetic when a new generation of reformers called for treating mentally ill individuals in smaller, friendlier settings, closer to their homes. We believed that these facilities would

be better places for the patients. We knew that they would be better places to work.

This trend was called "deinstitutionalization." Today, deinstitutionalization is no longer a visionary proposal. It is a fact of life.

In 1969, there were 428,000 patients in public mental health care facilities. In 1978 -- the last year for which complete statistics are available -- there were only 146,000 patients in public mental hospitals.² According to the National Institute of Mental Health, more than twice that number -- over 300,000 mentally ill -- have been reinstitutionalized into nursing homes.³

As early as 1974, it became clear to our union that deinstitutionalization was creating more problems than it solved. In 1974, AFSCME published the first comprehensive study of deinstitutionalization focusing on conditions in Illinois, Wisconsin, New York State, California, and Massachusetts.

The title of that report told the whole story -- "Out of Their Beds and Into the Streets."

The report found that patients had been dumped out of public hospitals, and into abusive, profitmaking nursing homes, boarding homes, flophouses, and other accommodations ill-suited to caring for the mentally ill. Patients' stays in these private facilities were paid by public funds -- the taxpayers' money -- in the form of Medicare, Medicaid, welfare and Supplemental Security Income.⁴

Five years later, these findings are confirmed by daily newspaper headlines:

** Within ten days last month, 45 people died in a series of fires at three boarding homes in Missouri, in Pennsylvania, and here in Washington, D.C. -- facilities that housed deinstitutionalized mentally ill. There are one million residents of such facilities through the nation. Approximately one half of these residents were discharged from mental hospitals.⁵

** In New York State, the population of state mental health facilities has declined from 70,765 in 1969 to 27,116 in 1978.⁶ Tens of thousands of discharged mental patients have found their way into private boarding homes, and the result has been a national scandal marked by abuse of the patients -- and an alliance between boarding home operators on the make and politicians on the take. The special prosecutor for nursing homes -- Charles Joseph Hynes -- has publicly called for a halt in administrative discharges of patients from mental health institutions.⁷

** In California, according to the Los Angeles Times, more than 61,000 mentally ill people have been left without any care at all as a result of a decade of wholesale discharges of patients from public facilities.⁸ A federal investigation of this "dumping" is now underway.⁹

Mr. Chairman, I'm not here today to bring this Subcommittee the bad news that the nation's mental health care policies are a disaster. We already know that. I'm here to tell you that the Administration's proposed new national mental health care policy -- as detailed in the proposed "Mental Health Systems Act" -- will not change this situation.

This proposed legislation does virtually nothing to improve conditions in existing public facilities.

This proposed legislation does little to improve care for the chronically ill or for the segments of the population who are already under-served by the private psychiatric establishment.

This proposed legislation would rely even more heavily upon a system of community mental health centers that has failed to serve those whom the private psychiatric establishment has ignored. This legislation would pour more federal money into these centers based upon their simple "assurances" that they will now treat people whom they have failed to treat in the past.

This proposed legislation would provide a meager \$46 million for more than 20 different activities throughout the nation including planning for deinstitutionalization, staff training and retraining, prevention, community services and institutional upgrading to improve mental health care facilities.

Here in Washington D.C., when the federal government finally agreed to improve conditions at St. Elizabeths Hospital, the President proposed -- and Congress approved -- total funding of \$53 million.¹⁰

If it takes more than \$50 million to get just one hospital accredited, then it is ludicrous to assume that only \$46 million will make more than the slightest improvements in the entire system of mental health care in all 50 states.

There is a crisis of accountability and accessibility in the system that the Administration would rely upon -- the community mental health centers.

The Civil Rights Commission,¹¹ the U.S. General Accounting Office¹² and Ralph Nader's¹³ research organizations have all found that the community mental health centers do not provide adequate services for the poor, the elderly, and the chronically ill.

In theory, the community mental health centers may be accountable to the National Institute of Mental Health -- but NIMH has never revoked the funding of even one community mental health center during the entire 16 year history of the program.

The proposed legislation is an exercise at denying reality. It provides little or nothing for the state mental health care facilities that still are the only facilities to provide care for the chronically ill and dispossessed of our society.

This legislation largely ignores and under-funds protections for the current employees of state institutions who would be displaced if the trend towards institutional cutbacks and closures continues.

Finally, this legislation ignores the major federal programs for the mentally ill: the \$5.4 billion Medicare, Medicaid, Social Services, and Supplemental Security Income Programs. Despite recommendations by the First Lady,¹⁴ the General Accounting Office,¹⁵ the President's Commission on Mental Health,¹⁶ and you, Senator Kennedy,¹⁷ this legislation fails to address the inequities in these programs -- or to impose tighter cost and quality controls upon private providers.

A realistic and humane mental health policy would build upon the strengths of our existing institutions. It would correct the flaws in existing programs and treat the inadequacies in existing facilities. It would draw upon the talents and dedication of current mental health care employees.

** We must provide additional funding to maintain adequate public facilities for mentally ill people who need constant care.

** State and local governments must adopt a policy of refusing to discharge patients unless there is clear evidence that equal or better community facilities exist.

** Unlike nonprofit providers and local governments, the states have the necessary tax base to maintain community care facilities assuring access to all citizens. Title IV of the proposed legislation must be amended to provide for state operation of community mental health centers. In New York State, AFSCME Local 1000, the Civil Service Employees Association, has reached an agreement with Governor Carey to cooperate in creating a network of state-operated mental health care facilities on the community level. New York's system may develop into a model for the nation.¹⁸

** All states must be required to specifically account for each patient who has been deinstitutionalized. State plans must contain information on deinstitutionalized individuals, including their age, sex, race, and place of residence.

Community mental health centers must then be required to locate patients and assure that they receive proper follow-up and after-care support services. The burden of care must be shifted from the state hospital to the community mental health center once a patient is deinstitutionalized. Each community mental health center must be required to submit patient data annually, showing that the center has served the deinstitutionalized patients in its catchment area, according to the patient data in the state plan.

** The Supplemental Security Income Program provides nearly \$1.7 billion annually in benefits to the mentally disabled. To alleviate the plight of the hundreds of thousands of discharged patients in substandard boarding homes and welfare hotels, each community mental health center must be required to conduct outreach and case management services for mentally ill SSI recipients. Community mental health centers must be required to establish referral services with social security district offices and assume responsibility for adequate community placements and after care services.

** The SSI program must also be changed: There is no justification for prohibiting patients in public institutions with more than 16 residents from receiving these funds,¹⁹ when that money is made available to patients in private facilities, even if hundres of SSI recipients reside in them.

** Medicaid must be amended to remove funding inequities that prohibit institutional coverage for persons 21-65. In addition, as recommended by the President's Commission on Mental Health, a new category of intermediate care must be created: the Intermediate Care Facility for the Mentally Ill.²⁰ This will assure adequate services to the 300,000 mentally ill patients in nursing homes.

** The provisions in existing medicare statutes which discriminate against the aging, mentally ill, must be eliminated. Inpatient mental health services should be reimbursed on the same basis as comparable general health services.

** In states where deinstitutionalization is being carried out, workers must receive guarantees that they will have access to new job opportunities in the new, community-based facilities, and that they will be retrained to fill these jobs. Employee protections must be written into the bill comparable to the protections afforded to workers under the recently-passed amendments to the Health Planning and Resources Development Act (S.544). The U.S. Secretary of Labor should be entrusted with the final authority to sign off on these employee protection programs before any funds can be released under the "Mental Health Systems Act." ²¹

Mr. Chairman, AFSCME believes that this proposal should not impose an excessive fiscal burden upon the taxpayers. It costs no more to care for patients than to abuse them; no more to treat the mentally ill than to enrich profiteers; no more to build quality facilities that will last than to support inadequate boarding homes which must be closed down.

The cost to our nation in money spent and lives wasted -- this is incalculable.

Fundamentally, we are not talking about dollars and cents. We are talking about men, women and children -- human beings. The mentally ill are the most helpless people in our society... and a society is judged by how it treats its most helpless citizens.

Notes

1. W. Schofield Psychotherapy: The Purchase of Friendship. Prentice-Hall, Eaglewood Cliffs, New Jersey, 1964. In the past 15 years "Y.A.V.I.S." has been modified by certain authors to include "W" (for White) and an additional "S" (for Successful or Sexy).
2. House Select Committee on Aging. A state-by-state census of inpatients was prepared for the hearings on April 25, 1979.
3. Letter from Dr. Herbert Pardes, Director, N.I.M.H., to Jerry Wurf, President AFSCME, February 8, 1979.
4. Henry Santiestevan Deinstitutionalization: Out Of Their Beds And Into The Streets. AFSCME, Washington, D.C., 1974 (3rd printing, 1979).
5. Lacy McCrary Philadelphia Inquirer, April 25, 1979. Article entitled "Mrs. Carter: States Abandon Mentally Ill": "The states, she charged, 'are not trying to take care of those in boarding homes. They are just trying to get more (patients) out of institutions so the federal government can pay for them and take them off their (state) budgets.'"
6. House Select Committee on Aging. Op.cit..
7. Charles J. Hynes, New York State Deputy Attorney General for Nursing Homes, Health and Social Services. Private Proprietary Homes for Adults (Second legislative report). March 31, 1979. See also, Hynes' testimony before House Select Committee on Aging, April 25, 1979 and Lacy McCrary in Philadelphia Inquirer article entitled "Boarding Homes for Mentally Ill - 'dismal failure'", April 29, 1979.
8. Representative Claude Pepper (D-Fl). Column entitled "Freeing the Mentally Ill" in the Los Angeles Times, July 5, 1978.
9. Lou Cannon and Joel Kotkin. The Washington Post. "Crisis Grows in California Mental Hospitals", April 16, 1979.
10. ADAMHA News. "Secretary Predicts St. E's Accreditation Early Next Year", October 20, 1978.
11. United States Commission on Civil Rights. The Age Discrimination Study U.S. Government Printing Office, Washington, D.C. 1977. "The area of mental health services represents one of the most glaring examples of discrimination on the basis of age." p.6.
12. U.S. General Accounting Office. Need for More Effective Management of Community Mental Health Center Program (1974) and Returning the Mentally Disabled to the Community: Government Needs to Do More. (1977) Chapter 5 of the 1977 report is especially relevant. "In general, the CMHC program has developed apart from the public hospital system. Many CMHC's did no view reducing the use of state mental hospitals as a primary goal and therefore did not direct much effort toward this goal. The lack of a formal link between the CMHC's and the public mental hospitals helped fragment responsibility for the mentally ill released from mental hospitals. It also appears to have hindered the accomplishment of two CMHC program goals -- reducing the use of mental hospitals and providing a coordinated system of care for the mentally ill." p.72.

13. Franklin D. Chu and Sharland Trotter. The Madness Establishment: Ralph Nader's Study Group Report on the National Institute of Mental Health. Grossman Publishers, New York, 1974. "...in 1969...the Joint Information Service of the American Psychiatric Association and National Association for Mental Health found that community mental health centers had apparently lost sight of their congressional mandate. The Joint Information Service found instead that some centers consciously discriminated against poor and chronically ill patients who came to them for help." p.33. The same chapter also contains an excerpt from the November 8, 1971 report of the Senate Special Committee on Aging: "Community mental health centers, authorized by legislation eight years ago, are failing to meet the needs of the elderly". p.41.
14. Rosalynn Carter. Statement Before the Senate Subcommittee on Health and Scientific Research, February 7, 1979.p.6.
15. U.S. General Accounting Office. Returning the Mentally Disabled to the Community: Government Needs to Do More. Op.cit. See chapters 6, 7 and 9.
16. The President's Commission on Mental Health: Report to the President from The President's Commission on Mental Health. U.S. Government Printing Office, Washington, 1978. See Volume I, Chapter VI, "Insurance for the Future". pp.30-32.
17. Senator Edward M. Kennedy. Statement on S.1177, The Mental Health Systems Act. Congressional Record. 96th Congress, 1st Session, May 17, 1979.p.S6159.
18. Memo from Robert J. Morgado, Re: Implementation of Major Mental Hygiene Initiative, June 15, 1978.
19. Social Security Act, Section 1611(e)(1)(C). According to the 1977 G.A.O. report, (cited above) "...The prohibition seemed to conflict with the deinstitutionalization objective of treating the mentally disabled in the least restrictive environment suitable to their needs". p.128.
20. President's Commission on Mental Health. Op.cit. Volume I, p.24.
21. See also the Rail Passenger Service Act (Amtrak), 45 USC 565 and the Urban Mass Transportation Act (UMTA), 49 USC 1609.

Senator KENNEDY. Our last witness is Paul Friedman, director of the mental health law project.

Mr. Friedman.

STATEMENT OF PAUL R. FRIEDMAN, DIRECTOR, MENTAL HEALTH LAW PROJECT, ACCOMPANIED BY LESLIE SCALLET, STAFF ATTORNEY

Mr. FRIEDMAN. My name is Paul R. Friedman. I am director of the mental health law project here in Washington, a nonprofit public-interest organization which conducts law reform advocacy on behalf of mentally disabled persons. Our group has participated in a good many of the landmark cases—such as *Wyatt v. Stickney*, *O'Connor v. Donaldson*, the *Willowbrook* case in New York, the *Mills* case in the District of Columbia and most recently *Addington v. Texas* handed down several weeks ago by the Supreme Court—which have, in the past few years, established basic legal rights for mentally handicapped people.

As we have learned from our representation of mental patients in these and similar cases around the country, institutionalized people throughout our country are daily deprived of meaningful treatment programs due to understaffing. They are stripped of any semblance of privacy; they are subjected to hazardous physical plant conditions and an inadequate diet; all too often they are abused and brutalized. As one Federal court has characterized the situation, what is at stake for these patients is “the very preservation of human life and dignity.”

In the community, mentally handicapped persons—many of whom have recently been dumped out of institutions—are denied proper housing, are arbitrarily refused employment on the basis of their label, and are deprived of a wide array of fundamental rights enjoyed by normal citizens.

These sorry situations still prevail despite some exciting developments in the last decade. However, as a result of recent legal decisions, mentally handicapped persons today have begun to come into their own as citizens with rights, rather than as beggars or alms seekers. Actions on their behalf have aimed to stop abuses of their civil rights and to improve the services available to them. The administrators of institutions and other programs for mentally handicapped persons no longer have unreviewable discretion to grant or deny favors. Now public scrutiny is being extended to all facets of the service delivery system, not only within institutions but within the community at large.

There is general agreement that perhaps the single most significant factor in improving the quality of services to mentally handicapped persons in the last 7 or 8 years has been the patients' rights movement and emphasis. In fact, in our view, there is a unique relationship between civil rights and the equality of services. Having rights and a meaningful mechanism to enforce those rights is a very important aspect of improving the quality of any service delivery system.

The remarks I am about to make on the proposed bill, S. 1177, are based in part upon the experience I had serving as coordinator of the task panel on legal and ethical issues established by the President's Commission on Mental Health. This was an interdis-

plinary group made up of consumers, advocates, mental health professionals and paraprofessionals. The report of the task panel to the full Commission discusses a number of complex legal issues which affect mentally handicapped persons and recommends a number of detailed reforms in specific areas, and I would ask that the task panel report be made part of the record.

Senator KENNEDY. We will have it as part of the record. Relevant parts will be filed in the record.

Mr. FRIEDMAN. Thank you.

On behalf of the Mental Health Law Project, I deeply appreciate the opportunity to comment on S. 1177. I will try to be very brief.

A number of points I would make were very well covered by people who preceded me. I have one central theme which was raised in your questioning of Secretary Califano earlier, Senator Kennedy: the curious absence of any specific provisions for advocacy for the clients of the mental health service system. I will try to say why I think that is so important.

Mental care involves more than "coordination," "flexibility," and "linkages"—the words and issues that dominate this bill. The mental health system should be designed primarily to meet the needs of its clients and to protect the rights of its clients. This bill, in our opinion, unduly reflects provider concerns and part of this imbalance in emphasis is demonstrated by the exclusion of any meaningful provisions to protect patients' rights.

The imbalance is further demonstrated by the concern—albeit very important—shown in the bill for the employees of mental institutions, to assure that people who have given service in one sector can be trained to provide service as we shift the emphasis of care from institutions to the community. But we hear much about the concerns of the providers and the concerns of the staff and too little about the needs and rights of the patients.

The key point that the Task Panel on Legal and Ethical Issues made in its report to the Commission was the importance of building a strong patients' rights and consumers' perspective into any reforms in the service delivery system. The Commission agreed. It adopted the task panel's strong statement that:

We are keenly aware that even the best-intentioned efforts to deliver services to mentally handicapped persons have historically resulted in well-documented cases of exploitation and abuse.

Senator KENNEDY. What have the States been doing? Why haven't the State programs been sufficient to deal with this?

Mr. FRIEDMAN. The basic problem is a conflict-of-interest problem. For instance, as you may be aware, there has been terrific resistance by the State attorneys general to a bill that would address one tiny part of this problem by giving the Justice Department standing to sue on behalf of patients suffering systemic exploitation and abuse in public institutions. There, the reaction has been very vigorous. It touches on delicate issues of federalism.

It is very difficult for a State, which has primary responsibility to deliver services, to create an independent advocacy system, which is the only kind which can be effective. Such a system must at times challenge the State's administrative decisions.

There are three basic points that are virtually self-evident. First, mentally disabled people are especially vulnerable to abuse, neglect

and deprivation of their legal rights. Because of their handicapped condition, they are singularly unable to protect their own interests.

Second, the rights of mentally disabled persons are not self-enforcing. After a number of important test cases were brought, some States have enacted legislation to tighten up vague and amorphous criteria for civil commitment or to give handicapped children—often excluded from “regular” schools—the right to be served in the public school system. But these become mere paper rights in the absence of an effective advocacy mechanism. Most of the States have no such mechanism, so on paper we see what looks like a dramatic change, but in terms of actual impact on people’s lives, we still have a long way to go. Third, therefore, independent legal advocacy programs are essential.

I know you, Senator, have a long standing interest in this area. I won’t attempt to repeat in detail the catalog of rights violations that appear in Federal court and congressional committee records.

Senator KENNEDY. Which one would you favor that we follow in terms of a pattern? The ones we have developed in developmental disabilities bill, or do you have other programs that you think were more successful?

Mr. FRIEDMAN. I was listening with interest to your discussion with Secretary Califano on that point—the protection and advocacy system.

Senator KENNEDY. Or the legal services program?

Mr. FRIEDMAN. Yes. There are some problems with each of the approaches. Let me just briefly give you our sense of the situation.

The protection and advocacy agencies are an important start. The most obvious problem they have is woeful underfunding, which leads to understaffing and inability to service the very large constituency that they are mandated to serve.

There is another basic problem. That is that the program channels funds through the State Governors and the disability councils which are appointed by the State Governors. Such a conflict of interest limits independent advocacy.

The abuses we are talking about are part of a pattern of systematic malnutrition or lack of privacy or physical or chemical restraint or mass drugging in the States’ institutions. But if the P. & A. agency is located in the Governor’s office, as it often is, it cannot provide independent, effective advocacy. That is one problem with the present P. & A. model. The other obvious point is that mentally ill persons, under the old definition of “developmental disability,” have not been covered by protection and advocacy agencies at all.

The legal services system would appear to be a very good model for the delivery of advocacy services to mentally handicapped persons. In fact, there are particular legal services offices around the country that have brought cases and expressed interest in this area and have done an excellent job. But there are difficult political problems in getting the Legal Services Corporation to recognize, as an important priority, the need to represent mentally disabled persons. Part of it has to do with the corporation’s very broad mandate to represent poor people and cover all of their legal needs. And the structure of the legal services model allows local boards to set priorities. In general, mentally handicapped people are under-

represented, poorly organized, politically powerless and dispersed. The general experience has been that local legal services offices do not define working with this group as a high priority when they set priorities.

Perhaps the best approach in the immediate future, is simply to give project grants out of a funding block that is at a level significant enough to make a difference. We would take strong exception to Secretary Califano's view of the situation—that what is appropriate at this point is a relatively minuscule research and demonstration project to begin to develop models. We can point to specific models, individual ABA-sponsored projects, individual legal services projects, the New Jersey Department of the Public Advocate and certain of the P. & A.'s which have been very effective. As the Secretary described the program, the level of funding is a farce, we think. It would also be 1-year funding only, which couldn't lead to successful research results in any event. As Hilda Robbins from the Mental Health Association put it earlier, the models are already there. What we need now is the commitment and the fiscal resources to do something meaningful.

I have one other thought: that the formula grant approach, as used in the P. & A. program, practically speaking is a very bad approach. What happens is that, in trying to spread a relatively small amount of support for advocacy programs across the whole country, many P. & A. agencies are funded at the minimum \$20,000 level. Now there is congressional authorization for an increase to \$50,000 as a minimum grant, although no appropriations have been made for that level. An office can barely hire a secretary and a part-time social worker or part-time attorney on such funding. It cannot even handle its intake needs, let alone think about the more basic and systemic problems. It would be better to give reasonable funding on a project-grant basis and at least do the job right in a limited number of programs, rather than place an impossible burden on agencies around the country. Otherwise you set up unreasonable expectations and demands which are crushed and frustrated.

Senator KENNEDY. Senator Schweiker?

Senator SCHWEIKER. I will certainly support an amendment to the bill which includes a patient's rights section and an advocacy section. I think these are very critical points. I certainly agree with the thrust of the witness' testimony about gains we have made already and gains we will probably make in the immediate future.

I really have no further questions, Mr. Chairman.

Senator KENNEDY. How important is advocacy in terms of our whole commitment to recognizing the special needs of the mentally ill?

Mr. FRIEDMAN. We honestly feel, Mr. Chairman and Senator Schweiker, that it keeps the service delivery system honest. We are especially pleased by the strong support that the 1 million consumer members of the Mental Health Association and the Association of Community Mental Health Centers have given to this idea that advocacy is a crucial component. The legal advocates are the only people who, without a conflict of interest, can secure the services that their clients need and implement the rights their clients have through negotiation or letter-writing or litigation, if necessary. It is

the independence and the ability to go to court to vindicate important statutory or constitutional rights that gives them their special effectiveness.

All you need to do is pick up the newspapers to see how the best-intentioned efforts of the service deliverers can fail without this check-and-balance component in an overall system. I have clippings here from recent Washington papers. Here is a headline from the metro section of the Washington Post—"Bed Sore Infection Kills St. Elizabeth's Patient." This is going on under the eyes of Secretary Califano, even as a \$50-million attempt goes on to build up the physical plant of the hospital.

"Suit Says Country Judges Illegally Committed 290 Persons." This is in Virginia, right across the river. There is a good statute on the books. It provides for the right to counsel in civil commitment hearings to protect people against unfair deprivation of liberty. But it has become a mockery—a rubberstamp process where a patient is assigned a lawyer the day before the hearing. There is no preparation. The lawyers come from a small coterie of fellows who hang out around the courtroom. They are not properly trained or motivated. Some 290 commitments took place of patients, who often wished to resist the involuntary commitment and deprivation of liberty, without their lawyers ever calling a single expert witness on a patient's behalf or calling a single lay witness to give support to a patient's side of the story, such as why he might need some services, but nevertheless had a right to retain his basic freedom.

"Nine Elderly Die In Fire at District Foster Home." This is a matter of unbelievable pain to us at the mental health law project. Six years ago, we sued St. Elizabeth's Hospital. We won a terrific order from a Federal District Court judge here, proclaiming that patients who are "warehoused" at St. Elizabeth's Hospital—patients who did not need to be there but who were kept there because there was nothing in the community for them—had a right to receive the services they needed in a more normal community-based setting. This meant they had a right to live in supervised apartments or group homes or foster homes instead of the hospital and to get services in Community Mental Health Centers or sheltered workshop programs or day programs or job placement programs, like the excellent Green Door program recently established in D.C. The District Government and St. Elizabeth's Hospital were supposed to have been in a planning process to implement this decree. But it has not happened.

One of the issues raised by the fire was that there was a licensing that act had been enacted by the D.C. Council to try to upgrade the very substandard, literally life-endangering hotels and foster homes in the District. But no licences had been issued yet. We think if there were a vigorous local advocacy program for the District's mentally disabled citizens, lawyers and advocates would get to these homes and would press for enforcement of statutes on the books, so that tragedies like this might be averted.

Senator KENNEDY. All right. Thank you. We want to thank you and Leslie Scallet who worked very closely with our staff. It was very fine testimony, very helpful.

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

Senator KENNEDY. All of your testimony will be made a part of the record.

[The prepared statement of Mr. Friedman follows:]

Testimony of Paul R. Friedman

Mental Health Law Project

on S. 1177

The Mental Health Systems Act

Senate Subcommittee on Health and Scientific Research

May 24, 1979

My name is Paul R. Friedman and I am Director of the Mental Health Law Project, which is a not-for-profit public-interest organization engaged in law-reform advocacy on behalf of mentally disabled persons. It has been responsible for legal research and litigation which have established a number of basic rights for consumers of mental health and mental retardation services. On behalf of the Project, I appreciate this opportunity to comment on S. 1177, the Mental Health Systems Act.

I was also Coordinator of the Task Panel on Legal and Ethical Issues of the President's Commission on Mental Health. The Task Panel represented the full diversity of perspectives and expertise among professionals, policymakers and consumers. It included social workers, psychologists, psychiatrists, lawyers, educators, a mental health commissioner, civil servants and recipients of mental health services. Given the complexities of legal and ethical issues in the mental health field, it was remarkable that the members of the Task Panel -- working closely together and with full respect for each other's views -- were able to reach a consensus on significant reforms in a number of areas. Our report (which appears in Vol. IV of the PCMH Report) fully documents these issues, and I request that it be made a part of the record of these hearings.

Mentally handicapped citizens traditionally have been cared for under an "alms" model of services. Treatment and other services were "favors"

to be granted by legislators or administrators. The mentally handicapped had no effective recourse when such favors were denied. Courts adopted a hands-off attitude. Recently, however, lawyers and other advocates representing mentally handicapped people have employed litigation, legislation and administrative reform in a more systematic effort to articulate and implement the statutory and constitutional rights of this historically neglected minority group. As a result of some landmark legal decisions, mentally handicapped people have begun to come into their own as citizens with rights, rather than as "alms seekers." Actions on their behalf have aimed to stop abuses of their civil rights and to improve the services available to them. The administrators of institutions and other programs for mentally handicapped persons no longer have unreviewable discretion to grant or deny favors. Now public scrutiny is being extended to all facets of the delivery of service within institutions and to the full range of rights within the community at large.

The fact that the President's Commission established a Task Panel on Legal and Ethical Issues is ample evidence of the importance which this perspective has assumed in the mental health field over the last ten years. In its Findings and Assessment, the Commission recognized eight significant developments within the past quarter century which have contributed to the movement toward community-based rather than institution-based services for the mentally disabled. Two of the eight involve the legal system:

- The civil rights and consumer movements have been the impetus for legislative and court activities which have accelerated the release of patients from large mental institutions.

--Reforms of State laws have led to changes in commitment procedures, and court decisions emphasizing patients' rights have set minimum standards for patient care in institutions. (Vol. I at 3.)

Legal developments have played a crucial role in efforts to improve the quality of services and to provide them in less restrictive community settings.

S. 1177 -- The Mental Health Systems Act

This bill represents both the continuation of this movement and a new step forward. Since 1963, the federal government has supported development of community mental health services as a preferred alternative to institutions. This bill, based on the recommendations of the President's Commission on Mental Health, marks federal recognition of several major problems with earlier efforts:

- ° The continued neglect of chronically mentally ill children and adults and other underserved groups.
- ° The need for coordination of mental health and other support services at the state level and in communities.
- ° The need for ongoing federal support for certain key services that will probably never generate revenue.

We certainly support the bill's findings and statement of national goals and its emphasis on deinstitutionalization and coordination of services for the chronically mentally ill. These are goals we have pursued through legal reform.

However, there are some major shortcomings in the bill. These result primarily from its focus on the needs and perspectives of service providers, with only lip service given to the perspective of consumers of mental health services. We recognize the vital role of mental health practitioners and administrators, and their dedication to providing the best possible service to their clients. But the mental health system is supposed

to be designed to meet the needs of clients rather than to suit the convenience of those who operate the system.

To be sure, those interests often coincide. But sometimes they do not. Without impugning the motives or good faith of the vast majority of mental health practitioners, it is obvious that a system which relies ultimately on the power of involuntary treatment holds the potential for conflict between provider and client. In the words of the President's Commission:

We are keenly aware that even the best intentioned efforts to deliver services to mentally handicapped persons have historically resulted in well-documented cases of exploitation and abuse. (Vol. I at 42.)

Without even addressing the most obvious case of conflicting interests represented by involuntary treatment, one can also assert that the provider system -- simply as a system -- has a set of concerns only indirectly related to client needs. The client has an interest in efficient and high-quality services and should be involved in policy decisions about the best way to organize and pay for such services. But it makes little immediate difference to a client whether his mental health services are paid for by a grant directly from the federal government to the local provider or whether the state has played an intermediate role in the process. We do not deprecate the importance of such matters. We wish simply to point out that mental health care involves more than "coordination," "flexibility," "linkages" and "comprehensive v. single services." Yet these are the words and the issues that dominate this bill.

Patients' Rights

The clearest evidence of the bill's concentration on provider concerns is its exclusion of meaningful provisions to protect patients' rights. This

issue may be of only marginal importance to many mental health providers. Some appear to feel threatened by the idea of patients' rights, which they see as interfering with the treatment process or undermining their authority. Yet it is of central importance to consumers. The key point that the Task Panel on Legal and Ethical Issues made in its report was the importance of building a strong patients' rights and consumers' perspective into any reforms in the services system. The Commission agreed, and proposed a national goal to "assure that mental health services and programs operate within basic principles protecting human rights and guaranteeing freedom of choice." (Vol. I at 10.) That goal is not realized in this bill.

One of the eight major divisions of the PCMH Report, Protecting Basic Rights, begins:

The protection of human rights and the guarantees of freedom of choice are among the most basic principles of society. Mental health programs and services must not disregard these values. (Vol. I at 42.)

The Task Panel made a number of specific recommendations to carry out this purpose, many of which appear in the PCMH final report. Among these are the establishment of advocacy systems, enforcement of federal laws and regulations prohibiting discrimination against the mentally disabled, safeguarding confidential information in mental health records, improving procedural protections for individuals in civil commitment or guardianship proceedings, and recognizing the rights of those receiving care.

Yet the bill barely mentions this area. The only direct reference to patients' rights is a requirement that the state plan for mental health services "describe the legal rights of persons in the state who are mentally

ill or otherwise mentally handicapped and what is being done in the State to protect those rights. . ." § 602(7) (emphasis added). There is a requirement that HEW promulgate standards of care for mental health services (§ 626), but no provision for the enforcement of such standards. The emphasis throughout the bill is on helping the states and other providers to improve their administrative and coordinating capacity.

The idea of a "federal-state-local partnership" (§ 2) is quite attractive from the perspective of better coordination and building incentives for the states to adopt fully the longstanding federal policy objective now stated in § 2(b)(3):

to minimize unnecessary or inappropriate institutionalization and ensure that persons requiring long-term residential care due to mental illness or disability receive such care in the least restrictive settings possible . . . (emphasis added).

The bill relies heavily on the states to implement the policy of deinstitutionalization, for example through the proposed pilot program for state administration of federal grants (Tit. V). However, providers alone cannot be relied upon for this sort of assurance. Providers have other quite legitimate concerns which they balance with the general goal of deinstitutionalization.

For example, the bill refers in several places [sections 100(b)(2), 102(4), 602(8)] to the need to protect the rights of institutional employees who may be adversely affected by the move to community services. We certainly support efforts to ease the transition for employees away from institutional employment. But the stark contrast between the attention and the seriousness given to employees' rights and that "once-over lightly" given to patients' rights is unfortunate, to say the least. Could this difference have something to do with the relative powerlessness and lack of political clout of mentally handicapped people? The bill's failure to include

measures to protect patients' rights reflects the very bias in the system which the PCMH recommendations were designed to remedy.

The rights perspective is not a substitute for the "helping" or provider-oriented model of service delivery. Rather it is a necessary counterbalance to the unavoidable tendency of the system to define clients' interests in terms of its own needs. As Mr. Justice Brandeis put this perspective so eloquently in his dissenting opinion in Olmstead v. United States:

Experience should teach us to be most on our guard to protect liberty when the government's purposes are beneficent. Men born to freedom are naturally alert to repel invasion of their liberty by evil-minded rulers. The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding.

At his May 15 press conference unveiling the bill, President Carter stated:

We hope to . . . guarantee the basic human rights or civil rights of the mentally ill through advocacy programs. Quite often if a person is mentally ill, we assume they are subhuman, and on many occasions their basic legal rights are not only taken away from them, but are never explained to them.

That is a very succinct statement of the major problem we see in this bill: its failure to guarantee those labeled mentally ill their human dignity and legal rights. The national goal of protecting basic rights should be built into §§ 2, 100, 300 and 400. And we respectfully urge that the Congress consider specific provisions to define the rights of the mentally handicapped and to establish effective advocacy programs to protect their rights.

In the remainder of my statement I will stress three major themes:

(1) That mentally disabled people are especially vulnerable to abuse, neglect and deprivation of legal rights as well as singularly handicapped in protecting their own interests;

(2) That rights are not self-enforcing;

(3) That independent legal advocacy programs are essential to guarantee protection of rights.

In elaborating on these themes, I will draw heavily upon the findings of the President's Commission on Mental Health, the report of the Task Panel on Legal and Ethical Issues and the experience of other vulnerable populations, as well as on my own experience and that of the Mental Health Law Project in representing mentally handicapped people throughout the country.

(1) Mentally disabled people are especially vulnerable and singularly handicapped in protecting their own interests.

History is replete with abuses of mentally disabled people. Volumes of testimony before courts, state legislatures and Congressional committees -- in addition to repeated sensational media exposes -- document the problems and give evidence of the need for some established mechanism to protect patients.

It is not necessary today to repeat the horror stories that have been brought to light when lawyers or investigative reporters or citizen committees have toured mental institutions. Instead, I would like to submit for the record some recent articles from the local papers -- the Washington Post and Star -- illustrating the variety of abuses faced by mentally disabled people. Although the names change, virtually the same stories appear regularly on breakfast tables throughout the nation.

Many individuals are simply unable to speak up for themselves, even to protest abuses of their rights. Institutional staff may be horrified, but often have no one to whom they can report abuses without fearing retaliation. As Judge Kenneth Keating, in a decision of New York's highest court, observed:

When we are dealing with the rights and liberties of thousands of people, the risk of error is too great to leave the correction of errors to family or mental institutions from which may come the abuse. A civilized society cannot do otherwise. In re Buttonow, 297 N.Y.S. 2d 97, 105 (Ct. of App. 1968).

Society has recognized its duty to provide an active and articulate advocate where vulnerable people face discrimination and deprivation of such important rights as personal liberty. E.g. Gideon v. Wainwright, 372 U.S. 335 (1963) (felony defendants); In re Gault, 387 U.S. 1 (1967) (juveniles); Argersinger v. Hamlin, 407 U.S. 25 (1975) (misdemeanor defendants).

The need for and significance of legal counsel as a means of ensuring equal access to justice is the cornerstone of the American legal system. Counsel plays a critical and, in some cases, dispositive role in involuntary commitment proceedings; where active attorneys are employed, the number of committed persons plummets. "Developments in the Law -- Civil Commitment of the Mentally Ill," 87 Harv. Law Rev. 1190, 1285 (1974). Courts have recognized the vital role of an advocate wholly committed to the clients' interest. See, e.g., Davis v. Watkins, 384 F.Supp. 1196 (N.D. Ohio 1974); Heryford v. Parker, 396 F.2d 393 (10th Cir. 1968).

Yet many members of the legal profession have viewed mental health advocacy as not fully "adversarial" in nature, and therefore outside the realm of traditional legal representation. The vast majority of mentally handicapped people have neither the financial resources to hire an attorney nor the personal resources to know that their rights have been violated or to seek out such free assistance as may be available. Lawyers --both those in private practice and those in public legal assistance programs -- are often uncomfortable dealing with the mentally disabled and shun them

as clients in the same way that society shuns them through discrimination and institutionalization.

Virtually all states do provide for the appointment of counsel in civil commitment cases where the person facing commitment cannot afford an attorney. But the so-called representation is often pro forma at best, and rarely resembles the vigorous advocacy expected by other clients. Appointments are often made from the same few members of a closed panel. Attorneys often meet their clients, if they meet them at all, at the commitment hearing. Few if any questions are asked, nor are documents closely examined even for gross deficiencies. Hearings may average less than five minutes each.

The Mental Health Law Project is currently challenging such a "system" in Arlington County, Virginia. The Project has closely studied all commitment hearings conducted in Arlington County between January 1976 and October 1978. Despite clear statutory as well as constitutional protections for persons facing civil commitment, we found that the actual practices of court-appointed attorneys and the pro forma hearing process systematically deprive respondents of their rights.

A total of 377 petitions were filed during this period. Of these, 87 either resulted in a "voluntary" admission to the hospital or were dismissed without a hearing. Of the remaining 290 cases in which the respondent did not agree to hospitalization and in which a civil commitment hearing was therefore held, all 290 respondents were represented by attorneys from a list maintained by the court. All were committed.

In 92% of the cases, the hearing was held within 24 hours of the filing of the petition, making a mockery of notice and preparation requirements. Records do not show a single occasion on which the appointed attorney requested additional time to prepare. In 85% of the hearings, one

of the same two general practitioners acted as certifying physician. Despite a statutory requirement that the certifying physician must be "skilled in the diagnosis of mental illness," no attorney ever challenged their qualifications. In 77% of the cases, the physician did not even complete the form properly. These were no mere technicalities; in 91% of the instances, there was a failure to certify whether the physician had probable cause to believe the respondent required involuntary hospitalization. Yet no attorney objected to the incomplete certifications.

In no case did the attorney summon an independent expert witness on behalf of his client. In 94% of the cases, no lay witness was called either. Attorneys routinely failed to cross-examine witnesses adverse to their clients' interests. Despite the right to appeal, in the 290 commitments only four appeals were taken.

One appellate judge has described a similar appointment system as follows:

The record presented by this case is as bleak a picture as has ever been presented of justice in Milwaukee County. A massive and systematic deprivation of the constitutional rights of people who are unable to voice their own protests has been accomplished by the co-operation of the bench and bar of Milwaukee County. It is unconscionable that lawyers and judges, who are trained in the law and who have a special duty to protect the constitutional rights of those who are unable to protect themselves, could participate in such a scheme to bilk citizens of their constitutional rights. Although this suit names the director of Milwaukee County institutions, the onus of this debacle lies squarely with the lawyers and judges who operate this "greased runway to the county mental health center" as the Milwaukee Journal recently characterized the commitment system. Despite frequent and continued criticism of the system by the newspapers, bar associations, mental health groups and others, the Probate Court Judges continued to operate a system which they must have known was illegal in every facet of its operation. State ex rel Memmel

v. Mundy, Case No. 441-417, Wis. Cir. Ct., Milwaukee
Cty., August 18, 1976, reported at 1 MDLR 183
(1977)

A few states, such as New Jersey, Ohio, and New York have established statewide systems to represent mentally handicapped individuals. Some public defender organizations, such as that in the District of Columbia, have also established specialized mental health programs. We certainly support such efforts, but we must also point out their limitations. First, they are the rare exception. Incentives are needed to establish advocacy services for the mentally ill and to expand existing programs. Second, most such programs are limited to the commitment hearing and other matters directly related to institutionalization. Typically they are prevented, either by authorizing legislation or by resource limitations, from providing representation in other matters, such as accelerating the establishment of community-based alternatives to institutions, overcoming obstacles to community placement, or assisting those in the process of deinstitutionalization or at risk of initial institutionalization to solve other problems or obtain other services that would enable them to remain in the community.

Congress has already recognized the special need for protection for vulnerable people. The Developmentally Disabled Assistance and Bill of Rights Act (P.L. 94-103) mandates a nationwide system of "Protection and Advocacy" programs for developmentally disabled individuals. The conference committee, in reporting on the reasons for including a bill of rights and an advocacy system, stated that

these rights are generally included . . . in
recognition . . . that the developmentally dis-
abled, particularly those who have the misfortune
to require institutionalization, have a right to

receive appropriate treatment for the conditions for which they are institutionalized, and that this right should be protected and assured by the Congress and the courts. H. Rept. No. 94-473 (Sept. 11, 1975) at p. 42.

The Rehabilitation Act Amendments of 1978 (P.L. 95-602) extended this concept to other "severely handicapped" groups, although funds have not yet been appropriated to implement this provision. The Older Americans Act Amendments of 1978 (P.L. 95-478) continues and expands a special emphasis on legal services for the elderly which began in 1975. Some mentally ill individuals would theoretically qualify for advocacy services under each of these programs. However, the realities of stringent resource limitations and the significant differences in the content of remedies sought by mentally ill clients make such eligibility illusory, for the mentally ill constitute a small and not very popular minority in each category.

As compared with these other vulnerable and disadvantaged groups, the mentally ill have a special need for protection. They are even less likely to be able to rely on the continuing support and concern of family and friends. If they are able to speak for themselves their label often damages their credibility. As the President noted, too often people do not even bother to consider that they have rights. It is revealing that national legislation has been passed specifically to protect the rights of each of these other groups, while no mental health legislation -- including the current bill -- yet does so specifically for mentally ill persons.

(2) Rights are not self-enforcing.

The past few years have seen great strides in the establishment of basic rights for the mentally disabled. Since its inception in 1972, the Mental Health Law Project has applied legal strategies for the protection of mentally disabled persons confined to substandard institutions, excluded

from public schools or facing discrimination in the community. The need for such advocacy was rooted in the almost total deficit in effective representation for such people. Our test cases have established a number of fundamental rights of people labeled "mentally" or "developmentally" disabled, such as the right to treatment (Wyatt v. Stickney), the right to protection from harm (the "Willowbrook case," NYSARC v. Carey), the right to education for handicapped children (Mills v. Board of Education), the right to liberty (Donaldson v. O'Connor), the right to adequate compensation for institution-maintaining labor (Souder v. Brennan), and the right to treatment in the least restrictive setting consistent with individual need (Dixon v. Califano).

One measure of our success so far is two landmark Supreme Court decisions, the first in this century recognizing that civilly confined mental patients have rights. In O'Connor v. Donaldson, the Court held that a nondangerous civilly committed person who was capable of surviving in the community on his own or with the help of friends, and who was receiving no treatment, could not be held in a mental institution against his will. It further held that he could collect damages against institutional personnel who had knowingly or maliciously violated his right to liberty. And just last month, the Court held in Addington v. Texas that the Constitution requires a high standard of proof -- "clear and convincing" evidence of mental illness and likelihood of danger rather than the usual civil standard of a "preponderance" of the evidence -- before a person can be deprived of his liberty in a civil commitment proceeding. The Court recognized that civil commitment is a very significant deprivation of liberty, even though it is done for the purpose of providing treatment.

As counsel for plaintiffs in these cases, the MHLP views them as only the beginning of a major reform of antiquated legal notions about the mentally handicapped. The legal rights of the mentally disabled were for so long wholly ignored that there are large portions of the law in this area that have scarcely been touched for decades. Like mental health treatment itself, the law must be brought into step with current thinking about mental disability and treatment.

Such cases have also stimulated the enactment of new federal and state legislation to implement rights. For example, many of the due process hearing procedures and the individualized education plans required of state recipients of federal funds under the Education for All Handicapped Children Act (P.L. 94-142) and the regulations implementing § 504 of the Rehabilitation Act of 1973, prohibiting discrimination on the basis of mental or physical handicap, trace almost verbatim the judicial order secured in Mills.

Some state legislatures have responded to suits (or sought to avoid them) by tightening commitment procedures or enacting a bill of rights for the mentally handicapped. But neither federal nor state legislation will enforce itself. The history of neglect and exploitation of the mentally disabled forbids us to trust to good intentions and high-sounding paper guarantees. At the same time that we work to increase legislative and administrative establishment of rights, we must also recognize the need for an ongoing system to assure that those rights are respected in practice.

Most mental health providers support the concept of patients' rights. But many feel that they themselves can best protect their patients' rights. Even some who understand and support the need for independent advocacy, however, may too easily sacrifice this concern if faced with what

they perceive as a choice between resources for advocacy and resources for mental health services. Apparently that is what happened in drafting this bill. The President, the Secretary and the bill itself all recognize the importance of legal rights. Yet no support is included for practical measures to enforce those rights.

- (3) Independent legal advocacy programs are essential to guarantee protection of rights.

The dominant themes of the President's Commission on Mental Health Report -- and the Mental Health Systems Act -- are (a) development of community alternatives to institutions, (b) attention to neglected populations and (c) improving the quality and accountability of mental health service delivery. During the 1970s, legal advocacy has made a major contribution in each of these areas. The PCMH recognized this, and adopted the recommendations of the Task Panel for (1) the establishment of a specialized advocacy system for the mentally ill and (2) greater activity on the part of the Legal Services Corporation as well as public legal assistance groups and the private bar. (Vol. I at 42, 69)

We believe that legal advocacy provides an effective way to stimulate the mental health system to move in the direction we all desire -- away from unnecessary and inappropriate institutionalization and toward high quality community services.

Advocacy can assure that individuals' interests are not compromised by large-scale social engineering. And advocates can help to carry out the monitoring and enforcement requirements that are built into this bill. The difficulties of federal enforcement are well known, especially where the ultimate sanction is to deny federal funds to the clients of offending programs. Independent advocates would provide a separate and more flexible

form of monitoring and enforcement. In addition they would help clients to participate actively in program planning and operation, as encouraged in §§ 402(b)(3), 602(5) and 621(5).

It is essential for the client to know that someone is looking out only for his or her interest. Within the mental health system, the client typically feels completely powerless. The advocate can help to assure that the system in fact pays attention to the individual, and that the individual feels fairly treated. For example, one advocacy project found that the yearly periodic review for a client lasted approximately 5 minutes and relied largely on the preceding year's findings. When an advocate began attending the review lasted about 1/2 hour and was far more thoughtful.

Among the major roles advocates can play are:

- Explaining to clients their rights, service system rules, and what is happening to them.
- Helping clients to articulate their desires or express their feelings.
- Representing clients in informal negotiations with treatment staff or in internal reviews of their status or treatment plans.
- Helping clients and staff to overcome barriers to deinstitutionalization, such as obtaining access to housing or eligibility for generic programs.
- Helping to bring mental health needs to public attention.
- Representing clients in formal judicial or legislative proceedings, both those involving the mental health system and those that may involve other agencies or individuals.

HEW has proposed to fund "demonstration programs" in mental health advocacy. While even the small amount of money to be distributed

(\$700,000) is greatly welcome in the field, we must point out several major problems with this approach. First, a number of advocacy projects already exist which could be used as models. Some are mental health projects funded by private foundations (including 17 sponsored by the American Bar Association). Others are funded by HEW itself through the Older Americans Act or the Developmentally Disabled Assistance and Bill of Rights Act. These are not aimed at the mentally ill, but their experience could certainly be used. Several states -- notably New Jersey, New York and Ohio -- have some years of experience with statewide advocacy programs for the mentally handicapped. Several local public defender offices (as in the District of Columbia) or legal services offices (as in Washington State, Minnesota and Wisconsin) have established special programs to represent mentally handicapped clients. The National Institute of Mental Health has supported the Mental Patients Advocacy Project at Northampton State Hospital in Massachusetts for several years, as an experimental training project.

Secondly, it seems unlikely that a one-year demonstration program would generate the kind of evaluation or hard conclusions usually sought by a serious effort to try a new idea. The amount of money available is so small that only a few grants can be made, and the lack of continuation funding will hardly encourage programs to make long-range plans. It is likely to be seen as a one-shot infusion of federal funds and used to keep starving programs alive or to allow existing advocates to expand their activities for a while. This would in no way "demonstrate" how a stable, long-term advocacy system, as envisioned by the Task Panel, would operate.

That is not to say that we oppose the HEW effort -- only that it is not adequate either to the already-demonstrated need for advocacy services

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or to its own stated purpose. The Secretary's Task Force on Deinstitutionalization -- to which two of my colleagues at the Mental Health Law Project, Margaret Ewing and Leslie Scallet, served as consultants -- recommended that HEW provide demonstration funds for advocacy projects, but only as a stopgap until the legislation anticipated as a result of the President's Commission on Mental Health would establish a permanent advocacy support program.

Mental health advocacy has now reached a crucial period in its short history. Just when programs have begun to gain real expertise and establish their credibility, most face the end of "seed" or other initial funding. The private foundations which have supported many projects in the formative stages now expect to "wean" them to longer-term public support. Yet no such public support exists.

Some legal services programs provide representation to mentally disabled people. But the Legal Services Corporation, which supports legal services for the poor by funding local offices across the nation, rarely earmarks funds for specific groups' needs. Local programs set their own priorities, largely based on the interest and expertise of staff attorneys and the expressed needs of the community. It is not surprising that in the nation as a whole the mentally ill do not receive their share of legal services, few legal services attorneys have the interest and specialized training needed, and mentally disabled people rarely show up in local legal services offices asking for help. For one thing, many are confined to institutions or live isolated lives in the community. For another, many do not understand their legal rights or know that they are eligible for legal assistance. It is unlikely that very many overworked and minimally-funded legal services offices will undertake the special training and outreach

necessary to represent this client group unless practical incentives are available. (This in fact has happened in the case of the elderly, now that funds are available under the Older Americans Act.)

A recent Legal Services Corporation survey of "unmet needs" underscored the problem. Many legal services programs around the country reported that representation for the mentally disabled is badly needed, but also that they do not have the resources to provide it.

Another problem is the income test for legal services representation. While the great majority of long-term mental patients would certainly qualify as "poor," not all people who have mental health problems and need advocacy are technically poor. Yet many do not have control over their own resources; others cannot find a private attorney willing to represent a person labeled mentally ill.

The American Bar Association has worked for several years to increase the interest and ability of the private bar to provide legal assistance to mentally disabled clients. It has established a Commission on the Mentally Disabled, which publishes the highly respected Mental Disability Law Reporter. The Commission has also operated a direct advocacy demonstration at three state hospitals in Pennsylvania and administered a program of grants to local bar associations to establish mental disability advocacy projects. The latter two programs were funded by a private foundation on a seed-money basis, but that funding is now terminated. The State of Pennsylvania has adopted the ABA mental health advocacy projects but recent budgetary decisions are likely to force the projects to close down within a few months. Unless additional funding sources are developed, the good start made by many local bar programs will be wasted.

A few states, as mentioned earlier, have established mental health legal advocacy programs. But these too have serious limitations. Most are restricted to dealing with problems relating to civil commitment or to institutionalization itself. The host of community rights issues that are so important to deinstitutionalization -- zoning, employment discrimination, housing and many more -- go largely untouched. As part of an NIMH contract to produce a state legislative guide, the Mental Health Law Project has developed a model advocacy statute, with commentary describing the problems and a proposed program. It appears at 2 MDLR 270 (September-December 1977). I request that this article be included in the record of these hearings.

A number of other states have established nonlegal programs to protect patients' rights. These include ombudsman and "rights representative" programs such as those in Michigan, California, Wisconsin and Rhode Island. Some are statewide, others are started in a single institution. Such programs can be useful in solving day-to-day grievances, in sensitizing staff to patients' rights and in suggesting policy or system changes. We would hope that some states will use the broad discretion in §§ 302 and 501 of this bill to establish or improve their procedures to recognize and protect patients' rights. And, as we noted earlier, we hope that the Act will include additional requirements that state and local programs assure protection of rights as part of all plans, standards and grant applications.

However, in building rights protection into the mental health system, it is important to distinguish between the responsibility and role of providers and the role of independent advocates. Neither is a substitute for the other. There must be a commitment by providers to respect and

protect rights. But no protective mechanism which is ultimately responsible to the service provider can, if it is necessary to do so on behalf of the patient, challenge that provider effectively.

As one "patient representative" in a western state institution told one of my colleagues recently, the mere existence of an interested local legal services attorney was the only thing that made the institution superintendent listen to the "patient representative." And as one veteran institution superintendent explained, "We've got to have external advocacy, because I stop pushing from within at some point." (Quoted in Herr, "Advocacy: The Missing Link to Fundamental Rights and Services," Georgetown Health Policy Center, Protection and Advocacy Systems for the Developmentally Disabled, Clarke and Sterns, eds., 1977 at 7.)

States and other providers are far more likely to establish or seek funding for rights systems which they can control than to support programs which may challenge their administrative positions. This is simply human nature. Even if a state-operated program has a high degree of independence, the potential threat of retaliation is always present as a constraint on "too vigorous" advocacy. This is the basis of the President's Commission recommendation that advocacy systems for the mentally ill should (1) include but not be limited to legal advocacy and (2) be independent of service providers. (Vol. I at 42)

Federal support is necessary to enable mental health advocacy programs to establish and maintain themselves as independent of service providers. Resources earmarked for the "mentally ill" ordinarily go to mental health service providers, who are not particularly interested in funding advocates who may help clients to challenge their decisions. Resources

earmarked for "independent advocacy" ordinarily go to legal service providers, who are not particularly interested in the mentally ill. The nascent mental health advocacy movement has relied largely on seed money that is fast disappearing. Funding is badly needed, both to retain experienced advocates and organizations and to encourage legal services and other lawyer and nonlawyer advocates to undertake the necessary training and to develop new programs. Federal resources can make the difference.

Experience with the Protection and Advocacy System

In 1975, Congress passed the Developmental Disabilities Assistance and Bill of Rights Act (P.L. 94-103). That Act includes a statement of the rights of developmentally disabled people (§111) and mandates creation of independent statewide systems to "protect and advocate" their rights as a condition of receiving federal developmental disabilities funds (§ 113). The Mental Health Law Project has extensive experience with the program; we have provided technical assistance and legal backup support to the P&As in 22 states under special grants from HEW. Although the system has been fully operational for only a short time and full evaluations have yet to be completed, we have already learned a great deal from the P&A experience.

Since the beginning of the Developmental Disabilities "Protection and Advocacy" program less than two years ago, the concentration on mental retardation and developmental disabilities issues among the still-small corps of mental disability legal advocates nationwide has far overshadowed concern for mental health issues. As the Task Panel and the PCMH recognized, the mentally ill deserve similar attention.

The following are some accomplishments and activities of individual P&A programs around the country. This sample illustrates the wide range of advocacy strategies and styles that can be used effectively.

1. Helped write and later testified in favor of a state statute which permits group homes for developmentally disabled individuals to locate in single family residential areas -- free of local zoning prohibitions.
2. Individual representation in obtaining education for handicapped children, including parent representation at hearings, under P.L. 94-142.
3. Trained volunteer advocates and parents in understanding their rights and learning to represent the rights of their children.
4. Developed a working relationship with legal services organizations to ensure adequate representation of individual clients.
5. Developed consumer organization affiliations to establish a network of community advocates for individuals and with regard to specific issues.
6. Formed coalitions to work on issues of national importance to developmentally disabled people, e.g., sterilization.
7. Monitored institutions for the developmentally disabled with an eye toward legal solutions or negotiation for improved services and reasonable physical safety.
8. Prepared materials for publication.
9. Hotlines and referral or advice by telephone or on a walk-in basis.
10. General case representation, for example:
 - a. Denial of custody to an epileptic mother on the basis of this disability without a showing of inability to care for the child.

- b. 12-month (rather than 9-month) education/residential placement.
 - c. Segregated schools for handicapped children who could function in a regular school.
 - d. Individual institutional matters.
 - e. Class action institutional lawsuits.
 - f. Attempt to obtain community services and ensure monitoring in the community.
- 11. Amicus briefs.
 - 12. Testimony and drafting of a state bill of rights for developmentally disabled citizens.

It is too early to tell whether this model is entirely satisfactory. In any case, it would be useful for both population groups to try a somewhat different model for the mentally ill. Two problems have surfaced repeatedly in the P&A program. One is the impossibility of carrying out a broad mandate to protect the rights of all developmentally disabled people with a very small amount of resources. Congress has recognized this problem, and recently raised the authorization level to \$9 million for FY 1979 (although appropriations have not been forthcoming). The second problem is that the P&A's inclusion as part of the state plan gives state authorities an effective veto over P&A operations. This conflicts with the clear requirement of the Act that the P&A should be independent of service providers.

It is very difficult, for example, for a P&A which is located in the Governor's office to sue the Governor if that becomes necessary. Some P&As report that they have received direct or indirect instructions not to engage in litigation. This violates both the letter and the spirit of the Act's mandate to assure legal remedies. Attempts are currently underway

to remedy or mitigate some of these problems through HEW regulations. But we hope that they can be avoided from the start in any new mental health advocacy program.

A Mental Health Advocacy System

Mental health advocacy programs can benefit from this experience. The basic idea is sound -- a network of advocacy programs, assisted by backup support centers. Local and statewide programs can develop the in-depth knowledge about problems in their areas and the important relationships with mental health system personnel, media, legislators and community leaders that are vital to real progress. Once it is recognized that the advocates will not disappear (at the end of a one-year grant), it is also more likely that the system and clients alike will take them seriously. Advocates can try a variety of strategies rather than depending only upon litigation in order to have maximum immediate impact with scarce and temporary resources. They can build alliances with citizen and consumer groups as well as with mental health professional groups on many issues.

The Task Panel on Legal and Ethical Issues emphasized "legal advocacy." This certainly does not mean that only lawyers can be advocates. It does mean that the panel viewed access to the legal system as essential "clout" for advocates, and that the ethical obligation of lawyers -- ultimate loyalty to the client -- must be the basis of the client/advocate relationship. That is why the Commission recommended that advocacy systems "include but not be limited to legal advocacy" and "be independent of service providers." Attorneys must be available at all times to determine when legal remedies are needed and to provide legal representation. Much of the important work of investigation, negotiation, advocacy in administra-

tive settings and interaction with mental health service staff can be done as well or better by nonlawyers. These may be mental health professionals, laypersons, citizen volunteers, ex-patients, paralegals or student trainees. But all advocates must adhere to the model of vigorous advocacy of the clients' view and avoidance of any conflict of interests.

The two key prerequisites for an effective advocacy program are:

- (1) Authority and capacity to pursue legal, administrative and other appropriate remedies to protect the rights of those receiving mental health services or those who have been labeled mentally ill.
- (2) Independence from any agency which funds or provides treatment or other services to mentally disabled people, or which determines policy for such services.

The experience of both the Legal Services Corporation (with its national backup centers in such areas as housing, health and welfare law) and the P&A system (with its regional technical assistance and national legal backup centers) illustrates the importance of and need for reserving a portion of mental health advocacy funds for technical assistance, training, legal backup and other support services for the advocacy projects. The Administration on Aging program of legal services for the elderly, for example, plans five bi-regional training and support centers and a variety of clearinghouse and similar technical assistance programs.

The Department of Justice also provides a very necessary form of national "backup" assistance to institutionalized persons. We have testified in support of S. 10 and H.R. 10 to assure that the Department continues to play this role in cases where there is a systematic pattern of abuse of rights. However, the Justice Department's resources are limited; it could not possibly become involved in every case that arises. Nor would this be an appropriate role for the federal government. Many cases can be handled without litigation.

Most importantly, advocates who are on the scene, at an institution or at least within the state, are more likely to understand the circumstances and the options better than any national group. They will also be around to monitor implementation of an agreement or a court order. They have a greater stake in fitting the resolution to local problems and resources, and a greater ability to do so. Local or state advocacy projects can take account of individual problems, as well as system-wide abuses, and can deal with the whole range of institution and community issues. On the other hand, the Department of Justice, under the proposed legislation, would focus on large-scale, constitutional issues dealing with institutionalized persons. In short, the Department of Justice provides a vital link in the advocacy system -- but cannot possibly substitute for the kind of advocacy we support today.

Other important components that should be built into advocacy programs are: (A) Active client involvement in program design and policy. The bill recognizes the importance of the right to comment on plans and programs [§§ 402(b)(3), 602(5), 621(5)]. The same principle is important for advocacy programs. (B) A full-time staff including but not limited to attorneys. Part-time people may have divided loyalties. As noted elsewhere, attorneys are essential, but other advocates can provide very important skills. (C) Cooperation with legal services and other advocacy organizations. This will reduce duplication and encourage alliances. (D) Access to clients and records. One of the biggest problems that advocates have faced in the past is the system's resistance to opening itself to scrutiny. In order to be effective, advocates must be guaranteed reasonable access to clients and to clients' records, subject only to necessary privacy protections for patients. (E) An evaluation component.

A minimum of \$50,000 per project per year is necessary. The experience of both the ABA bar-funding projects and the P&As, many of which received only \$20,000 in their first year, amply demonstrates the futility of expecting effective advocacy from a single, junior staff person or from a staff that spends much of its time and energy on band-aid fundraising in order to survive. Congress recently raised the minimum P&A grant to \$50,000 (P.L. 94-602).

The project grant route -- as opposed to the formula grant, nationwide approach of the DD Act -- should be adopted. The dominant mode of federal mental health funding takes this approach. In a time of limited resources, it is also unrealistic to expect that available resources will match national need for advocacy services. On the basis of current experience we estimate that at least \$60-75 million per year is needed. Assuming that resources on that scale will not be made available soon, we believe that the most responsible course would be to encourage quality programs and build the national network over a period of years. For the same reasons, we urge the use of a peer review mechanism to choose among applicants. Only people who have the appropriate training and experience, and who are not part of governmental systems that would create conflicts of interest, should review applications.

Grants or contracts should go to either statewide or local projects, and applicants should be encouraged to serve the whole spectrum of institutionalized and community-based clients so that no artificial barriers are perpetuated. In addition, national and /or regional backup centers, training programs and technical assistance should be made available to assure that advocates, consumers, citizen groups, mental health professionals and other groups can learn about client rights and advocacy techniques.

If the program is administered within HEW, it should be as independent as possible from agencies whose primary contacts and traditional clients have been service providers. Ideally this would mean a separate office within the Office of the Secretary. Another possibility would be the Office of Civil Rights. In any event, the program should be completely separate from the Public Health Service and the Office of Human Development Services. One alternative would be for the Secretary to contract with an organization outside the executive branch to administer the program, thus avoiding even the appearance of conflict of interest. One possibility to consider would be the Legal Services Corporation itself. HEW and LSC have an interagency agreement on cooperation around the AoA advocacy program for the elderly, which could serve as a starting place.

Finally, we would recommend that the Congress pay continuing attention to the protection of patients' rights, perhaps by requiring periodic reports on the national situation and on progress of the advocacy system. Any such report should be coordinated with the Civil Rights Commission, whose jurisdiction has recently been expanded to include the handicapped (P.L. 95-444).

The mentally disabled citizens of this nation deserve to be treated with respect and dignity. This bill -- with the addition of meaningful protections for patients' rights -- can be an important step in that direction. I would like to conclude by thanking the Subcommittee for inviting our views. We would be happy to provide any further information.

Senator KENNEDY. The committee stands in recess.
[Whereupon, at 12:30 p.m., the subcommittee recessed subject to the call of the Chair.]

MENTAL HEALTH SYSTEMS ACT, 1979

MONDAY, JUNE 11, 1979

U.S. SENATE,
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:05 a.m., in room 4232 Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

Present: Senator Kennedy.

Staff present: Stuart Shapiro, M.D., David Riemer, J.D., and David Winston.

OPENING STATEMENT OF SENATOR KENNEDY

Senator KENNEDY. We will come to order.

I am pleased to open the third in our series of hearings on national mental health policy and the Mental Health Systems Act, which I introduced on May 17, 1979.

I believe we have begun to develop a useful and responsive mental health care system in this country. It has been 16 years since the passage of the original Community Mental Health Centers Act under President Kennedy, and during these years we have seen considerable progress. Yet today, we still struggle with the problems of deinstitutionalization, patient stigma, and increased demands for additional resources in times of tight economy. S. 1177, while far from perfect, reemphasizes our commitment to respond to the needs of the mentally ill with a humane system of mental health and other services, and with the addition of certain important amendments I believe we will see the development of an improved system we can all point to with pride.

The report of the President's Commission on Mental Health clearly documents that to date we have done a poor job of responding to the mental health needs of minorities and women. Persons are much more receptive to receiving services when those services are delivered by individuals who share the unique prospective, value system and beliefs of the group being serviced. In spite of this, less than 2 percent of the psychiatrists in this country are black, and the data for other minorities and disciplines are equally appalling. For example, nationwide less than 0.4 percent of psychologists are Hispanic, less than 8 percent of the social workers are black, and there are only 13 American Indian psychiatrists in the country. Many problems of mental illness are caused or exacerbated by the interaction of man with his environment. When that environment is hostile, there is increased possibility of some emo-

tional defect. This is especially significant for minority group members in this country. Issues of expanding our knowledge base of effective treatment methods for minorities and the responsiveness of the National Institute of Mental Health to this need must receive review.

Another issue which we want to address during our hearing this morning is the program administered by the NIMH's National Center for the Prevention and Control of Rape. Over 65,000 instances of rape are reported in this country each year, and the best estimates of the actual incidence of rape is four times that number. With a population of over 100 million women in this country and with no change in this rate, chances are better than 1 in 15 that a woman will be a victim of rape sometime during her lifetime.

We want to give special attention to what can be done to build on the small research and demonstration effort which has been carried out by the National Center for the Prevention and Control of Rape over the last 5 years. Additional funds are clearly needed if we are to provide services for rape victims and provide training for personnel, to deal with rape victims and provide better networks and sources of information for those who are seeking to reduce the incidence of rape, and to ameliorate the impact of what can be the most terrifying event in a woman's life.

We have with us today a number of experts in the field of mental health. I look forward to their testimony which I anticipate will be most helpful as we develop mental health legislation during this session of the Congress.

We will have our first panel, which we want to welcome to our subcommittee this morning. Dr. James Collins, chairman, Department of Psychiatry, Howard University School of Medicine; Mr. Rodolfo Sanchez, national executive director, National Coalition of Hispanic Mental Health and Human Services Organizations; Mr. Mark Tajima, Washington coordinator, Pacific Asian Coalition; and Dr. Nancy Felipe Russo, Federation of Organizations for Professional Women and member of the Subpanel on Mental Health of Women of the President's Commission on Mental Health.

STATEMENTS OF DR. JAMES COLLINS, CHAIRMAN, DEPARTMENT OF PSYCHIATRY, HOWARD UNIVERSITY SCHOOL OF MEDICINE; RODOLFO SANCHEZ, NATIONAL EXECUTIVE DIRECTOR, NATIONAL COALITION OF HISPANIC MENTAL HEALTH AND HUMAN SERVICES ORGANIZATIONS; MARK TAJIMA, WASHINGTON COORDINATOR, PACIFIC ASIAN COALITION; AND DR. NANCY FELIPE RUSSO, FEDERATION OF ORGANIZATIONS FOR PROFESSIONAL WOMEN AND MEMBER OF THE SUB-PANEL ON MENTAL HEALTH OF WOMEN OF THE PRESIDENT'S COMMISSION ON MENTAL HEALTH

Senator KENNEDY. Dr. Collins?

Dr. COLLINS. Good morning, Mr. Chairman.

I am pleased to be here today to testify concerning the proposed Mental Health Systems Act. As only 1 of 24 million black Americans in this country, I cannot presume to present to you the mental health concerns of this entire population. In my position as chairman of the Department of Psychiatry of Howard University Hospital, however, I am in contact with many black mental health

leaders in this country and will attempt in the allotted time to express some of their concerns about S. 1177. Thomas Bryant, the Chairman of the President's Commission on Mental Health, in his letter of transmittal to President Carter, stated that:

For many members of America's ethnic and racial minority populations, the mental health personnel and services that are available are either inadequate or fail to take into account the different cultural traditions.

This finding is unfortunate since the black population was found to be at increased risk of developing various mental disorders which may be attributable to social and environmental conditions.

The President's Commission on Mental Health reported, based on data from the Division of Biometry and Epidemiology at the National Institute of Mental Health, that black males consistently show the highest rate of mental disorders. State hospital data showed that black males from ages 18 to 34 had an extremely high rate of mental illness when compared to other age and racial groups. Blacks are more likely to be in mental institutions than whites and twice as likely to suffer the fatal consequences from mental illness. Furthermore, blacks are more than eight times as likely than whites to become institutionalized because of drug addiction. Death from alcoholism is three times more common among blacks than whites. Finally, over 40 percent of inmates in Federal institutions are black. Many of these individuals suffer from diagnosable mental disorders.

The President's Commission on Mental Health also found that blacks are poorly represented in the mental health disciplines of psychiatry, psychology, social work, and nursing. According to the President's Commission report, there are only 350 to 500 black psychiatrists in the country at this time, representing less than 4 percent of the Nation's 15,500 psychiatrists. In 1974, the last year data was available, only 1.7 percent of postgraduate physicians training in psychiatry were black U.S. citizens. In 1977, the American Psychological Association membership of approximately 30,000 was only 4 percent black.

There is no data available on the national distribution of black psychiatric registered nurses at this time. However, the Division of Biometry and Epidemiology at NIMH reports that 9.1 percent of all registered nurses in community mental health centers are black. If this trend continues, blacks will forever remain underrepresented among mental health professionals in this country.

I do not believe that only black mental health workers should treat black patients. There is considerable evidence, however, that most traditional psychotherapies require a trusting relationship between therapist and patient. Racial, cultural and socioeconomic differences can significantly reduce this trust. These cultural differences may explain why minorities are more often hospitalized and treated with medications than white patients.

The Mental Health Systems Act with some revisions could make major advances in reversing the negative mental health statistics of black Americans.

Title I of the Mental Health Systems Act proposes to assist States and communities to develop and/or improve mental health services for the chronically mentally ill adults and children. Title II proposes to support State efforts to prevent mental illness.

Among many blacks, there is cautious concern about any plan that calls for increased State control of Federal funds for mental health service and training programs aimed at special populations. History has shown us that many of the Federal funds never reached the designated population. Only 12 percent of all general health expenditures are allocated to mental health. The high risk population has now been expanded to include children, adolescents, chronically mentally ill, women, Vietnam veterans, the deaf, physically handicapped, migrant farmworkers, blacks, Native Americans, Asian Americans and Hispanics. These groups will have to compete for the limited resources available at the State level.

Mr. Chairman, we must assure the minority community that there will continue to be a Federal capacity for monitoring compliance and equity in the implementation of the proposed new legislation at the local level. Racial minorities must be included in this monitoring process.

Title IV proposes to provide increased flexibility in affording the underserved populations better access to mental health care by making this care available in traditional medical facilities or ambulatory health care centers.

As a former general practitioner, I can attest to the significant number of patients presenting to these facilities requesting treatment for multiple physical complaints who, in fact, were suffering from diagnosable mental disorders. They could not or would not go to traditional psychiatric facilities until a crisis precipitated a hospitalization. Most primary care physicians feel inadequately trained to treat these patients, but with the provisions of grants under this title, consultation and inservice training of mental health may be provided to these primary care physicians. Mental health practitioners could also be employed by these centers to provide direct consultation to this population.

I believe this would significantly improve the availability of traditional psychiatric treatment to these underserved individuals and increase the acceptability of early psychiatric intervention by the public. In those health centers which serve black communities, few patients have easy access to trained psychiatrists because of the critical shortage we mentioned previously.

At Howard University Hospital we will start a new course in crisis intervention and brief psychotherapy this fall. This course was developed for the primary care physician and other mental health workers. Similar programs could be initiated in other areas if funds are made available under the linkage concept of this title. Finally, maintenance grants will support such activities as prevention, consultation and education, outreach and case management for which direct service payments are not generally available. This title does allow for the continued funding of all community mental health center funding commitments made under the existing legislation. We feel that title IV best exemplifies the spirit of the President's Commission on Mental Health in its goal of making high quality mental health services available at reasonable cost to all who need them.

Title VI attempts to improve coordination of State activities by designating a single State mental health planning agency and providing for citizen participation in the review and comments on

proposed State programs. Technical assistance is also available to those States in need of assistance in program development. The ceiling of 2 percent of any grant appropriation for any fiscal year, however, may be too limited for certain geographical areas lacking in mental health personnel.

In summary, then, my colleagues and I are in support of the passage of S. 1177 after consideration by your committee of the concerns previously outlined.

As you know, Mr. Chairman, there are two pending bills, one in the House and one in the Senate, H.R. 761 and S. 925, which pertain to minority mental health. My colleagues and I propose that elements of these bills should be considered for inclusion in the final legislation of the Mental Health Systems Act.

S. 925, section 232, proposes that the Secretary of the Department of HEW shall establish at the level of the Office of the Administrator within the Alcohol, Drug Abuse, and Mental Health Administration an identifiable administrative unit with authority for the National Institutes on Drug Abuse, Alcohol Abuse, and Alcoholism and Mental Health, to be known as the Office for Minority Concerns.

H.R. 761 proposed to amend the Public Health Service Act to provide for the establishment of a Division of Minority Mental Health Programs within the National Institute of Mental Health. At the present time there exists within NIMH a Center for Minority Group Mental Health Programs under the direction of Dr. James Ralph, a black psychiatrist. This Center, with only 4 percent of the total NIMH budget, has been able to significantly increase the number of qualified minority mental health researchers. This has assisted us in our attempts to better understand factors related to the higher incidence of mental disorders in minority populations. To a limited degree, the Center has increased mental health manpower by providing training fellowships to qualified minority mental health trainees. This Center is severely limited in that it has no regular congressional appropriation for these programs.

We believe that S. 925 which proposes the establishment of an Office for Minority Concerns that will help to formulate minority mental health policy is critically needed.

H.R. 761 proposes the elevation of the Center for Minority Group Mental Health Programs of the National Institute of Mental Health to a Division for Minority Mental Health Programs. This bill further proposes that there be appropriated sums as may be necessary to carry out these programs. We feel it is critical for minorities to be represented both at the policy and programing levels at ADAMHA if the spirit of S. 1177, the Mental Health Systems Act, is to be implemented.

In closing, my colleagues and I thank you for the opportunity to testify before your committee and feel confident that you will consider our concerns in the final legislation of the Mental Health Systems Act.

Senator KENNEDY. A very fine statement.

[The following was received for the record:]

MENTAL HEALTH PERSONNEL
CONSULTED FOR THIS TESTIMONY

1. LEMUEL B. CLARK, M. D.
ACTING ASSOCIATE DIRECTOR
DIVISION OF MENTAL HEALTH SERVICES PROGRAMS
NATIONAL INSTITUTE OF MENTAL HEALTH
ROCKVILLE, MARYLAND
2. WILLIAM H. DENHAM, PH. D.
DIRECTOR
DIVISION OF MANPOWER AND TRAINING PROGRAMS
NATIONAL INSTITUTE OF MENTAL HEALTH
ROCKVILLE, MARYLAND
3. LAWRENCE E. GARY, PH. D.
DIRECTOR
MENTAL HEALTH RESEARCH AND DEVELOPMENT CENTER
INSTITUTE FOR URBAN AFFAIRS AND RESEARCH
HOWARD UNIVERSITY
WASHINGTON, D. C.
4. DELORES L. PARRON, PH. D.
SENIOR PROFESSIONAL ASSOCIATE
DIVISION OF MENTAL HEALTH AND BEHAVIORAL MEDICINE
INSTITUTE OF MEDICINE
NATIONAL ACADEMY OF SCIENCE
WASHINGTON, D. C.
5. SHERMAN RAGLIN, M.S.W.
CHIEF OF CITIZENS PARTICIPATION PROGRAM
MENTAL HEALTH SERVICES SUPPORT BRANCH
DIVISION OF MENTAL HEALTH SERVICES PROGRAM
NATIONAL INSTITUTE OF MENTAL HEALTH
ROCKVILLE, MARYLAND
6. JAMES RALPH, M. D.
CHIEF
CENTER FOR MINORITY GROUP MENTAL HEALTH PROGRAMS
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7. HENRY TOMES, PH. D.
DIRECTOR
MEHARRY COMMUNITY MENTAL HEALTH CENTER
NASHVILLE, TENNESSEE
8. ROBERT WILLIAMS, PH. D.
DIRECTOR
BLACK STUDIES CENTER
WASHINGTON UNIVERSITY
ST. LOUIS, MISSOURI

Senator KENNEDY. Dr. Russo?

Dr. RUSSO. Good morning. On behalf of the Federation of Organizations for Professional Women, I thank you for this opportunity to testify.

I am a former member of the Subpanel on the Mental Health of Women with the President's Commission on Mental Health, and in addition to my prepared statement, I would like to have the summary of that report as well as the complete report of that subpanel also read into the record.

The Mental Health Systems Act, as it is currently proposed, addresses the problems of unserved, underserved, and inappropriately served groups; but to be most effective, the act really needs to address the problems created by sex role stereotyping and sex bias for these groups.

Programs devoted to minorities must reflect an understanding of the special problems of minority women, and these problems differ by minority group.

Programs targeted for children must reflect the special problems that stereotyping creates for both boys and girls. Although I will focus on problems related to women today, I want to remind us all that sex role stereotyping affects the mental health of adults and children of both sexes.

Explicit recognition of the crosscutting nature of bias due to sex and race helps clarify the different service delivery problems of the unserved, underserved, and inappropriately served populations that are now lumped together in the act. Increasing access to inappropriate service would not be an improvement for an unserved or underserved group. In fact, you could even argue it would do more harm than good, especially when the so-called service may involve such things as electroshock and drug therapy. Increasing the access of minority women to overmedication doesn't seem to be an advance.

So I would suggest that changes need to be made throughout the act to reflect a priority of developing appropriate service to unserved, underserved, and currently inappropriately served populations, and women should be added to the list of priority groups in the act.

Efforts to develop the community support services for the deinstitutionalized and their families are long overdue, and I applaud them. But the stereotyped assumptions about family roles that so impair the effectiveness of deinstitutionalization may similarly detract from the programs of this act. Programs must be based on a realistic sex-fair assessment of the needs of patients and their families.

Further, the training and educational assistance provisions should explicitly provide for training and education directed toward the special problems that age, sex, race, and cultural and ethnic bias create for patients and their families. The providers are part of the problem, and we need some outside support to get some solutions.

A final comment on prevention. Sex-role stereotyping impairs women's adaptive strengths, their coping resources, their competencies—qualities essential to the primary prevention of mental health problems.

Yet it is clear from the program initiatives of the National Institute of Mental Health that examination of the link between stereotyping and mental health will continue to be ignored.

This is particularly unfortunate for women who are at higher risk for depressive disorders. Sex role considerations are major contributing factors to women's high risk for depression yet there is little interest for developing prevention efforts directed toward this widespread and serious problem.

There also appears to be little interest in identification and prevention of special problems sex bias creates for female children. For example, consider the way that the programs designed for children continue to ignore the prevalence of family sexual abuse.

We also need prevention efforts also that will include development of treatment approaches that will not themselves create problems because they are based on unrealistic stereotyped assumptions about the lives of females and their families.

The Center for Prevention is a good idea, but I urge you to include in its legislative mandate a requirement that it address research and service efforts toward the mental health needs of women and female children and that its staff include professionals who have demonstrated competence and expertise in the needs of both.

In summary, sex bias and sex role stereotyping continue to detract from the efficacy of the Nation's mental health delivery system. My prepared statement considers these issues in relation to the act in more detail, but obtaining the needed changes will require a legislative mandate to address the issues of sex bias. So whether or not these needs will be addressed or ignored will very much depend on you.

Thank you very much.

[The prepared statement of Dr. Russo and the subpanel report referred to follows:]

TESTIMONY BEFORE THE SENATE SUBCOMMITTEE
ON HEALTH AND SCIENTIFIC RESEARCH
JUNE 11, 1979

NANCY FELIPE RUSSO, PH.D.
COUNCIL MEMBER, FEDERATION OF ORGANIZATIONS FOR
PROFESSIONAL WOMEN AND MEMBER OF THE SUBPANEL ON
THE MENTAL HEALTH OF WOMEN, PRESIDENT'S
COMMISSION ON MENTAL HEALTH

THE PRESIDENT'S COMMISSION ON MENTAL HEALTH (PCMH) POINTED OUT THAT TOO MANY AMERICANS DO NOT HAVE ACCESS TO PERSONNEL TRAINED TO RESPOND TO THEIR SPECIAL NEEDS BECAUSE OF THEIR AGE, SEX, CULTURAL BACKGROUND AND THE NATURE OF THEIR DISABILITY. CONCERN WAS ALSO EXPRESSED FOR THE FAILURE OF MENTAL HEALTH PRACTITIONERS TO RECOGNIZE, UNDERSTAND, AND EMPATHIZE WITH WOMEN'S FEELINGS. THE REPORT OF THE COMMISSION'S SUBPANEL ON THE MENTAL HEALTH OF WOMEN CONSIDERS THE PROBLEMS OF WOMEN IN GREATER DEPTH. I WOULD LIKE TO REQUEST THAT BOTH THE SUMMARY AND THE COMPLETE REPORT OF THE SUBPANEL BE READ INTO THE RECORD.

THE MENTAL HEALTH SYSTEMS ACT, AS CURRENTLY PROPOSED, GOES A LONG WAY IN ADDRESSING THE PROBLEMS OF PERSONS "UNSERVED, UNDERSERVED, AND INAPPROPRIATELY SERVED" BY THE CURRENT SYSTEM OF MENTAL HEALTH SERVICE DELIVERY. TO BE MOST EFFECTIVE, HOWEVER, THE ACT MUST EXPLICITLY ADDRESS PROBLEMS CREATED BY SEX ROLE STEREOTYPING AND SEX BIAS IN MENTAL HEALTH TRAINING, SERVICE, AND RESEARCH. AS PARTIAL STEPS TOWARD DOING SO, I SUGGEST THE FOLLOWING CHANGES IN THE PROVISIONS OF THE ACT.

A STRONG STATEMENT OF PURPOSE

THE STATEMENT OF PURPOSE OF THE ACT SHOULD EXPLICITLY INCLUDE ELIMINATION OF SEX AND RACE BIAS IN THE MENTAL HEALTH DELIVERY SYSTEM AS A SPECIFIC OBJECTIVE. THERE IS AMPLE EVIDENCE TO CONCLUDE THAT SEX ROLE STEREOTYPING AFFECTS THE MENTAL HEALTH OF ADULTS AND CHILDREN

OF BOTH SEXES.¹ FURTHER, THE DISADVANTAGED STATUS OF WOMEN DIRECTLY AFFECTS THE MENTAL HEALTH OF ADULT WOMEN AS WELL AS FEMALE CHILDREN. MENTAL HEALTH STATISTICS (E.G., TABLES 1,2) CLEARLY SHOW THAT VARIABLES ASSOCIATED WITH DIFFERENCES IN AGE, SEX, AND RACE INTERACT. PROGRAMS DEVOTED TO MINORITIES MUST REFLECT AN UNDERSTANDING OF THE SPECIAL PROBLEMS OF MINORITY WOMEN--AND THESE PROBLEMS DIFFER BY MINORITY GROUP. PROGRAMS TARGETED FOR CHILDREN MUST REFLECT SPECIAL PROBLEMS THAT STEREOTYPING CREATES FOR BOTH BOYS AND GIRLS.

EXPLICIT RECOGNITION OF THE CROSS-CUTTING NATURE OF SEX (AND RACE) BIAS HELPS CLARIFY THE DIFFERENT SERVICE DELIVERY PROBLEMS OF THE UNSERVED, UNDERSERVED, AND INAPPROPRIATELY SERVED POPULATIONS THAT ARE NOW LUMPED TOGETHER IN THE ACT. INCREASING ACCESS TO INAPPROPRIATE SERVICE WOULD NOT BE AN IMPROVEMENT IN THE SYSTEM FOR AN UNSERVED OR UNDERSERVED GROUP. SOME WOULD ARGUE THAT IT COULD EVEN DO MORE HARM THAN GOOD, ESPECIALLY WHEN THE "SERVICE" MAY INVOLVE SUCH DRASTIC PRACTICES AS ELECTROSHOCK AND DRUG THERAPY. INCREASING THE ACCESS OF MINORITY WOMEN TO OVERMEDICATION DOES NOT SEEM TO BE AN ADVANCE.²

CLARIFICATION OF DEFINITIONS

THE DEFINITIONS OF PRIORITY POPULATION GROUPS SHOULD REFLECT THE RECOGNITION OF THE INCREASED RISK OF MENTAL ILLNESS DUE TO FACTORS ASSOCIATED WITH AGE, SEX, RACE, CULTURAL AND ETHNIC STATUS, AND THE NEGLECT OF THE MENTAL HEALTH DELIVERY SYSTEM TO PROVIDE APPROPRIATE SERVICES TO HIGH RISK GROUPS.³ OBVIOUSLY, CHANGES WOULD THEN NEED TO BE MADE THROUGHOUT THE ACT TO REFLECT THE PRIORITY OF DEVELOPING APPROPRIATE SERVICE TO UNSERVED, UNDERSERVED AND CURRENTLY INAPPROPRIATELY SERVED POPULATIONS, ESPECIALLY CHILDREN AND YOUTH, THE AGED, THE CHRONICALLY MENTALLY ILL, RACIAL OR ETHNIC MINORITIES, POOR PERSONS IN RURAL AREAS AND WOMEN.

EVALUATION

THE ACT SHOULD INCLUDE A STRONG EVALUATION COMPONENT WHICH SPECIFICALLY DESIGNATES A MANDATE TO EVALUATE PROGRAMS WITH REGARD TO:

1. THE CRITERIA FOR DETERMINING THEIR TARGET POPULATION,
2. THE REALITY OF THE ASSUMPTIONS THAT ARE MADE ABOUT THE LIVES OF WOMEN AND THEIR FAMILIES,
3. THE DEGREE TO WHICH PROGRAM OBJECTIVES ARE RELATED TO WOMEN'S NEEDS,
4. THE DEGREE TO WHICH THE SPECIAL NEEDS OF WOMEN ARE MET IN THE DELIVERY OF THE SERVICES.⁴

THE DATA GATHERING PROCEDURES OF BOTH THE STATE AND FEDERAL GOVERNMENTS SHOULD BE DESIGNED TO FACILITATE SUCH EVALUATION.

THE CHRONICALLY MENTALLY ILL

THE CRUCIAL NEED FOR EVALUATION IS PARTICULARLY DEMONSTRATED IN THE INADEQUACY OF THE PROGRAMS DESIGNED TO MEET THE NEEDS OF THE CHRONICALLY MENTALLY ILL PATIENT. DEINSTITUTIONALIZATION HAS CREATED MAJOR PROBLEMS FOR THE MENTALLY ILL AS WELL AS FOR THEIR FAMILIES AND THE COMMUNITIES IN WHICH THEY LIVE. DEINSTITUTIONALIZATION DIFFERENTIALLY AFFECTS WOMEN IN TWO WAYS: FIRST, THE BURDEN FOR THE CARE OF DEPENDENTS TRADITIONALLY FALLS ON WOMEN; SECOND, WOMEN WHO ARE MENTALLY ILL HAVE NO ONE TRADITIONALLY ASSIGNED TO CARE FOR THEIR NEEDS. IF YOU BREAK DOWN THE STATISTICS ON NUMBERS OF RESIDENT PATIENTS IN STATE AND COUNTY HOSPITALS BY SEX AND AGE, YOU FIND THAT THE DROP IN NUMBER OF RESIDENT PATIENTS BROUGHT BY DEINSTITUTIONALIZATION POLICIES IS ACCOMPANIED BY A DRASTIC CHANGE IN SEX RATIOS OF THE PATIENTS. (SEE TABLE 3). IN 1965, THERE WERE 97 MALES PER EVERY 100 FEMALES IN STATE AND

COUNTY MENTAL HOSPITALS. IN 1975, THE FIGURE WAS CHANGED TO 117 MALES PER 100 FEMALES.

EFFORTS TO DEVELOP COMMUNITY SUPPORT SERVICES FOR PATIENTS AND MEMBERS OF THEIR HOUSEHOLD WHO MAY ASSIST THE CHRONICALLY MENTALLY ILL PATIENT ARE LONG OVERDUE AND ARE TO BE APPLAUDED. BUT HISTORICALLY, DEINSTITUTIONALIZATION EFFORTS--ON FEDERAL AND STATE LEVELS--HAVE NOT BEEN BASED ON REALISTIC ASSUMPTIONS ABOUT THE LIVES OF PATIENTS AND THEIR FAMILIES. THEY APPEAR TO HAVE ASSUMED THAT PATIENTS ARE MALE AND THAT THEY ARE YOUNG AND AFFLUENT ENOUGH TO HAVE INTACT FAMILIES WITH HOMEMAKERS TO CARE FOR THEM. I WILL NOT REITERATE THE STATISTICS ON FEMALE-HEADED HOUSEHOLDS, DIVORCE AND WIDOWHOOD, AND WOMEN WHO WORK TO KEEP THEIR FAMILIES ABOVE THE POVERTY LINE; BUT I DO FEAR THAT THE STEREOTYPED ASSUMPTIONS ABOUT FAMILY ROLES THAT HAVE IMPAIRED THE EFFECTIVENESS OF DEINSTITUTIONALIZATION WILL SIMILARLY DETRACT FROM THE EFFECTIVENESS OF THE PROGRAMS OF THIS ACT.

THUS, IN THE PROVISIONS OF TITLE I, THE SECRETARY SHOULD BE SPECIFICALLY DIRECTED TO ENSURE THAT THE PROGRAMS TO DEVELOP AND COORDINATE COMMUNITY-BASED SERVICES ON THE FEDERAL AND STATE LEVEL ARE BASED ON A REALISTIC, SEX-FAIR ASSESSMENT OF THE NEEDS OF PATIENTS AND THEIR FAMILIES.

FURTHER, IN LINE WITH THE ACT'S STRENGTHENED STATEMENT OF PURPOSE, SECS. 101(4) AND 101(4)(A) SHOULD EXPLICITLY PROVIDE FOR TRAINING DIRECTED TOWARD IMPROVING THE COMPETENCIES OF PERSONNEL THROUGH INCREASING KNOWLEDGE OF, SENSITIVITY TO, AND EMPATHY WITH THE SPECIAL PROBLEMS CREATED FOR PATIENTS AND THEIR FAMILIES DUE TO FACTORS ASSOCIATED WITH AGE, SEX, RACE, AND CULTURAL AND ETHNIC STATUS. THOSE TRAINING GOALS SHOULD ALSO BE APPLIED TO ALL PROVISIONS IN THE ACT DEALING WITH TRAINING AND EDUCATIONAL ASSISTANCE.

PREVENTION

EARLIER TESTIMONY DESCRIBED PRIMARY PREVENTION AS INTERVENTION DEVOTED TO BUILDING ADAPTIVE STRENGTHS, COPING RESOURCES, AND BEHAVIORAL COMPETENCIES IN INDIVIDUALS AND FAMILIES. THERE IS SUBSTANTIAL EVIDENCE THAT SEX ROLE STEREOTYPING IMPAIRS WOMEN'S ADAPTIVE STRENGTHS, COPING RESOURCES, AND COMPETENCIES. YET, IT IS CLEAR FROM THE PROPOSALS FROM THE NATIONAL INSTITUTE OF MENTAL HEALTH THAT WITHOUT A LEGISLATIVE MANDATE FOR PREVENTION EFFORTS TO ADDRESS SPECIAL PROBLEMS OF WOMEN AND FEMALE CHILDREN, EXAMINATION OF THE LINK BETWEEN SEX BIAS AND MENTAL HEALTH WILL BE IGNORED.

THIS IS PARTICULARLY UNFORTUNATE FOR WOMEN, WHO ARE AT RISK FOR DEPRESSIVE DISORDERS AT A RATIO OF ABOUT TWO TO ONE COMPARED WITH MEN. SEX ROLE CONSIDERATIONS HAVE BEEN FOUND TO BE MAJOR CONTRIBUTING FACTORS TO WOMEN'S HIGH RISK FOR DEPRESSION. YET, THERE APPEARS TO BE LITTLE INTEREST IN DEVELOPING THE PREVENTION EFFORTS DIRECTED TOWARDS THIS SERIOUS PROBLEM FOR ADULT WOMEN.

THERE ALSO APPEARS TO BE NO INTEREST IN THE IDENTIFICATION AND PREVENTION OF SPECIAL PROBLEMS OF FEMALE CHILDREN. FOR EXAMPLE, CONSIDER THE WAY THAT THE PROGRAMS DESIGNED FOR CHILDREN CONTINUE TO IGNORE THE PREVALENCE OF FAMILY SEXUAL ABUSE. YET, SEXUAL ABUSE BY AN ADULT MALE IS CURRENTLY PART OF THE NORMATIVE EXPERIENCE OF AMERICAN GIRLS. SEVERAL LARGE-SCALE STUDIES, CONDUCTED OVER THE PAST FORTY YEARS IN WIDELY DIFFERENT POPULATIONS, CONSISTENTLY DOCUMENT THE FACT THAT APPROXIMATELY ONE GIRL OUT OF EVERY FOUR IS SEXUALLY MOLESTED DURING HER CHILDHOOD OR ADOLESCENCE. FAMILY NEGLIGENCE OR COMPLICITY IS A FACTOR IN A MAJORITY OF CASES, AND IN AS MANY AS ONE-THIRD OF THE CASES, THE OFFENDER IS A RELATIVE. THE BEST AVAILABLE DATA INDICATE THAT AT

LEAST ONE GIRL IN 100 IS SEXUALLY ABUSED BY HER FATHER, INCEST OCCURRING MOST OFTEN IN FAMILIES WHERE FATHERS ARE EXCESSIVELY DOMINANT AND MOTHERS POWERLESS TO INTERVENE. SUCH STUDIES SUGGEST THAT ALTHOUGH BOYS ARE OCCASIONALLY SUBJECTED TO SEXUAL ABUSE BY ADULT RELATIVES, THE OVERWHELMING MAJORITY OF VICTIMS (AT LEAST 90%) ARE GIRLS. FAMILY SEXUAL ABUSE FOLLOWS THE GENERAL PATTERN OF SEXUAL CRIMES, IN WHICH MOST OFFENDERS ARE MALE AND MOST VICTIMS FEMALE. (SEE HERMAN, ON THE REFERENCE LIST).

WE ARE SLOWLY BECOMING AWARE OF THE PREVALENCE OF INCEST AND ITS AWESOME CONSEQUENCES. FOR EXAMPLE, IN 1979, 18% OF THE 189 CASES SERVED BY THE CHILD SEXUAL ABUSE VICTIM ASSISTANCE PROJECT AT CHILDREN'S HOSPITAL NATIONAL MEDICAL CENTER IN WASHINGTON, D.C. WERE FOUND TO HAVE GONORRHEA. NEARLY 3/4 OF THE GONORRHEA CLIENTS WERE GIRLS. THE MEAN AGE WAS 5.4 YEARS. ONLY 3 OF THE ABUSERS WERE NOT RELATED TO THE VICTIMS.

SINCE YOU ARE RECEIVING TESTIMONY ON THE PROBLEMS OF RAPE, I WILL NOT CONSIDER THEM HERE. LET ME SAY THAT PROBLEMS SUCH AS RAPE, INCEST, DOMESTIC VIOLENCE, AND DEPRESSION CONTINUE TO BE INADEQUATELY OR INAPPROPRIATELY ADDRESSED BY PROGRAMS FOR MENTAL HEALTH TRAINING, RESEARCH, AND SERVICE DELIVERY. WE NEED PREVENTION EFFORTS TARGETED TOWARD SUCH PROBLEMS THAT WILL INCLUDE DEVELOPMENT OF TREATMENT EFFORTS THAT WILL NOT EXACERBATE THE PROBLEMS BECAUSE THEY ARE BASED ON UNREALISTIC, STEREOTYPED ASSUMPTIONS ABOUT THE LIVES OF FEMALES AND THEIR FAMILIES. THE SUBPANEL REPORT DETAILED ITS CONCERN WITH THE PERSISTENCE OF SEX BIAS AND SEX ROLE STEREOTYPING THAT AFFECTS WOMEN AS PROVIDERS AND CONSUMERS IN THE MENTAL HEALTH DELIVERY SYSTEM. IT ALSO CONTAINS FURTHER RECOMMENDATIONS FOR DEALING WITH THESE PROBLEMS.

OUR EXPERIENCE WITH THE MENTAL HEALTH BUREAUCRACY SUGGESTS THAT ONLY OUTSIDE PRESSURE WILL PROVIDE THE NECESSARY IMPETUS FOR NEEDED CHANGE. I SUPPORT THE CREATION OF A CENTER FOR PREVENTION; BUT I URGE YOU TO INCLUDE IN THIS LEGISLATIVE MANDATE A REQUIREMENT THAT IT MUST ADDRESS SOME OF ITS RESEARCH AND SERVICE EFFORTS TOWARDS THE SPECIAL MENTAL HEALTH NEEDS OF WOMEN AND FEMALE CHILDREN, AND THAT ITS STAFF INCLUDE PROFESSIONALS WHO HAVE DEMONSTRATED EXPERTISE IN THE NEEDS OF BOTH.

SUMMARY

IN SUMMARY, SEX BIAS AND SEX ROLE STEREOTYPING CONTINUE TO DETRACT FROM THE THE EFFICACY OF THE NATION'S MENTAL HEALTH DELIVERY SYSTEM. THE SAME HARMFUL SEX ROLE STEREOTYPES FOUND IN SOCIETY AT LARGE ARE REFLECTED IN MENTAL HEALTH RESEARCH, TRAINING, AND SERVICE DELIVERY. PROBLEMS OF WOMEN AND FEMALE CHILDREN CONTINUE TO BE INADEQUATELY AND INAPPROPRIATELY ADDRESSED, AND DATA NEEDED FOR ACCOUNTABILITY ARE LACKING. EXTENSION OF INADEQUATE OR INAPPROPRIATE SERVICES TO WOMEN IN UNSERVED AND UNDERSERVED POPULATIONS WOULD NOT BE AN IMPROVEMENT IN THE DELIVERY OF MENTAL HEALTH SERVICES. PREVENTION EFFORTS, AS PROPOSED, IGNORE MAJOR PROBLEMS OF WOMEN AND FEMALE CHILDREN AND SHOULD INCLUDE A FOCUS ON THE LINK BETWEEN SEX BIAS AND MENTAL HEALTH. OBTAINING NEEDED CHANGES WILL REQUIRE A LEGISLATIVE MANDATE TO ADDRESS ISSUES OF SEX BIAS. THIS ACT IS AN OPPORTUNITY TO PROVIDE THAT MANDATE.

Table 1 Distribution of additions to federally funded CMHC's by sex, race, and diagnostic grouping, United States 1975
(COMMUNITY MENTAL HEALTH CENTERS)

Sex and diagnostic groups	Race					
	Total	White	All other races	Total	White	All other races
Both sexes, total.....	919,037	Number 761,848	157,189	Percent 100.0%	100.0%	100.0%
Alcohol disorders.....	89,338	74,183	15,155	9.7	9.7	9.6
Drug abuse.....	28,638	23,253	5,385	3.1	3.1	3.4
Mental retardation.....	31,003	22,737	8,266	3.4	3.0	5.3
Depressive disorders.....	122,948	105,741	17,207	13.4	13.9	10.9
Schizophrenia.....	91,914	68,462	23,452	10.0	9.0	14.9
Organic brain syndromes.....	22,443	17,727	4,716	2.4	2.3	3.0
Other psychoses.....	19,188	15,952	3,236	2.1	2.1	2.1
Transient situational disturbances and behavior disorders of childhood and adolescence.....	120,642	100,161	20,481	13.1	13.1	13.0
Other nonpsychotic.....	191,964	166,679	25,285	21.0	21.9	16.1
Social maladjustment.....	66,395	59,940	6,455	7.2	7.9	4.1
No mental disorder ^a	134,564	107,013	27,551	14.6	14.0	17.6
Males, total.....	439,381	362,402	76,979	100.0%	100.0%	100.0%
Alcohol disorders.....	69,665	58,011	11,654	15.9	16.0	15.1
Drug abuse.....	18,785	15,226	3,559	4.3	4.2	4.6
Mental retardation.....	17,719	12,960	4,759	4.0	3.6	6.2
Depressive disorders.....	37,171	32,393	4,778	8.5	8.9	6.2
Schizophrenia.....	46,204	34,015	12,189	10.5	9.4	15.8
Organic brain syndromes.....	11,161	8,837	2,324	2.5	2.4	3.0
Other psychoses.....	8,894	7,311	1,583	2.0	2.0	2.1
Transient situational disturbances and behavior disorders of childhood and adolescence.....	65,238	53,968	11,270	14.8	14.9	14.6
Other nonpsychotic.....	75,912	66,185	9,727	17.3	18.3	12.6
Social maladjustment.....	26,224	23,526	2,698	6.0	6.5	3.5
No mental disorder ^a	62,408	49,970	12,438	14.2	13.8	16.3
Females, total.....	479,656	399,446	80,210	100.0%	100.0%	100.0%
Alcohol disorders.....	19,673	16,172	3,501	4.1	4.0	4.4
Drug abuse.....	9,853	8,027	1,826	2.1	2.0	2.3
Mental retardation.....	13,284	9,777	3,507	2.8	2.4	4.4
Depressive disorders.....	85,777	73,348	12,429	17.9	18.4	15.5
Schizophrenia.....	45,710	34,447	11,263	9.5	8.6	14.0
Organic brain syndromes.....	11,282	8,890	2,392	2.4	2.2	3.0
Other psychoses.....	10,294	8,641	1,653	2.1	2.2	2.1
Transient situational disturbances and behavior disorders of childhood and adolescence.....	55,404	46,193	9,211	11.6	11.6	11.5
Other nonpsychotic.....	116,052	100,494	15,558	24.1	25.2	19.3
Social maladjustment.....	40,171	36,414	3,757	8.4	9.1	4.7
No mental disorder ^a	72,156	57,043	15,113	15.0	14.3	18.3

^a Includes deferred diagnosis and nonspecific conditions

Table 2 Distribution of additions to federally funded CMHC's by age, sex and race, United States 1975

Sex and age	Race					
	Total	White	All other races	Total	White	All other races
	Number			Percent		
Both sexes						
Total...	919,037	761,848	157,189	100.0%	100.0%	100.0%
Under 15	146,591	118,085	28,506	16.0	15.5	18.1
15-17...	67,016	54,862	12,154	7.3	7.2	7.7
18-24...	172,747	142,475	30,272	18.8	18.7	19.3
25-44...	354,561	295,993	58,568	38.5	38.9	37.3
45-64...	141,215	119,676	21,539	15.4	15.7	13.7
65+....	36,907	30,757	6,150	4.0	4.0	3.9
Males						
Total...	439,381	362,402	76,979	100.0%	100.0%	100.0%
Under 15	89,740	72,690	17,050	20.4	20.1	22.1
15-17...	33,689	27,626	6,063	7.7	7.6	7.9
18-24...	80,700	65,803	14,897	18.4	18.2	19.4
25-44...	155,444	128,781	26,663	35.4	35.5	34.6
45-64...	63,927	54,298	9,629	14.5	15.0	12.5
65+....	15,881	13,204	2,677	3.6	3.6	3.5
Females						
Total...	479,656	399,446	80,210	100.0%	100.0%	100.0%
Under 15	56,851	45,395	11,456	11.9	11.4	14.3
15-17...	33,327	27,236	6,091	6.9	6.8	7.6
18-24...	92,047	76,672	15,375	19.2	19.2	19.2
25-44...	199,117	167,212	31,905	41.5	41.8	39.8
45-64...	77,288	65,378	11,910	16.1	16.4	14.8
65+....	21,026	17,553	3,473	4.4	4.4	4.3

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Table 3 Number of resident patients at end of year, State and county mental hospitals, by sex and age:
United States 1965-1975

Year and sex	Age							
	Total	Under 15	15-24	25-34	35-44	45-54	55-64	65+
Both sexes								
1965....	475,202	6,134	27,913	42,637	66,499	89,323	102,366	140,330
1966....	452,089	6,289	27,280	41,436	62,116	82,925	97,337	134,710
1967....	426,309	6,579	25,655	38,509	57,013	77,723	92,493	128,337
1968....	399,152	6,365	25,315	36,546	52,623	71,166	86,997	120,160
1969....	369,969	6,751	25,100	34,933	47,215	64,268	80,282	111,420
1970....	337,619	6,565	26,764	34,349	42,904	57,465	70,485	99,087
1971....	308,983	6,378	26,591	33,095	39,272	52,030	63,235	88,382
1972....	274,837	5,767	24,532	30,976	34,447	45,102	55,534	78,479
1973....	248,518	5,355	23,323	29,756	30,868	39,523	49,078	70,615
1974....	215,586	5,029	25,153	29,835	29,860	31,887	39,158	54,664
1975....	191,391	4,289	20,953	25,993	27,309	28,224	36,428	54,195
Male								
1965....	233,958	4,445	17,781	25,267	33,690	44,452	51,705	56,618
1966....	222,190	4,499	17,329	24,812	32,151	41,078	48,629	53,692
1967....	211,415	4,736	16,550	23,395	29,851	38,261	46,738	51,884
1968....	199,517	4,660	16,401	22,770	28,275	35,273	44,044	48,094
1969....	185,584	4,945	16,332	21,731	25,609	31,641	40,517	46,809
1970....	171,427	4,702	17,618	21,555	23,562	28,337	35,638	40,015
1971....	158,057	4,454	17,643	20,793	21,817	25,649	31,961	35,760
1972....	142,532	4,152	16,629	20,007	19,820	22,409	27,994	31,521
1973....	131,410	3,738	16,317	19,568	17,992	19,890	24,466	29,439
1974....	114,781	3,367	15,333	18,147	15,801	16,745	20,052	25,336
1975....	103,327	3,036	14,693	17,771	13,876	14,395	16,951	22,605
Female								
1965....	241,244	1,689	10,132	17,370	32,809	44,871	50,661	83,712
1966....	229,899	1,790	9,951	16,622	29,963	41,847	48,708	81,018
1967....	214,894	1,843	9,105	15,114	27,162	39,662	45,755	76,453
1968....	199,635	1,705	8,914	13,776	26,368	35,893	42,953	72,046
1969....	184,385	1,806	8,768	13,202	21,606	32,627	39,765	66,611
1970....	166,192	1,863	9,146	12,794	19,342	29,128	34,847	59,072
1971....	150,926	1,924	8,948	12,302	17,455	26,381	31,294	52,622
1972....	132,305	1,615	7,903	10,969	14,627	22,693	27,540	46,958
1973....	117,108	1,617	7,006	10,188	12,676	19,633	24,612	41,176
1974....	100,805	1,662	9,820	11,688	14,059	15,142	19,106	29,328
1975....	88,064	1,253	6,260	8,222	9,433	13,829	17,477	31,590

NIMH, DB&E

Footnotes

¹The following reference list provides a sampling of such ample documentation.

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2 For example, at minimum, Section 2(a)(1) should read "...poor persons, persons in rural areas, and women often lack access to adequate and appropriate mental health services...."; Section 2(b)(2) should read "to develop appropriate community-based services...poor persons, persons in rural areas, and women;..."

3 Specifically, the definition should read "...any of the following groups which are unserved by any appropriate mental health program...rural residents, women or any other group determined by the Secretary...."

4 An example of the inadequacy of current data gathering efforts for testing hypotheses about the efficacy of program needs can be found in a recent study that was of the utilization of mental health service by Federal employees in the Washington metropolitan area. The study was jointly funded by The Civil Service Commission and NIMH, involved Blue Cross and Blue Shield and the professional organizations representing psychologists, psychiatrists, social workers and nurses.

The number of individuals using outpatient mental health services are reported as follows:

Number of individuals using outpatient mental health services during 1977 by age and sex

<u>Age</u>	<u>Male</u>	<u>Female</u>	<u>Total</u>		<u>% of age group Total</u>	
			<u>No.</u>	<u>% of all ages</u>	<u>Male</u>	<u>Female</u>
0-14	1031	451	1482	9.5	70	30
15-25	951	1099	2050	13.2	46	54
25-44	3301	5489	8790	56.8	38	62
45-64	1240	1797	3037	19.6	41	59
65+	<u>45</u>	<u>80</u>	<u>125</u>	<u>0.8</u>	<u>36</u>	<u>64</u>
All ages	6568	8916	15484	100	42	58

*Von Korff, M.R. & Kramer, M. Mental and nervous disorders, utilization and cost survey. National Institute of Mental Health, U.S. Office of Personnel Management: May 1979.

Clearly, adult women are more likely to be represented in these outpatient statistics than adult men. The question is why? One hypothesis is that providers' stereotyped attitudes towards women perpetuate a status of dependency. The data on the frequency of visits show that the majority of patients had a low to moderate number of visits, while a small proportion had a large number of visits. The six percent of the patients that have more than 100 visits in 1977 accounted for over 25% of the outpatient services. If women were found disproportionately represented in the statistics on repeated visits, it would be a clear signal to do more indepth evaluation to ascertain why, and particularly to examine the possible contribution of stereotyping by the provider to the prolonged treatment. Yet, I understand that the form of the data precludes answering that simple question. This is but one minor example of a widespread, serious, problem.

Report of the Special Populations Subpanel
on
MENTAL HEALTH OF ASIAN/PACIFIC AMERICANS

Submitted to
THE PRESIDENT'S COMMISSION ON MENTAL HEALTH

February 15, 1978

Special Populations Subpanel:
Mental Health of Asian/Pacific Americans

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SUBPANEL ON MENTAL HEALTH OF ASIAN/PACIFIC
AMERICANS (AAPA)

This report attempts to do several things, (1) make a general statement with regard to the frame of reference with which the Asian/Pacific Subpanel confronted the task set before it, in the section below entitled, "Statement on Philosophy and Perspective," (2) give a brief overview concerning the status of Asian and Pacific Americans in terms of mental health in the section entitled, "The Condition of Asian and Pacific Americans in Terms of Mental Health," (3) present a series of recommendations on research, services, training, and pertinent social policy issues in the section entitled, "Recommendations," and (4) state some concluding thoughts.

In the section entitled, "The Philosophy and Perspective of the Asian/Pacific Subpanel on Mental Health," a number of questions are raised regarding the definition of "mental health" and "special populations" as utilized by the President's Commission on Mental Health. In addition, the subpanel raises further questions about why basic, systemic, causal factors, within American society, e.g., racism, are not sufficiently addressed in the Charge to the Task Panel on Special Populations.

The section on the "Condition of Asian and Pacific Americans in Terms of Mental Health" provides a brief overview of a variety of developments in the Asian and Pacific American communities relevant to mental health issues. This section is designed to supplement the extensive material presented in the recommendations. In short, the Asian and Pacific American condition with respect to mental health issues is undergoing significant and rapid change. This nearly chaotic change process is being stimulated by immigration from several Asian and Pacific countries, the arrival of Indo-Chinese "refugees," and a variety of other factors and forces at local, State, and national levels. The mental health needs of this changing Asian and Pacific American population are rising, while by contrast relatively few additional resources (e.g., research, services, and/or training), are available to meet these increasing needs.

The Recommendations section deals with issues regarding (1) service delivery, (2) personnel and training, (3) research, and (4) social policy. A special emphasis upon high priority populations including the developmentally and physically disabled, the foreign-born wives of American servicemen, etc., are also included in the recommendations. The recommendations call for greatly expanded efforts in all of the above areas to begin closing the gap between needs and available resources. Note, however, the needed resources have to be relevant and culturally sensitive. Also, the content areas of focus as indicated above, were considered by the Subpanel participants as being interrelated and far from mutually exclusive. Thus, the expansion of these efforts need to be correlated, for maximum impact. The Subpanel members decided that, at least for now, there would be no listing of the recommendations in any serial order of priority. All areas of recommendations were essentially equally important.

In the Conclusion section, the Asian/Pacific Subpanel emphasized the need for its input to be appropriately represented in both the reports of

the Task Panel on Special Populations and the final report to the President by the President's Commission on Mental Health. Further, in the view of the Asian/Pacific Subpanel, the benefit in helping to develop the report of the President's Commission on Mental Health will be evaluated on the basis on concrete results. Obviously, a large number of people will be very disappointed if an appropriate report goes to the President and the concrete results are not considered responsive to the Commission's report. In this regard, the Asian/Pacific Subpanel thinks that the Public Committee for Mental Health will be very important in helping to stimulate and monitor positive outcomes from the report of the President's Commission on Mental Health. The Subpanel called for appropriate Asian and Pacific American representation on the Public Committee for Mental Health, and any other similar bodies that may be established, particularly since there was no appropriate Asian and Pacific American representation on the President's Commission on Mental Health.

RECOMMENDATIONS

The report of the Subpanel on Mental Health of Asian/Pacific Americans contains numerous specific recommendations for action to address the mental health problems identified by the deliberations of the groups. This brief summary only highlights some of the 67 recommendations. The rationale for each recommendation is included in the body of the report.

A. Social Policy Issues

1. (a) mental health policies contain specific provisions which acknowledge the unique cultures, languages, and lifestyles (including immigration experience) of the Asian and Pacific Americans.

 (b) mental health policy should reflect the cultural, racial, and ethnic differences of the Asian and Pacific Americans (e.g., bilingual/bicultural education and affirmative action programs).
2. That the President and Congress quickly enact an income maintenance program which will assure every person in the United States appropriate economic security, which will promote family solidarity, and an opportunity for capacity building.
3. Repeal of Public Law 94-484 because sections of it are considered racist and discriminatory.
4. Immigrants and refugees coming to the United States should be allowed the same basic benefits as American citizens. Immigration laws should provide equity, efficiency, and dignity to those wanting to enter the United States.
5. The rights of Asian and Pacific American patients in health and mental health settings be duly recognized, particularly as they relate to their unique cultural, linguistic characteristics, and historical/life experiences.
6. The enactment of a bill to establish a Division for Minority Group Mental Health Programs to include Asian and Pacific Americans, Blacks, Hispanics, and Native Americans as per Senator Inouye's bill (S. 2373).
7. Asian and Pacific Americans must be appointed to serve on the National Advisory Mental Health Council, NIMH (National Institute of Mental Health), and all other Federal, State, and local governmental boards, review committees, commissions, councils, and policymaking bodies, and especially where substantial numbers of Asian and Pacific Americans are affected.

8. That Federal and State funds be specifically allocated for the development and support of bilingual and bicultural rehabilitation programs that serve the Asian and Pacific Americans with developmental needs.
- B. Delivery of Mental Health Services and Training and Personnel Issues
1. To maximize utilization of mental health services by Asian and Pacific American populations, it is recommended that provision be made for
 - (a) culturally relevant modalities of mental health care, including traditional or folk medicine;
 - (b) staffing by bilingual/bicultural personnel;
 - (c) contracting to Asian community-based organizations for delivery of services, wherever such services exist;
 - (d) integration of existing mental health services with other community services, such as youth services, family services, services to children, services to the aged, services for developmentally disabled, etc.; and
 - (e) liaison between Asian and Pacific American community organizations and mental health providing agencies.
 2. Mechanisms be developed at the Federal level to secure strict enforcement of, and compliance to, existing legislation pertaining to all mental health facilities; and there be participation by Asian and Pacific Americans in the implementation of such procedures.
 3. (a) sufficient numbers of Asian and Pacific American personnel be employed and assigned to teams or units, in order to maximize their visibility and impact upon service delivery to Asian and Pacific American communities.
 - (b) in areas with high concentrations of Asian and Pacific Americans, facilities should be designated as providing specialized services to Asian and Pacific Americans, with appropriate bilingual/bicultural staffing.
 4. Training and licensure requirements must be reexamined and modified to take into account shortage of bilingual and bicultural licensed personnel to serve Asian and Pacific American communities.

5. (a) indigenous paraprofessionals from such communities be accepted for employment in the mental health field.
- (b) for those persons who have had training in their home country, provision should be made for training with built-in career ladders to assure future career development.
6. Administrative, program, and fiscal arrangements must be made to allow Asian and Pacific American residents to be served across catchment boundaries when appropriate services do not exist in their catchment areas. In catchment areas with small Asian and Pacific American populations, two or more catchment areas should pool resources whenever feasible.
7. It is recommended that provision be made for direct Federal funding to Asian and Pacific American community groups or organizations to develop models of service delivery to their own communities, such as community-based multipurpose service delivery centers and satellite outreach centers.
8. Mechanisms for reimbursement for health and mental health services (e.g., national health insurance, Medicare, etc.) must include culturally traditional forms of assistance (i.e., acupuncture, herbs, etc.).
9. Asian and Pacific Americans (consumers and providers) must be included at all levels of the decisionmaking process in programs which serve Asian and Pacific American clients.
10. Educational programs for non-Asian and Pacific American mental health service providers must be required in all areas that serve Asian and Pacific American clientele in order to increase knowledge and sensitivity to those clients.
11. Consultation and educational programs for Asian and Pacific American nonmental health service providers sponsored by community mental health agencies in communities with Asian and Pacific American populations.
12. Development of Regional Asian and Pacific American Multi-Disciplinary Mental Health Training Centers which also render comprehensive mental health services to AAPA target populations.

13. The development, planning, and implementation of the Asian and Pacific American Multi-Disciplinary Mental Health Training Centers concepts must involve and actively seek input from the AAPA communities they are to serve.
14. Development of State and national recruitment mechanisms to identify, inform, and select potential mental health service caregivers for Asian and Pacific Americans in all mental health related fields.
15. Training programs for Asian and Pacific Americans must include support for programs which are community-based.
16. Training funds specially designated for the development of Asian and Pacific American mental health paraprofessionals and professionals to serve Asian and Pacific Americans must be increased.
17. Asian and Pacific American focused curriculum and teaching materials must be developed and implemented in all mental health disciplines.
18. Agencies should hire bilingual/bicultural Asian and physical disabilities staff at the administrative, management, planning, and supervisory levels.
19. Training funds should be specifically designated to deal with the special needs of the Asian and Pacific American with developmental needs to train more bilingual/bicultural Asian and Pacific American staff, and support the growth of consumer and self-help groups.
20. Needs of citizens of the Pacific Islands (Guam, American Samoa, Marianas, and other trust territories) should be given special attention through:
 - (a) A special task force of key mental health leaders, especially those knowledgeable of developing countries, and Island leaders in the field of mental health to examine the mental health needs and problems of the Islanders and to propose programs to meet mental health needs.
 - (b) Funds be appropriated to study the impact of change, racism, and colonialism on the mental health conditions of the Islanders.
 - (c) Funds be provided to develop mental health programs for training and service delivery which are relevant to the Islanders needs and resources.

21. To respond to the mental health needs of Asian and Pacific American wives of U.S. servicemen:
 - (a) Establish and maintain a nationwide crisis line service in the several languages of the Asian and Pacific American wives.
 - (b) Develop and disseminate orientation materials to Asian and Pacific American military wives, their spouses, and service providers.
 - (c) Urge the U.S. Department of Defense to develop and provide orientation programs for Asian and Pacific American wives and their husbands prior to their arrival in the United States.
22. A federally funded outreach program be established to serve communities with a substantial concentration of Asian and Pacific Americans with developmental needs.
23. The current Administration should encourage and support innovative service delivery approaches to Asian and Pacific Americans with developmental needs.

C. Research

1. Research monies should never compete with the meager level of funding available for service delivery.
2. In view of past inequities experienced by Asian and Pacific Americans, special earmarked funds for AAPA research at all levels of government should be provided and maintained.
3. Adequately funded research training programs must be developed to create research capabilities within the Asian and Pacific American communities.
4. That policy-makers for service delivery and research programs, as well as grant-reviewers, include Asian and Pacific American persons who are sensitive to the special needs of the AAPA communities.
5. There must be substantial investigation of ongoing racism and its effects on AAPA communities and individuals.
6. Normative patterns of functioning among and within AAPA communities must be studied and identified.
7. There is a need for research efforts to identify gaps in services available to AAPA communities and individuals.

8. There is a need for the development of culturally appropriate and relevant psychological assessment and tools.
9. There is a need to both identify and remedy information gaps especially those pertaining to such baseline data as census information, current population status, service utilization patterns, and service needs.
10. Exploratory research must be conducted in the areas of:
 - (a) Geographic location of Asian and Pacific Americans with developmental needs.
 - (b) Incidence and prevalence data concerning Asian and Pacific Americans with developmental needs.
 - (c) Types of developmental needs and disabilities affecting the Asian and Pacific American population.
 - (d) Types of physical problems of Asian and Pacific Americans with developmental needs.
 - (e) Types of mental health needs of the Asian and Pacific Americans with developmental needs.
11. Negative labeling of Asian and Pacific Americans must be eliminated. Terms that are derogatory to one specific ethnic minority group should not be used. For example, it is recommended that the current use of the word "mongoloid" be changed to "Down's Syndrome."

D. Prevention

1. Prevention services in health and mental health programs must be provided adequate resources and must be an integral component of any health or mental health planning, services, and research.
2. There should be establishment and expansion of preventive programs of consultation and education which would impart bilingual/bicultural mental health and developmental disability information to Asian and Pacific American families and individuals, as well as community organizations and service providers.

ACKNOWLEDGMENTS

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Senator KENNEDY. Thank you.

Mr. Sanchez?

Mr. SANCHEZ. Thank you, Mr. Chairman.

On behalf of our 190 local agencies, 5 national organizations and hundreds of individual members in over 165 cities in 30 States, we commend you for once again taking the leadership to provide minorities and underserved populations in our country the opportunity to be heard.

For the sake of brevity, I wish to summarize the main points of our written testimony submitted for the record. In the statement, we identify several areas where the proposed mental health systems act should be strengthened and modified.

These areas are as follows:

Provisions should be included to require that in programs funded under the act bilingual and bicultural services should be provided in areas with a substantial number of bilingual and bicultural persons. These services should be planned and delivered by appropriate bilingual and bicultural personnel.

Where the act addresses the role of the States in mental health systems, we urge you to consider several points. Specific measures should be required to insure that the States afford equal access to services to Hispanics, other minorities and the poor and that States involve us in developing and assessing these services. Too often, Senator, as I travel around the country, talking with our constituency, with Pacific/Asians, with Native Americans, and black communities, they relate to me the lack of services that are being provided to them and worst of all, they have no recourse because they don't have the strength. As you well know, sir, people are delivered services according to power, and political power is very important. That is something we minorities in this country have not achieved yet.

States should be mandated to collect, analyze, and report data on racial, ethnic, and special populations. If we are not adequately counted, we will be discounted, and if we Hispanics do not exist in the data systems, we will not be considered in the planning process or, at least, our needs will not be legitimized.

Input from Hispanic and other minority providers and consumers should be incorporated in the development and review of State mental health plans. Technical assistance should be provided to help consumers and citizens take part fully in this process.

One might ask, "Why isn't this being done?" Well, if you look around the country, you will find that there are less than a half a dozen Hispanic directors in the total system of community mental health centers. You will also find that there are no Hispanic mental health commissioners in the States. You yourself mentioned earlier, when you opened this session, the horrible condition and plight of minorities in mental health training and related professions.

State pilot programs in prevention should include a clear emphasis on addressing primary prevention needs of minorities and special populations. I myself, sir, have a personal experience to share.

Fifteen years ago my oldest sister was institutionalized, my mother and father knew nothing about mental illness, and, worst of all, there was no one to help them through this crisis. Even now,

just 3 weeks ago, I was visiting my home—my sister is still sick, sir, but lives at home now—and I asked her why she was not going to the outreach program and she answered me, “Because they gave me my pills, told me to go home and take them and there was no need to come back.”

I think too often, sir, these institutions are taking the easy way out and are giving patients pills and telling them to go home because they have not developed alternative programs that are most relevant to our minority community.

With regard to funding for services under title IV, we have several concerns. There should be some mechanism to provide continuous support for graduate community mental health centers, especially those in designated poverty areas which have taken their commitment to community mental health seriously but are struggling financially to survive and maintain quality service.

In some of these areas it is becoming clear that local communities and State agencies realistically cannot be expected to pick up the cost. It makes little sense, sir, to assure continued support for consultation and education services and linkage grants unless we are also assured support to provide services to those in need, regardless of ability to pay.

Last week, I called your own home State and was told by Ms. Frieda Garcia of the Solomon Carter Fuller Mental Health Center in Boston that its outreach capacity in the consultation and education program has been built up to 45 slots. How can they go out and make outreach and then encourage the people to use services while money for services are being curtailed. This is happening not only in your home State, but also in Arizona, Colorado, Illinois, and Florida, according to Hispanics in these areas where we conducted our telephone poll. To me, this is a totally different, opposite way of approaching the problem.

We feel that the proposed title IV initiation and development grants offer our communities an opportunity to develop culturally and linguistically relevant services. These should be seen as alternatives within existing systems, not as parallel or opposed to existing systems.

Those who argue otherwise remind me of what my father used to say, “Hay gente que ni come y ni deja comer.” This means, sir, there are those who will not eat and will not let others eat.

If existing centers or systems have not been able to develop and provide the kinds of services we desperately need and can utilize, then our communities need the chance to do so and thus fill this existing gap.

Last year, sir, I received a call from one of our member agencies in Chicago—the Pilsen-Little Village Community Mental Health Center—and was told that they had a emergency treatment program and as the crunch for funds came, a State mental health hospital was now going to take this program. This institution had never incorporated—and even to this day hasn’t—any program for Hispanics or sought alternatives to treatment for Hispanics and minorities in this area. This is a blatant example of what happens to minorities when there is a shortage of funds. Those in power will take away from the weak. I just heard last week also that

although we were able to save the program last year through a variety of interventions, the center has since lost the program.

In my 5 years' experience as national executive director of COSSMHO with extensive exposure to our communities, I have been also receiving another clear message: we need a national patient advocacy effort.

For us this means both advocates and materials in our culture and language. These could be well utilized in patient education programs providing nontechnical information to consumers and their families on mental health issues, treatment alternatives, and proper usage of medication.

Further, we believe the act would be strengthened and a stronger emphasis would be given to minority services, training, and research if there were included provisions to create the position of an Associate Director for Minority Mental Health Concerns within NIMH. Adequate funds should be provided to enable this position to carry out its activities in minority training research and services.

In conclusion, sir, if you were to ask me, "Mr. Sanchez, in less than 1 minute, tell me how you view this legislation?" I would say to you, sir, that while it is a step in the right direction, I consider this legislation to be vague and not specific enough to insure the protection of minorities in this country.

Without specific language, sir, we will be left "behind the eight ball" once again. When I visit the HEW regional offices and the offices of the health administrators in all 10 regions, I see very few Hispanics holding Federal positions in these agencies who can monitor the effectiveness of community mental health centers. When I ask why, I am usually told, "Well, we are understaffed. We only have three or so people for this division." When we are fortunate to have some minorities in these Federal agencies, they tell me there is no compliance language they can grab hold of when they monitor these community mental health centers. Nor do others feel obligated to do so because there was never any regulations written addressing minority—specific provisions in the existing legislation.

With that, sir, I conclude my statement, and I thank you again for this opportunity.

[The prepared statement of Mr. Sanchez follows:]

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TESTIMONY ON THE MENTAL HEALTH SYSTEM ACT

Presented Before the
Senate Subcommittee on Health and Scientific Research

By
Rodolfo B. Sanchez
National Executive Director
of
COSSMHO

June 11, 1979

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of COSSMHO--The National Coalition of Hispanic Mental Health and Human Services Organizations, I am pleased to submit this statement and thank you for inviting our organization to do so.

COSSMHO represents over 190 local mental health and human service agencies, five national organizations, and hundreds of individuals working to deliver services and conduct related research and training in more than 165 cities in 30 States, the District of Columbia, and the Commonwealth of Puerto Rico. The COSSMHO membership is actively engaged in reaching out to and serving the diversity of Hispanic American communities across this country, including Cubans, Latinos, Mexican Americans/Chicanos, and Puerto Ricans.

The purpose of this statement is to share with you significant issues and concerns of Hispanic communities that should be addressed in the mental health legislation you are now considering. These issues and concerns in this statement reflect those that were identified in a nationwide telephone survey among the COSSMHO membership. Included among them were Hispanic community mental health service providers and planners representative of both Hispanic geographical and Hispanic subgroup diversity in such States as Massachusetts, Arizona, California, Pennsylvania, Illinois, Colorado, Texas, and Florida, to name only a few. In addition, this statement incorporates the findings of COSSMHO's National Hispanic Committee. This group was convened to assure follow-up action on the recommendations of the President's Commission on Mental Health. Its members are broadly representative of Hispanic mental health, drug and alcohol abuse experts drawn from among our membership and working in research, training, and service delivery areas in our communities.

The principal concern among Hispanic communities -- and one shared by other minorities and the poor -- is to strengthen the Mental Health Systems Act so that it fully and explicitly embodies the excellent work and spirit of the President's Commission on Mental Health, in particular as the recommendations of that Commission address underserved minority and special populations. In order to strengthen the Act where the current text is now weak or vague, we are requesting the addition of specific legislative or report language in various critical areas. Such language is a crucial first step in assuring that the issues and concerns confronting Hispanics, other minorities, and the poor will be accounted for in subsequent community mental health program regulations, guidelines, and implementation. Such language also provides a clear measure of accountability in these programs to Congressional intent. Moreover, we feel strongly that Hispanic and other minority provider and consumer input should be included in the development of the Federal regulations and guidelines that will guide the implementation of community mental health legislation as passed.

Specifically, new mental health systems legislation should incorporate the following points.

Provisions for Bilingual/Bicultural Services

Provisions should be added to require that where a substantial number of the population to be served are of limited English-speaking ability or are bilingual and bicultural, programs and projects funded under the Act shall provide, or make arrangements to provide, services in appropriate language and cultural contexts, and that such services shall be staffed by appropriate bilingual and bicultural personnel who will help plan, deliver, and assess

the services as well as provide guidance to others with respect to cultural sensitivities and bridging linguistic and cultural differences.

Without this clear assurance, the Act would represent a step backward for Hispanics and other bilingual/bicultural minorities from the protections found in existing law (P.L. 94-63) and from similar assurances recommended by the President's Commission on Mental Health (Vol. I, page 21 of the Final Report).

Strengthening the State Role

Provisions aimed at strengthening the State role in planning, coordinating, and delivering mental health services to communities should include specific measures to assure State compliance with national mental health priorities for minority and special populations. In monitoring and enforcing compliance, HEW's Office of Civil Rights should develop a strong, vigorous component in the mental health field similar to that in education.

Congressional leadership and local autonomy have been significant mechanisms by which Hispanics, minorities, and the poor have been able to have impact on mental health services in their communities. Past experience has shown that, historically and structurally, State mental health authorities have tended to be non-responsive to the needs of Hispanics, minorities, and the poor. These authorities tend to be the least developed entities in knowing our needs, our social and cultural resources, and our aspirations. For example, at State and subState levels, how many Hispanic and minority Commissioners are there, how many are there at critical policymaking, planning, and service delivery points in these systems?

We favor deletion of the Title V authority which might be utilized as a first step in routing all mental health funds through centralized State mental health authorities. At present, the commitment of States is elsewhere than to community mental health: in most States support for State institutions has not corresponded to the decrease in patients in State hospitals, and mental health budgets continue to favor institutional over community-based care. Such State control would diminish or damper local autonomy which has been a key element in delivering appropriate services to Hispanic and minority communities. Moreover, given the limited mental health dollars available, it makes little sense to pass Federal funds through another bureaucratic level and, after overhead charges are deducted, have less available for services.

In other sections of the bill addressing the State role, the following are points we urge you to consider. Our concern here is that, without strong inducement, States may do a little more in these areas, but we will not have a consistent programmatic effort toward solving our problems.

-- States should be mandated to collect, analyze, and report data on racial, ethnic, and special populations. State data systems should be cross-tabulated in such a way that data can be retrieved on specific racial and ethnic subgroups and on special populations within these subgroups.

Hispanics have long known that because we have been miscounted, uncounted, or undercounted, we have been discounted. If we do not exist in the data systems, we are not considered in the planning process, or at least our needs are not thus legitimatized. The result is that equitable resources do not flow to our communities. It is crucial that we be specifically identified and accounted for in

the planning structure, so that we will exist as far as the present and the future are concerned.

-- Input from minority/Hispanic providers and consumers should be required in the development and review of State mental health plans. Special technical assistance will be needed to insure active citizen and consumer involvement. Moreover, such plans should include a culturally relevant assessment of needs and a more realistic assessment of minority community resource capability in order to provide a clear direction for priority efforts.

-- States participating in pilot prevention programming should be required to direct a significant portion of their effort toward the primary prevention needs of underserved minority and special populations. For Hispanics, emphasis in this area on community education programs and on programs for children and families is especially significant, given the youthfulness of our population, its rapid rate of increase, and the disproportionately high numbers of low-income Hispanic families with children living in hazardous environments in major U.S. metropolitan areas. Closer attention and study should also be given to agricultural migrant worker families and children who often lack basic community support systems because of their seasonal migration patterns, as well as rural families in isolated areas which usually lack adequate resources. Strategies must be developed to integrate them and their needs into the mainstream of policy, research, and service planning.

Services Funding

There should be some mechanism to provide continued support for the

"graduate" community mental health centers, especially those in designated poverty areas which have taken their commitment to community mental health seriously, but now are struggling financially to survive and maintain quality services. In these areas -- many of which contain major concentrations of Hispanics and other minorities -- it is becoming evident that local communities and State agencies cannot realistically pick up the costs. Without some continued Federal support, these areas will revert to an unserved or underserved status, the investment of past years will be lost, and most importantly, the needs and expectations of the people will be neglected. It makes little sense to assure continued support for consultation and education services which generate service referrals and increased utilization if there are insufficient funds to provide services based on need, regardless of ability to pay.

Mechanisms for initiation and development grants may be regarded as a needed approach to enable minority and underserved communities to implement mental health programs sensitive to their own as well as to Federal and State priorities and commensurate with their resources. Currently, many of our communities may not yet have the capability, but do have the potential and the interest, to develop needed comprehensive mental health services or to develop the kinds of mental health services not available in current systems. Both financial and technical assistance are required to foster such expertise at the local level. For this reason we are especially concerned about the low Hispanic representation on ADAMHA staff in the Regional Offices. In five of these Offices serving areas with significant Hispanic concentrations (Offices headquartered in New York City, Chicago, Philadelphia, Seattle, and Kansas City), there are no such Hispanic staff. Yet the knowledge, skills, and expertise they would provide is crucial in offering appropriate and relevant technical

assistance to Hispanic community groups that will seek and utilize the proposed initiation and development grants.

We also feel that such grants should not be limited only to entities serving areas with no community mental health center. Studies have indicated that often such centers have not failed to provide adequate services to Hispanics and other minorities. Our communities should be able to compete for such grants even in areas with community mental health centers if it is evident that such centers cannot deliver appropriate mental health services to our populations.

Finally, the inadequacy of current service funding schemes is nowhere more dramatic or cruel than with regard to hope for improving community options in caring for the chronically mentally ill and for minorities as eloquently documented by the President's Commission. Other witnesses before this subcommittee have pointed out that solutions cannot be realistically devised without wide-ranging proposals for changes in a variety of Federal and State assistance programs. Yet until these remedies are provided, it is Hispanics, minorities, and the poor who bear the disproportionate impact of the problem. Significant proportions of these populations are still in institutions, are re-ghettoized in inadequate facilities in the community, or soon after their release from institutions must return to them because their communities have fewer resources to set up and maintain the required mental health and social support systems. Both economic and social support incentives should be provided to enable families, relatives, or friends to care for and maintain the chronically mentally ill in their own homes if they so choose. This is particularly important for Hispanics because of our heritage of emphasis on family supports.

Public policy in this regard should be modified to account for social and cultural forces and preferences in diverse communities.

Stronger Focus on Services, Research, and Training

The Act would be further strengthened by mandating change in the lead Federal mental health agency -- the National Institute of Mental Health. A stronger focus on minority mental health training, research, and services development, as envisioned by the President's Commission, would be provided by incorporating into the bill proposals to establish such a position as an Associate Director for Minority Mental Health Concerns within NIMH and to provide adequate funding for its program support and activities in the areas of training, research, and services programming.

Our pressing need now is for concerted, sustained action. If Hispanics and other minorities are to develop and provide appropriate mental health services to our communities, we must increase our number of trained mental health workers, both service and research personnel. Yet despite our well documented needs, institutional response has been slow, fragmented, and uncoordinated. Overall, what response there has been lacks a deep sensitivity to the gravity of our situation and a sensitive, comprehensive strategy to resolve it. The flow of dollars is one clear measure of commitment. For example, the NIMH Center for Minority Group Mental Health Programs, in operation for the past seven years, has made some progress, but it has been hampered by minimal staff and financial resources. As the Hispanic Panel on Mental Health of Hispanic Americans pointed out in its report to the President's Commission, research is one case in point. In 1976, the Minority Center processed 53% of all minority-relevant research grant applications submitted, but received only

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4% of the Institute's funds. As a result, it was able to fund only 16% of submissions whereas NIMH funded 25% of all submissions during the same period.

We thus urge that there be established a clear focal point and mechanism to increase, coordinate, and sustain institutional and programmatic responsiveness in NIMH. Similar efforts in the other ADAMHA Institutes -- NIDA and NIAAA -- also are needed to strengthen the minority focus in these mental health related fields.

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The Honorable Edward M. Kennedy
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Dear Senator Kennedy:

On behalf of COSSMHO--The National Coalition of Hispanic Mental Health and Human Services Organizations, we are requesting that in the proposed new Community Mental Health Systems Act (S. 1177), specific language be added requiring that programs and projects to be funded under this Act provide bilingual/bicultural services in areas where there is a substantial number of persons with limited English-speaking ability or persons who are bilingual and bicultural.

To our knowledge, the Administration's draft bill in this regard contains no such explicit assurances addressed to the service needs of millions of our citizens who are members of bilingual/bicultural minorities. This omission is clearly counter to the recommendations of the President's Commission on Mental Health (PCMH Report, Vol. I, p. 21) and is a step backward from the assurances found in existing law (P.L. 94-63) which recognizes the critical need for and the importance of providing services in appropriate language and cultural contexts. Unfortunately, our past experience has shown that even under the mandates of P.L. 94-63, compliance by the community mental health centers system has been spotty; however, such language has been an important instrument for inducing some accountability on the part of the centers to the needs of bilingual/bicultural U.S. citizens. Nor does our past experience lead us to expect that we can safely assume that attention to the bilingual/bicultural services issue is implied and will be given in practice without a Congressional mandate.

We recommend that the following language be considered for inclusion in this proposed new legislation: "Where a substantial number of the population to be served are of limited English-speaking ability or are bilingual and bicultural, bilingual and bicultural services shall be provided and shall be staffed by appropriate bilingual and bicultural personnel at service delivery and planning levels."

Thank you for your consideration of this important issue.

Sincerely,

Rodolfo B. Sanchez

Senator KENNEDY. Mr. Tajima?

Mr. TAJIMA. My name is Mark Tajima. I am the Washington Coordinator of the Pacific/Asian Coalition, a national organization of Americans of Asian and Pacific Islander descent. Mr. Chairman, I thank you for providing us with the opportunity to testify before your subcommittee today. It is very rare that Asian and Pacific Americans receive an opportunity to testify on matters of concern to our community.

PAC is a national coalition of Asian American and Pacific Islander groups which include a wide variety of ethnic groups. It includes Japanese, Chinese, Korean, Filipino, various Indochinese populations, Asian Indian, Guamanian, native Hawaiian, American Samoan, and a number of other groups. Asian/Pacific Americans constitute a very diverse heterogeneous population which is rapidly growing in number.

Like the Hispanic community, a large proportion of our population is limited English-speaking and foreign born so we have a special need for bilingual and bicultural services.

I am testifying before you today because too rarely is our population adequately serviced by the current mental health delivery system in the country today. The mental health needs of our communities are very extensive; in particular the Indochinese populations face special problems and difficulties in terms of adjustment to the United States. Very few, if any, community mental health centers are well equipped to deal with the Indochinese refugee problem.

In terms of the bill, PAC strongly endorses the bill's findings and objectives with respect to the need to provide better community-based services to underserved, unserved, and inappropriately served populations.

But PAC generally feels that the bill is very vague in terms of how to carry out the objectives. We have many doubts as to whether the bill, in its present form would address the needs of minority populations.

For one, we are concerned about the lack of specific language in the bill which addresses the needs of bilingual, bicultural populations. The 1975 act did include specific language which would require CMHC's to address the needs of limited English-speaking persons.

But this act does not have any explicit assurances that the mental health needs of limited English-speaking persons would be met. We would strongly urge you to add specific provisions which would strengthen S. 1177 in that respect.

One recommendation of the President's Commission on Mental Health which we strongly endorse is that mental health service programs, and I quote, "should actively involve ethnic and racial minorities in planning and developing services, provide culturally relevant services and staff them with bilingual, bicultural personnel and to contract with minority community-based organizations for the delivery of services."

Mr. Chairman, if this recommendation is implemented by the act, we feel it would go a long ways in addressing the needs of the Asian/Pacific American population.

In the area of prevention of mental illness, we feel that, prevention should be a high priority, and that preventive strategies should be directed at high risk populations such as immigrant and refugee populations which encounter special mental health needs.

As Mr. Sanchez said, with respect to the Hispanics, many Asian American/Pacific Islanders underutilize mental health services. For one, if you do not speak English, you would never know that the community mental health center exists.

I think there is a strong need for more Asian American mental health professionals, who would be more sensitive to the cultural, characteristics of Asian Americans, and be able to build a rapport with Asian American clients.

In terms of mental health planning and needs assessment, too often, due to our small numbers in many areas, the mental health needs of Asian Americans and Pacific Islanders are neglected. Like Mr. Sanchez stated there is a need for State planning to identify the availability of bilingual, bicultural services.

There is also a need for needs assessments of the mental health of minorities to include more than just utilization rates and incidence data, as Asian/Pacific Americans have historically failed to use mental health services which community mental health centers provide. Thus, if you used incidence data, you would come away with a determination that few needs exist when, in fact, there is a substantial latent demand for services which is not manifested in incidence data or utilization rates.

PAC also believes there is a strong need for cross catchment area service delivery for special populations. For example, due to the resettlement process, Indochinese refugees have been pretty much scattered throughout various metropolitan areas. In most catchment areas they are relatively small in number. So that few community mental health centers have the capabilities to address their needs. What is needed is a community-based, one-stop center which would provide services to Indochinese refugees across different catchment areas.

In terms of title IV, "Community Mental Health Services," we are extremely concerned about language in the section 402 initiation grants. We had originally viewed such grants as an effective way of facilitating the development of minority community-based service delivery.

But the language in the bill, at present, places a preference on initiation grants being allocated to areas not currently being serviced by community mental health centers. Most Asian Americans and Pacific Islanders in this country reside in urban areas where such centers exist—the problem being that such centers do not currently adequately service Asian Americans and Pacific Islanders. PAC urges that such a preference be struck from the bill in order to enable community-based organizations in our communities to qualify for section 402 initiation grants to deliver services.

We do support section 404 of title IV which would facilitate the integration of mental health and general health care programs. Many Asian Americans, when they have mental health problems, will not go to a mental health center, but will go to their physician and seek health care; and, in the process, discuss their mental

health problems. The integration of mental health and health care programs would be a big step forward.

As Mr. Sanchez mentioned, there is an extensive need for improved monitoring and enforcement activities to insure that community mental health centers and States meet their responsibilities to address the mental health needs of special populations. The National Institute of Mental Health employs few Asian Pacific Americans—even in regions such as region IX with a large Asian Pacific American population. NIMH has few bilingual and bicultural personnel who can assess whether CMHC's are adequately servicing Asian Pacific Americans.

In terms of training and research, as you mentioned in your introductory statement, there is very little in the bill addressing the training needs of minorities in the mental health field. PAC strongly recommends that additional language be added to the bill which would increase the training of minority mental health providers.

In addition, the payback requirements in title VII, section 633, should be modified to permit flexible payback service by minority recipients of traineeships. Minority trainees with bilingual and bicultural skills should be permitted to fulfill their obligated service requirement through serving bilingual and bicultural clients regardless of whether they are working in geographic areas without overall personnel shortages.

Oftentimes, the obligated service requirement has been aimed more at rural areas, ignoring the shortages of bilingual/bicultural mental health professionals in urban areas without overall personnel shortages.

I conclude my presentation by stating that PAC supports the Associate Director of Minority Concerns provision which Senator Inouye has proposed, provided that adequate funding and personnel support be allocated to the position of Associate Director.

We believe that without moneys earmarked for minorities and without an office which is looking out for minorities within NIHM, our mental health needs would continue to be not addressed.

Thank you for the honor of appearing before you, and I would be happy to answer any questions.

[The prepared statement of Mr. Tajima follows:]



PACIFIC/ASIAN COALITION

The first national coalition of Asian Americans and Pacific Island Peoples for human services and action

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THE MENTAL HEALTH SYSTEMS ACT (S. 1177)

before the

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

of the

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

JUNE 11, 1979

A VOLUNTEER ORGANIZATION

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Mr. Chairman and Members of the Committee:

My name is Mark Tajima. I am Washington Coordinator of the Pacific/Asian Coalition (PAC), a national organization of Americans of Asian and Pacific Islander descent. Mr. Chairman, I thank you for providing me with the opportunity to testify before your Subcommittee on a matter of great concern to Asian and Pacific Islander Americans.

PAC is a national coalition of Asian/Pacific Americans with a network of local affiliate groups scattered throughout the United States. PAC has a strong interest in mental health issues, and, since its founding in 1973, PAC has received a number of grants from NIMH to address the mental health needs of Asian/Pacific Americans.

I would like to preface my remarks on the proposed Mental Health Systems Act by stating that Asian/Pacific Americans are a rapidly growing, heterogeneous minority group whose mental health needs are currently neglected by the mental health system. Asian and Pacific Islander Americans include three to four million Americans of Chinese, Japanese, Korean, Pilipino, Asian Indian, Thai, Burmese, Laotian, Cambodian, Vietnamese, Hawaiian, Guamanian, and Samoan descent.

A significant proportion of Asian/Pacific Americans are newcomers to the United States who must contend with multiple problems of culture shock, language barriers, and role and status reversal. Mr. Chairman, as you are well aware of, mental health is a pressing need among refugees from Southeast Asia. The trauma from their hazardous flight from Southeast Asia, grief over lost loved ones, isolation and loneliness due to family separation and dispersal during resettlement, fears and anxiety over an uncertain future, plus the difficulties of cultural adjustment combine to create substantial mental health problems among the refugees. In sum, not unlike other racial minorities, Asian and Pacific Islander Americans are either unserved, underserved, or inappropriately served by the nation's mental health system.

Mr. Chairman, I will now briefly comment upon S. 1177 in relation to Asian/Pacific American mental health needs.

I. FINDINGS AND PURPOSE

PAC strongly endorses the bill's findings and objectives with respect to the need "to develop community-based services for unserved, underserved, or inappropriately served populations, especially children and youth, the aged, the chronically mentally ill, racial or ethnic minorities, poor persons, and persons in rural areas.

We are concerned about the absence of specific language in the bill which addresses the barriers to mental health service delivery for limited English-speaking and bicultural persons. In order for the bill to adequately address the mental health needs of Asian/Pacific Americans--many of whom are foreign-born and limited English-speaking--explicit assurances must be provided for the planning and delivery of culturally relevant services staffed by bilingual and bicultural personnel. Asian and Pacific Islander Americans--like Hispanics--require the availability of bilingual and bicultural services in our communities.

I would point out that the PCMH recommended that "mental health service programs should: a) actively involve ethnic and racial minorities in planning and developing services; b) provide culturally relevant services and staff them with bilingual, bicultural personnel; and c) contract with minority community-based organizations for delivery of services" (PCMH Report, Vol. I, p. 21). From our perspective, it is crucially important that S. 1177 effectively implement this recommendation.

II. TITLE II - PREVENTION OF MENTAL ILLNESS

PAC would recommend that Section 201 be amended to specify that project grants be targeted towards high risk populations. It is also important that prevention strategies include bilingual/bicultural components. Culturally relevant prevention efforts are a high priority for Asian and Pacific Americans who are often reluctant to seek mental health services until their problems become acute.

III. MENTAL HEALTH PLANNING AND NEEDS ASSESSMENT

The bill's language concerning needs assessments in the mental health planning process requires strengthening. Section 602 of Title VI should be amended to specify that the needs of racial minority groups be assessed. Furthermore, any assessment of the availability of mental health services should take into consideration the availability of appropriate services. For limited English-speaking persons, appropriate services should mean the availability of bilingual and bicultural services.

PAC is also concerned that needs assessments be based upon more than past incidence data or utilization rates. Such indicators underestimate the need for mental health services among traditionally unserved, underserved, and inappropriately served populations of which Asian/Pacific Americans are one. To plan mental health service delivery on the basis of incidence data, alone, would perpetuate inequities in the provision of mental health care.

Finally, state plans should be required to pay close attention to the need for cross catchment area service delivery for special populations. As noted in the PCMH, low volume, highly specialized services oftentimes cannot be practically delivered by each CMHC. In many parts of the country, Asian/Pacific Americans are dispersed over several catchment areas. To service such populations, we believe it would be more efficient to contract with a community-based organization to deliver appropriate services. The Indochinese refugee population constitutes one group for which cross catchment area service delivery would be desirable.

IV. TITLE IV - COMMUNITY MENTAL HEALTH SERVICES

PAC strongly supports Title IV's purpose of improving mental health services for groups with special needs, including racial or ethnic minorities.

We are concerned about the bill's current language which states that preference for Section 402 initiation grants be given to entities serving mental health service areas which have no community mental health center servicing it. Such language would mean that Asian/Pacific Americans would not benefit from Section 402 grants

which are intended to initiate services for the underserved because the vast majority of Asian/Pacific Americans reside in urban areas with CMHCs.

I would point out that studies have indicated that CMHC's have generally failed to provide adequate services to Asian/Pacific Americans as well as to many other special population groups. We would strongly recommend that Section 402 grants be made available on an equal basis to initiate services to underserved groups in areas with CMHC's, if it can be demonstrated that the CMHC has failed to provide adequate services to such groups.

We would also recommend that the bill provide for the utilization of Section 402 grants to support cross catchment area service delivery to underserved groups requiring low volume, highly specialized services.

Finally, PAC supports Section 404 of Title IV which would facilitate the integration of mental health and general health care programs.

V. MONITORING AND ENFORCEMENT ACTIVITIES

Greater emphasis should be placed on ensuring that CMHCs address the mental health needs of minorities. Without adequate monitoring and enforcement, statutory provisions, protecting the access of minorities to mental health care, are meaningless. Community representatives should be included in NIMH's site visits of CMHCs. For CMHC's servicing substantial numbers of limited English-speaking persons, bilingual and bicultural monitors should be included in site visits.

VI. TRAINING AND RESEARCH

Mr. Chairman, PAC greatly appreciates your concern for the need to train more minority mental health professionals and to expand the knowledge base on the special mental health needs of minorities. We would hope that the bill be amended to include provisions aimed at encouraging the training of minority mental health personnel as well as to increase the extent of research on minority populations.

In addition, the payback requirements in Section 633 of Title VII should be modified to explicitly permit flexible payback service by minority recipients of traineeships. Minority trainees with bilingual and bicultural skills should be

permitted to fulfill their obligated service requirement through serving bilingual/bicultural clients, even though the service may be performed in geographic areas without overall personnel shortages.

Gentlemen, it has been an honor for me to appear before you, and I will be happy to answer any questions.

Senator KENNEDY. Thank you very much for your statement. I just have a few questions, and then I will recognize Senator Inouye for his statement. All of your statements will be printed in the record along with the other materials requested.

Dr. Collins, you described a limited acute care psychiatric unit within the private hospital system. I am wondering what you might be able to tell us of the kinds of incentives that would allow that unit to become better integrated with the public health care sector and thus begin to address the issue of two standards of care which is of concern to us.

Dr. COLLINS. Yes, sir. I think it should be pointed out that in Washington perhaps the greater percentage of poor and black patients are not treated by black psychiatrists because of the inequity in numbers, so that in our unit, and other units in town, we would have to encourage majority or nonblack or nonminority psychiatrists to become sensitive to the needs and concerns of this population to do something to eliminate the inequity in reimbursement since we are talking about encouraging private practitioners to take an increasing number of patients who cannot afford to pay the current rates.

So I think the change in their attitudes, their perception of need and doing something to modify the inequity in reimbursement would be helpful.

Senator KENNEDY. Have they started that sort of effort to try to get that degree of cooperation?

Dr. COLLINS. We have in a very small way.

Senator KENNEDY. What could you suggest to us with regards to prevention and minorities? We had our first really significant legislation a year ago on disease prevention, and there is increasing appreciation and support for those efforts. What could you suggest to us that might be effective in trying to address this particular area of public policy as it affects blacks and other minorities?

Dr. COLLINS. I think we have to think of mental health or mental disease in two areas—those areas that have to do with biochemical and metabolic abnormalities or congenital defects or what have you, and research and prevention would have to continue in developing drugs and understanding of basic medicine that presents with psychiatric symptoms.

The second category would be those conditions which could be thought of as environmental, those factors within our environment that tend to be associated with what has been defined broadly as mental disease such as drug and alcohol misuse.

Certainly, NIMH has done a lot to begin to reverse the trend by making education, by making materials available to high school teachers, to the general population about the dangers of those conditions, and they have begun to show some effect.

In the area of stress and hypertension or other environmental factors that produce stress and depression in our populations, we would have to think of many of the factors that contribute in the environment so it would be broader than just mental health. I think that both of those areas would be critical and necessary.

Senator KENNEDY. Dr. Russo, you made an excellent statement about the role of women. I am wondering, with the change of the role of women in our society, and as women move into the job market and more positions of influence, whether this is bringing new stresses, new tensions, new needs? Or does it bring less because now some of the barriers of discrimination are being broken down? What can you tell us?

There has been a dramatic change, obviously, in the role of women in our society. I am just interested whether that is relieving tension or anxiety or adding to it and how we ought to be sensitive to it.

Dr. Russo. I wish I could give you an answer to that question based on data, but, unfortunately, we have not had the research efforts that would enable us to answer that question in an informed way.

Whether or not the increased and rapid changes in the roles of women cause stress or if those changes are themselves ways to alleviate the stress that the traditional role creates because it is no longer adaptive in this changing society is a major controversy.

If you look at the kinds of things that are associated with the rates of mental illnesses such as depression, you find that the state of marriage, as it is traditionally formed, appears to be associated with higher rates of mental illness for women than for men, and mental illness seems to be associated with increasing numbers of children.

Now, is that because there was something wrong with the traditional state of marriage? I would not say that. However, it is clear that there is something going on in today's society that makes our traditional roles associated with things that we define as mental illness.

We do not really know enough about the changes in employment opportunities and so on to know what kinds of new problems that those might create. We do know that our providers are not helping us understand the problems. We need more data.

Senator KENNEDY. Also in the area of prevention, is there anything that you could help us with in terms of good programs that are working for women today?

Dr. Russo. Well, the first thing I would suggest is that, again, in picking up the theme of some of the other people, you have to be really explicit in your legislation. It will take a legislative mandate to get people to look at these problems.

I think you are going to need a component that will be explicitly directed toward having competent professional experts in sex bias and sex role stereotyping and so on to look at these problems.

We need our research efforts to be directed toward understanding about how social roles create stresses. We have had a tradition of mental health education that teaches people to look inside the person for problems, and this is the orientation of the providers.

We have got to teach our providers to look at how people's strengths and weaknesses interact with the kinds of support systems in the environment to promote mental health or reduce mental illness.

We need to develop programs that will intervene and build adaptive strengths and competencies, and we need good evaluation data so that we can make all mental health programs accountable.

Senator KENNEDY. Mr. Sanchez, last year I visited the El Centro Mental Health Center in east Los Angeles. As a matter of fact, that is the second time I visited. That center got started on extremely limited resources, and it seems to have—obviously in only a few hours you can gain some central impressions—enormous value and meaning for members of the community.

What could you advise us as to ways that similar kinds of centers could be developed in other Hispanic areas?

Second, there has been a concern expressed by other members of the panel that, as we move more decisionmaking from HEW to the States, the underserved and minorities will get a smaller share of the resources, because generally they are, in quotes, "less powerful."

Do you look at it quite the same way? Maybe you can take a crack at both of those.

Mr. SANCHEZ. I will attempt, sir. First of all, El Centro is a member agency of COSSMHO. It took many years to develop this center. First, it started out as an intern program for social workers out of UCLA and USC.

It was not established as a center because the State recognized that there was a need. It was just that because of our numbers and the visibility we are getting by being projected as the largest minority within the next two decades, something had to be done. What really brought the center about were people working simultaneously with NIMH to get the necessary funds, because that money did come directly from the National Institute of Mental Health. In short, it took Federal intervention and Federal assistance, because the State had not done it.

When you are asking if minorities would have fewer resources if the States were to have more authority, one can look back and see that the States historically have never given mental health, the priority that it has been given nationally. Also, minorities at the State level lack leadership positions where they can make policy and allocate funds.

Assurance and protection by the Federal Government, the whole idea of civil rights, where did it come from? It came from the Federal Government's intervention. Why? Because the States had failed in this responsibility.

With regard to your question about the migratory patterns of Hispanics, I think that we are going to have to get some new data. Hispanics are now all over this country. I am amazed myself at this. There are Hispanics in large numbers in communities like Gary, Ind., in Minnesota, and all along the eastern seaboard. Many

think that the Puerto Rican community is only in New York City. Well, now it is in Delaware, in Connecticut, New Jersey, Pennsylvania, and so forth. For example, we have 27 agencies that are members of COSSMHO in Pennsylvania alone, and few usually think that Hispanics are in Pennsylvania.

Like Ms. Russo and Mr. Tajima, I have said that if we do not have specific language in this legislation, it will not carry out the spirit of the report of the President's Commission on Mental Health. Mrs. Carter is to be praised for its good work, but, sir, in all honesty, this legislation in no way, in my opinion, represents the good intentions of the Commission.

Senator KENNEDY. One of the great dilemmas that I have seen over a period of time is that if we get a specific section of legislation—for example, the training of minorities in medical schools, and we define it with exactness and preciseness, it does not get funded. We do not get the money for it. It does not come out in the administration's budget, or we have trouble in terms of being successful on the floor or in conference in getting needed resources. We end up with crumbs. This is a legislative dilemma which we want to work out with you.

All of you are pros in the sense of understanding both the legislative process, and whether you have been successful or not. We want to deal, as you heard from my opening statement, with the issues and the problems that we are facing in helping minority populations.

Mr. SANCHEZ. I agree with you, sir. I do not think that we want the whole pie or that we are going to be unrealistic. I cannot speak for my colleagues sitting here with me, but I hope that they would concur 16 years ago when the Community Mental Health Centers Act was enacted, we were told, "We cannot be specific. We will take care of you." In fact, I heard there was a meeting at the White House last Thursday and some individuals were discussing this new Mental Health Systems Act, and they were saying to some minorities present, "Well, I do not know why minorities are all so disturbed. You know, we will take care of you." If they are going to take care of me the way they have been taking care of us, sir, I will do without it.

Senator KENNEDY. Well, we are going to hear from one of the Senate's most forceful and articulate spokesmen, my good friend Senator Inouye, in just a few minutes. He is on the Appropriations Committee and sensitive to the issues that we have been talking about. And I know his testimony and his activity and influence will be of enormous importance to us as we work together.

I just have a final question for Mr. Tajima, and then we will hear from Senator Inouye, and that concerns the participation of Pacific and Asian Americans in the community mental health centers program. Is the general reluctance to participate basically a matter of culture and language? Are there other factors? Specifically what can be done about it?

My own sense is that we have to develop outreach programs to try to bring in the people in the community, whether the program is a community mental health center or a drug program or a neighborhood health center. But I am interested in your views, and if you could just comment on that briefly.

Mr. TAJIMA. Well, it is partially cultural factors which lead to a reluctance among many Asian Pacific Americans to utilize existing mental health services, which need to be more culturally relevant as the President's Commission on Mental Health pointed out.

Second, community mental health centers generally have not conducted any outreach, in attempting to service our population. For example, the one community mental health center which did fold after their 8-year funding was terminated was the Resthaven Community Mental Health Center, located in the middle of Los Angeles' Chinatown. Before it folded, a number of Asian groups filed a suit against Resthaven for failing to effectively serve Chinese Americans even though Resthaven was located in Chinatown.

There is relatively little research on the responsiveness of CMHC's to Asian/Pacific Americans. However, one case study of mental health service delivery in Seattle, conducted by Stanley Sue, found that Seattle's CMHC's were generally ineffective in meeting the mental health needs of Asian Americans. In contrast, a community-based organization, Asian Counseling and Referral Service—located in Seattle's Asian community—was highly effective because of its location, use of bilingual/bicultural staff, and community outreach efforts. In one year, it served more Asian American patients than 17 community mental health centers did over a 3-year period.

I think one important point that all of the panelists made is the need for greater prevention efforts with a significant proportion of prevention being community education and outreach. If this is done, you could see a higher utilization rate.

Senator KENNEDY. OK. We want to thank you very, very much for very, very helpful testimony. If my colleagues have questions, we will have them submit them to you. It has been very, very useful, and what we would like to do is work with you on specific language to achieve some of the points you made. I will ask our staff to follow up with you, all of you, on these points to see what can be done to deal with them legislatively. You might give some thought to that.

Thank you very much.

We welcome a distinguished colleague and a good friend, and as I mentioned earlier, a Member of the Senate who has been a real leader in the whole area of mental health legislation, primarily as it has affected Pacific Asians and members of minorities. He introduced legislation last year. I was glad to cosponsor that legislation. He has also been of great service on this issue on the Appropriations Committee.

Senator Inouye, we welcome you here. We look forward to your testimony.

STATEMENT OF HON. DANIEL K. INOUE, A U.S. SENATOR FROM THE STATE OF HAWAII

Senator INOUE. Mr. Chairman, I am most privileged to be here, and I am most grateful for your generous introduction, and like others, I wish to commend you for your efforts to improve the mental health services of this country.

A few weeks ago, I introduced S. 925 which would amend the Community Mental Health Centers Act of 1963 to establish an

Office of Minority Concerns within the Alcohol, Drug Abuse and Mental Health Administration. This bill, S. 925, calls for the development and effective utilization of knowledge about the ability of our Nation's minorities to cope with and to adapt to the stresses of our society, and as you have mentioned, this bill is very similar to S. 2373 which I had the great privilege of cosponsoring with you, sir.

Mr. Chairman, minorities presently represent approximately 20 percent of America's total population. Unfortunately, all indications are that these individuals continue to suffer from the stresses of prejudice and racism. Their income levels, housing conditions, educational attainments, and health predictors are substantially below those of our Nation as a whole. Many experts also continually emphasize that, although there is a disproportionately high level of schizophrenia, alcoholism, and drug abuse in these populations, the actual number of minority mental health professional and behavioral scientists remains distressingly low. I might also add that there is an urgent need for increased mental health services to Native American Pacific Islanders and in my State of Hawaii, native Hawaiians in particular.

Mr. Chairman, it may be of interest to you, sir, that today is the birthday of King Kamehameha. Kamehameha the Great is one of the great warrior kings of the Pacific kingdoms, and according to eminent anthropologists and social scientists, before the coming of the white man, there was no evidence of mental disorder, mental stress or mental illness in the Hawaiian Islands. [Laughter.]

Today, the University of Hawaii Medical School—

Senator KENNEDY. It did not have anything to do with the introduction of the Mai Tai, did it? [Laughter.]

Senator INOUE. It helped, sir.

As I was saying, sir, the University of Hawaii Medical School today serves the entire Pacific Basin which is Guam, American Samoa, the Commonwealth of Northern Marianas, and the U.S. trust territory in providing health and medical training and services including mental health programs.

I am especially pleased with our medical school's 1-year remedial premedical studies program for minority students of educationally disadvantaged backgrounds. Eighty-five percent of the students presently enrolled in the program are from the Pacific Basin.

In 321 community mental health centers surveyed by the National Institute of Mental Health, minorities represented less than 7 percent of the full-time staff positions. The 1970 census also shows that of 12,749 psychologists in this country, only 312 were black; only 17 were Hispanic; only 7 were American Indian and only 182 were Asian.

Of the 20,084 psychiatrists, 1,000 were Asian; 386 were black; 74 were Hispanic; and there were no American Indians in this field.

Although I originally intended to establish an Office of Minority Concerns within the Alcohol, Drug Abuse and Mental Health Administrations as stated in S. 925, I feel that at this time the designation of an Associate Director for Minority Mental Health would be most appropriate. This proposal, I believe, is consistent with one of the specific recommendations contained in the President's Commission on Mental Health report.

Further, I have received the active and vocal support of representatives of each of our Nation's ethnic minorities and the major mental health professions. Again, Mr. Chairman, your personal assistance in highlighting this special concern is deeply appreciated by all, sir.

Thank you very much.

[The prepared statement of Senator Inouye follows:]

TESTIMONY OF SENATOR DANIEL K. INOUE BEFORE SUBCOMMITTEE
ON HEALTH AND SCIENTIFIC RESEARCH, COMMITTEE ON LABOR AND
HUMAN RESOURCES -- JUNE 11, 1979

Mr. Chairman, I am most pleased to be here today to express my strong support for the designation of an Associate Director for Minority Concerns within the National Institute of Mental Health. I wish to commend you on your efforts toward improving the mental health services of this country.

On April 9, 1979, I introduced S. 925, which would amend the Community Mental Health Centers Act of 1963, in order to establish an Office of Minority Concerns within the Alcohol, Drug Abuse, and Mental Health Administration. S. 925 calls for the development and effective utilization of knowledge about the ability of our nation's minorities to cope with, and adapt to, the stresses of our society. As you know, last year, you and I jointly introduced S. 2373, which is extremely similar to S. 925.

On May 8, 1979, I introduced amendments to the Comprehensive Alcohol Abuse and Alcohol Prevention, Treatment and Rehabilitation Act; and the Drug Abuse and Treatment Act, S. 440 and S. 525, respectively. These amendments provide for the designation of an Associate Director for Underserved Populations within the National Institute of Alcohol Abuse and Alcoholism (NIAAA), and

the National Institute of Drug Abuse (NIDA). The office that would be created with the designation of an Associate Director will develop and coordinate prevention, treatment, research, training, and administrative policies and programs to assure increased focus on minority and other underserved populations. I feel that it is especially important that research, training, and delivery efforts be coordinated.

S. 440 and S. 525 passed the Senate as amended, and have been referred to the House Subcommittee on Alcoholism and Drug Abuse.

Minorities presently represent approximately 20 percent of America's total population. Unfortunately, all indications are that these individuals continue to suffer from the stresses of prejudice and racism. Their income levels, housing conditions, educational attainments, and health predictors are substantially below those of our nation as a whole. Many experts also have continually emphasized that although there is a disproportionately high level of schizophrenia, alcoholism, and drug abuse in these populations, the actual number of minority mental health professional and behavioral scientists remains distressingly low. I might also add that there is an urgent need for increased mental health services to Native

American Pacific Islanders, and in my own state, Native Hawaiians in particular.

There are many reasons why I feel that it is appropriate now to focus on minority concerns, for example, the University of Hawaii Medical School serves the entire Pacific Basin (Guam, American Samoa, the Commonwealth of the Northern Marianas, and the U.S. Trust Territory of the Pacific Islands), in providing health and medical training and services, including mental health programs.

I am especially pleased that in our Medical School's one-year remedial pre-medical studies program for minority students of educationally-disadvantaged backgrounds, 17 out of 19 students presently enrolled in the program are from the Pacific Basin.

In 321 community mental health centers surveyed by the National Institute of Mental Health, minorities represented less than 7 percent of the full-time staff positions. The 1970 Census also shows that of 12,749 psychologists in this country, only 312 were Black, 17 Hispanic, 7 American Indian and 182 Asian. Of 20,084 psychiatrists, 1,000 were Asian, 386 Black and 74 Hispanic. There are no American Indians in this field.

Although I originally intended to establish an Office of Minority Concerns within the Alcohol, Drug Abuse, and

Mental Health Administration (ADAMHA), as stated in S. 925, I feel that at this time the designation of an Associate Director for Minority Mental Health would be most appropriate. As you are aware, this proposal is not identical to the amendments I made to the Alcoholism and Drug Abuse bills (S. 440 and S. 525) in that I now feel we should specifically address the area of minority mental health.

My proposal addresses to some, what is a very minor concern, yet I believe it is one that definitely deserves recognition. The proposal is consistent with one of the specific recommendations contained in the President's Commission on Mental Health report. Further, I have received the active and vocal support of representatives of each of our nation's ethnic minorities and the major mental health professions.

Again, your personal assistance in highlighting this matter is deeply appreciated.

Senator KENNEDY. Thank you very much, Senator Inouye.

I think one of the points that ought to be made clear in the record is the very special role that the University of Hawaii plays in helping the Micronesians. This ought to be a national responsibility. I know that this has been something which is probably not as well understood in the mainland as it is, on the island where they know of the program and its effectiveness.

I do not know if there is anything more you would like to add on this or whether you might submit some additional information or whether Senator Matsunaga would comment on it, but I do want to say that I think you stated very clearly the nature of the problem and the job that needs to be done. We want to work very closely with you.

I more than welcome the attention and the stress that you have given to this issue, the importance that you placed on it in our own range of priorities, and we look forward to working with you.

Senator INOUE. I thank you very much. As you know, Mr. Chairman, although the laws of our land do not require it, we Hawaiians have always felt that there was a special obligation and a special kinship with the Pacific Islanders because of our insular nature, also some similarity ethnically, and even if it is a special burden on the taxpayers of Hawaii, we will continue to carry on this obligation.

However, I think it is high time that the Federal Government recognizes that it has a special obligation to American Samoans, to Guamanians, to Micronesians and the other trust islands.

If I may, sir, I would like to present to you two very prominent members of our community who have traveled far to be with you today and serve on this panel. The first is the chief of the division of mental health for the State of Hawaii, Dr. Denis Mee Lee.

The other is Dr. Gilbert Tanabe, who is the professor of psychology and acting chairman of the department of psychology, University of Hawaii, sir.

And lastly my distinguished colleague, he is also from Hawaii.

Senator KENNEDY. We welcome them, and we will now hear from Senator Matsunaga.

STATEMENT OF HON. SPARK M. MATSUNAGA, A U.S. SENATOR FROM THE STATE OF HAWAII

Senator MATSUNAGA. Thank you, Mr. Chairman. I am pleased to join with my colleague, Senator Inouye, in introducing this distinguished panel of witnesses who have traveled from Hawaii in order to testify before this subcommittee today on S. 1177, the Mental Health Systems Act, and S. 925, the Minority Concerns Act of 1979, and other mental health legislation pending before the subcommittee.

As you know, S. 925 proposes to establish formally an Office of Minority Concerns within the Alcohol, Drug Abuse, and Mental Health Administration of the Department of Health, Education, and Welfare. This proposal, which was originally introduced by Senator Inouye and myself during the 95th Congress, seeks meaningfully and affirmatively to address the often unique needs and problems encountered by our Nation's ethnic minority populations in obtaining necessary mental health services.

These needs and problems have been fully detailed in the "Task Panel Reports of the President's Commission on Mental Health" which were issued last year. Specific mention of the need for increased numbers of trained minority mental health professionals was also made in the "Final Report of the President's Commission on Mental Health," and I am very pleased to note that specific references to improve the delivery of mental health care to our ethnic minority populations have been made in the text of S. 1177.

I strongly believe, however, that the unique and diverse needs of our ethnic minority groups for greater numbers of trained minority mental health professionals, for more and better research into the mental health problems of ethnic minorities, and for improved community education on cultural diversity, ethnicity, and racism will be lost in the President's new mental health program initiative unless an office is formally established specifically and effectively to address these needs.

For the past 7 years, the Center for Minority Mental Health programs within the National Institute of Mental Health has administered a very modest but effective grant program aimed at these areas. However, limited funding and a great diversity of unmet needs have prevented the Center from making substantial overall improvements in the delivery of mental health services among our ethnic populations. In addition, throughout its existence, the Center has been an administrative entity with no specific legislative mandate or funding.

At present, our Nation's black, Hispanic, American Indian, Asian, and Pacific Island American populations comprise approximately 18 percent of our total population. However, it is a sad fact that a disproportionately large number of Americans who are members of these ethnic groups suffer from poverty, inadequate housing, health care, education, and unemployment, and experience higher rates of alcoholism, drug abuse, crime, and domestic violence than the American population at large. S. 925 would provide for a study of the part which racism plays in this disproportionate disadvantage, and how to develop systems to help minority populations to cope with the effects of racism.

No one can dispute the seriousness of the mental health needs of our ethnic minority populations in the light of these commonly accepted indices of social status and well-being. With the continued heavy influx of Asian, Hispanic, and Pacific Island immigrants into the United States every year, the current unmet mental health needs of our ethnic minority population will continue to increase dramatically with their dramatic increase in numbers unless a specific mandate is included in the Mental Health Systems Act to cope with this problem affirmatively.

Mr. Chairman, I appreciate having the opportunity to testify before the Subcommittee on Health and Scientific Research today on this most important issue. I strongly urge this subcommittee to review the unmet mental health needs of our ethnic minority population very carefully and to include the provisions of S. 925 as a part of S. 1177 when it is reported out of this subcommittee and the Committee on Labor and Human Resources.

Senator KENNEDY. We will certainly want to work closely with you in the final shaping of the legislation. There are excellent

provisions in the legislation which I was proud to be associated with and we want to work with you and Senator Inouye very closely in fashioning the ultimate version.

Dr. Lee, we would welcome whatever comments you would have.

**STATEMENT OF DR. DENIS MEE LEE, CHIEF, DIVISION OF
MENTAL HEALTH, STATE OF HAWAII**

Dr. LEE. Mr. Chairman, I am happy to join Senators Inouye and Matsunaga in support of this provision for an Office of Minority Concerns within ADAMHA. My responsibility in Hawaii is for the comprehensive community mental health system. It is one of the most extensive networks of mental health services administered by a State throughout the country.

I would like to assert at the outset that with the experience that we have gained in administering these programs throughout our State, the need for a clear national commitment to a specific effort which addresses the special mental health needs of minorities is of high urgency.

I believe the spirit of community mental health that was enunciated in 1963 by President Kennedy in initiating the Community Mental Health Centers Act, although it has spread tremendously throughout every corner of the country, has been inhibited in its complete fulfillment by a lack of clear commitment to understanding and responding appropriately to the needs of the minority populations.

The development of an office within ADAMHA would provide opportunity for a centralized fostering and coordination of the kind of research and training efforts, along with initiating those innovative services necessary to provide just that response which is needed at this time.

Hawaii presents a tremendous challenge for responding in a different way to the mental health needs of diverse populations. Someways it reminds me of the challenge that faced the original missionaries that traveled to Hawaii with a straightforward gospel and were required to mold and modify and tailor that gospel to meet the special needs of the peoples.

I think many of us in the mental health professions, researchers, and many of us who hear from consumers day by day are becoming increasingly aware of the need to tailor the traditional mental health gospel to better meet the specific and unique needs, and accommodate the very different values and concepts of minorities.

Hawaii is a State of minorities. There is no majority. The Caucasian group is the largest but represents just 27 percent of the population. A variety of other ethnic and cultural groups are distributed throughout the rest of the population.

The challenge that we are addressing in Hawaii today is to review from the ground up the way we provide mental health services and see how they might be redefined and revised substantially to meet those very special needs of the different population groups.

It is high time that we respond to the mental health needs as perceived by the native Hawaiians and the Pacific Islanders and have embarked upon a number of serious efforts to tailor our services appropriately. We have initiated an ethnocultural task

force which comprises representatives from 11 ethnic groups which are attempting to define the true mental health needs and how we might respond within the context of cultural values and norms.

The ethnocultural task force and the Hawaii Mental Health Division are anxious for a demonstration of a strong and concerted national effort and commitment to the special needs of ethnic populations. Together, we will be able to remold the service delivery system effectively to meet the needs of all the people of the country.

So, Mr. Chairman, I would want to only assert that we are strongly supportive of this proposition. We hope that it can be established and supported strongly so that we can look forward to new programs and new approaches which respond to minority groups.

I would be happy to respond to any questions.

Senator KENNEDY. Thank you very much.

Dr. Tanabe?

STATEMENT OF DR. GILFRED TANABE, PROFESSOR OF PSYCHOLOGY, UNIVERSITY OF HAWAII

Dr. TANABE. Thank you, Mr. Chairman.

A moment ago you mentioned the University of Hawaii. I am pleased to say that I brought along two pieces of written testimony, one on behalf of the School of Medicine, the University of Hawaii, and the other from the dean of the School of Public Health, also of the University of Hawaii.

I would like to note that Dr. Larry Koseki was also planning to make this trip. He is the deputy director of our State's department of social services. He got ill at the last moment and could not be here.

Briefly, I would like to make two points on S. 925 as it relates to, one, the training of minority health workers in our State of Hawaii, and, two, to the training of native American Pacific Islanders who reside in the broader Pacific Basin Area.

First of all, those of us who are in higher education in the State of Hawaii with its tremendously diverse ethnic population have been continuously concerned with the problems over very, very low enrollments of our local ethnic minorities especially the Hawaiians and the Filipinos in the professional schools of medicine, of psychology, of public health.

While our own local program efforts have targeted the enrollment of more minority students in these professions, we have still felt the need for leadership and coordination of mental health training opportunities at the national level as they might be reflected in altered guidelines for training grants and grants for research.

S. 925 will help in addressing the issue of under representation of Native American and Pacific Islander peoples in the mental health professions.

As for the Pacific Islanders, my second is related to Hawaii's role in the training of mental health professionals who come among the people who reside in the broader Pacific Basin Area. S. 925 will help to articulate and to make clear the Federal mandate and commitment to training of Pacific Islanders in the mental health

professions and support Hawaii's role in implementing programs to meet the needs of these people.

It is, finally, also our hope that S. 925 will help to make clear the distinctions between programs that are targeted for people of the Pacific Basin and those that are designed to help local minorities living in Hawaii as in the creation of formulas that would help to reduce the direct competition that we feel between these two groups of people for resources and health services training.

Thank you very much.

Senator KENNEDY. OK. We have heard a very interesting analysis of the problems of the minorities on Hawaii, with which we are becoming very familiar, at least in the Senate increasingly so, because of the work of Senator Inouye and Senator Matsunaga. We are enormously impressed with what is being done on the island itself and the way that those who have been interested in this issue have been able to convince both State officials and others of the importance of it and to take some very important responsibilities for it. We can learn a great deal from that experience. We are enormously grateful to all of you for your appearance here this morning.

Thank you very much.

We will have a panel on rape research, prevention, and services. Ms. Ina Lorton, director, Baltimore County Sexual Assault and Domestic Violence Center; and Dr. Martha Burt, research associate, Urban Institute.

STATEMENT OF MS. INA LORTON, DIRECTOR, BALTIMORE COUNTY SEXUAL ASSAULT AND DOMESTIC VIOLENCE CENTER; AND DR. MARTHA BURT, RESEARCH ASSOCIATE, URBAN INSTITUTE, A PANEL

Ms. LORTON. Mr. Chairman, as a rape victim, as a counselor who works intimately with sexual assault victims and as the director of a sexual assault crisis center, I am all too aware of the problems facing the victim of rape and of those facing the organization which would meet her emotional, physical, and legal needs.

It has become apparent to me that many of the issues of most concern to rape victims—appropriate medical care, sensitive and effective legal intervention and the secure and comfortable reintegration with her environment are becoming more familiar to the concerned lay person if not to the general public. The insensitivity, prejudice, and callousness with which previous generations treated the victim are not quite so prevalent today. There is lipservice, if nothing else, given by the media and by the providers of public safety and welfare to their responsibilities toward victimized individuals. We are hearing more frequently that it is the offender and not the victim who is accountable for the offense and that the act itself is one of violence and not of sex. We are also beginning to understand that the rape will affect the woman no matter how sexually experienced she may be; that it is an intrusion, a degradation, a violation, and a serious threat to her sense of self, safety, and well-being.

Although I am guarded in my language, I am convinced that these issues are becoming a matter of public record, if not yet a matter of public morality. What the public is not aware of, howev-

er, what has until now escaped legislative notice and what most American communities have not addressed themselves to is one of the most serious needs of victims. There has been virtually no recognition, except on the grassroots level of the responsibility of the larger community to provide ongoing assistance to victims of sexual assault. Perhaps as a vestige of those attitudes which condemn all female sexuality even those aspects which are beyond a woman's control or against her will, the Nation has not afforded these individuals the same concern, the same attention or proportionately the same share of the Federal or local dollar that is made available to other needed citizens.

As a result, the woman who has been forced to submit to the trauma of rape is further victimized by the very system which should be her primary support. The support services that she so desperately needs if she is to return to precrisis functioning are usually poorly staffed, ill-trained or ill-equipped or worse, totally lacking.

I want to share with you what I experience on a daily basis in trying to meet the emotional and physical needs of victims of sexual assault. My trials and tribulations, and satisfactions, are hardly unique, but rather they are all too familiar to the many other workers in the field. If anything, the temporary access that my center has had to funding has made our situation a far more encouraging one than those faced by other groups trying to provide similar services. As I speak, two other Maryland rape centers are floundering from lack of public support. Not only has the intense and sustained effort of concerned workers been unrewarded but the crisis level needs of those victims whom they serve go unrecognized and unmet.

A year and a half ago, I was hired to design and direct a program for Baltimore County's victims of sexual assault. Since local sources of guidance or direction were unavailable and there were not any precedents for an organization of this sort, my sole mandate—my sole mandate—consisted of a suggestion that I utilize a center operating in another county as my model to help victims. My staff was to be hired from the CETA pool and the physical plan for the center was to be contributed by a local hospital. I had been a volunteer for a rape crisis group; my 2-day training from them and my own firsthand knowledge of victims needs were my only directives. No one I knew had ever started or run a rape center. The literature available was scanty at best, inapplicable at worst, and the director of the other rape center was not freely available, although she had been awarded a small grant to provide technical assistance on a local basis. The National Center for Rape Control and Prevention, to whom I made my very first call on my new phone, was not able to provide the hands-on assistance I needed.

So functioning purely from intuition and determination, blissfully ignorant of any possible pitfalls, I developed procedures, begged and borrowed office furnishings, trained staff and established rapport with and elicited the support of the community.

The local CETA organization had agreed to provide seven workers. They could not assure that these individuals would have the educational level, the professional skills, and the intuitive concern, warmth, and sensitivity that the crisis center positions required.

Luckily, I was able to find individuals who met these characteristics. Again, more through luck than any conscious assessments of needs, we were able to develop a successful, serviceable organization.

A 24-hour-a-day hotline has now been established and approximately 50 new clients a month receive counseling, support, hospital and/or court companionship. Community education and the training of police and medical personnel are ongoing concerns. Although our center has proven itself to the community, established its credibility and served the misused and unhappy in a professional and caring manner, we have serious concerns about our ability to provide services past the end of this summer. The county has only been able to budget \$20,000 toward this center and revised CETA policies are forcing severe cutbacks in personnel. Workers lost through natural attrition are not being replaced, and our attempts to finding other sources of ongoing support have not yet been successful.

The only Federal agency which addresses the issue of rape directly, the National Center for Rape Control and Prevention, does not have any funds earmarked for direct service delivery. Other agencies which are willing to underwrite primarily volunteer groups do not service the kind of 24 hour, fully staffed organization that our community's needs demand.

Only by becoming a delegate agency of the Community Action Agency, a CSA grantee in our area, do we have any hope of assuring our continued existence. The regional office of this agency has looked unfavorably on our grant proposal since it does not reflect a priority issue of theirs and the matter is still being deliberated at the Washington level.

We have clients in serious need of counseling, support and information: an adolescent impregnated by her employer; a 4-year-old boy who has contracted genital herpes, an incurable disease, as a result of a sexual assault; an elderly homemaker raped by a burglar. And there are many others. We cannot, in conscience, abandon these clients. It is our obligation to insure that they receive the assistance that they need and deserve. But without Federal assistance, it is unlikely that we can even keep our door open.

Our experience can serve as an example, as an indicator of needs which affect not only us but centers nationwide. Rape-related service needs fall into five primary categories: direct service delivery which is the establishing and operating of rape crisis centers; evaluation and research which would assess our performance and would expand the body of operating knowledge in order to best serve the clients; training and technical assistance to insure the provision of quality services by new and by established centers; community education support; personnel and materials to sensitive the community as to the needs of the victims to encourage reporting and provide effective prevention information; payment of medical costs so that the woman is not further victimized by having to incur costs for the collection of evidence or for medical care.

At this moment, Mr. Chairman, there is in a Baltimore hospital a woman who has had to undergo a colostomy. She was raped and beaten so severely that she will never again be able to function properly as far as in a physical way. Her medical needs are not

covered by the State, and if she does not have insurance, then she will be in severe financial difficulty. Her emotional needs are not covered under our State legislation.

We also need centralized coordination of rape related services including evaluation, training, the dissemination of information perhaps in quarterly newspaper form, registry of centers, and a data bank for readily available statistical information.

These issues, Mr. Chairman, are discussed more fully in the formal testimony I have submitted to you.

The responsibility toward the rape victim is a shared one. The community's part in facilitating her passage through the crisis period into reintegration is a vital one. Local coordination is critical if the woman is not to be limited in her sources of support. But the efforts of the local community cannot answer the need alone. With Federal assistance, the pregnant adolescent, the sick and frightened youngster, the young mother or the senior citizen trying to deal with the trauma of rape can receive sensitive, skilled and appropriate intervention at this most vulnerable time.

Thank you.

[The prepared statement of Ms. Lorton follows:]

Ina Lorton
Director, Baltimore
County Sexual Assault, and
Domestic Violence Center

Testimony

On

Rape Related Service Delivery
For The Senate Sub-committee
For Health and Scientific Research,
Senate Committee on Human Resources

As a rape victim, as a counselor who works intimately with assault victims, and as the director of a sexual assault crisis center, I am all too aware of the problems facing the victim of rape and of those facing the organization which attempts to meet her emotional, physical and legal needs.

It has become apparent to me that many of the issues of most concern to rape victims--appropriate medical care, sensitive and effective legal intervention, and the secure and comfortable re-integration with her environment--are becoming more familiar to the concerned lay person, if not to the general public. The insensitivity, prejudice and callousness with which previous generations greeted the victim are not quite as prevalent today.

There is lip-service--if nothing else--given by the media and by the providers of public safety and welfare to their responsibilities towards victimized individuals. We are hearing more frequently that it is the offender and not the victim who is accountable for the offense, and that the act itself is one of

violence and not of sex. We are also beginning to understand that the rape will affect the woman, no matter how sexually experienced she may be; that it is an intrusion, a degradation, a violation, and a serious threat to her sense of self, safety, and well-being.

Although I am guarded in my language, I am convinced that these issues are becoming a matter of public record, if not yet a matter of public morality. What the public is not aware of, however, what has until now escaped legislative notice and what most American communities have not addressed themselves to, is one of the most serious needs of victims. There has been virtually no recognition, except on the grass roots level, of the responsibility of the larger community to provide on-going assistance to victims of sexual assault. Perhaps as a vestige of those attitudes which condemn all female sexuality--even those aspects which are beyond a woman's control or against her will--the nation has not afforded these individuals the same concern the same attention, nor proportionately the same share of the Federal or local dollar, that is made available to other needy citizens.

As a result, the woman who has been forced to submit to the trauma of rape is further victimized by the very system which

should be her primary support. Those support services that she so desperately needs if she is to return to pre-crisis functioning are usually poorly staffed, ill-trained or ill-equipped, or worse, totally lacking.

I want to share with you what I experience on a daily bases in trying to meet the emotional and physical needs of victims of sexual assault. My trials and tribulations--and satisfactions--are hardly unique, but rather they are all too familiar to the many other workers in the field. If anything, the temporary access that my center has had to funding has made our situation a far more encouraging one than those faced by other groups trying to provide similar services. As I speak, two other Maryland rape centers are floundering from lack of public support. Not only has the intense and sustained effort of concerned workers gone unrewarded but the crisis level needs of those victims whom they serve go unrecognized and unmet.

A year and a half ago, I was hired to design and direct a program for Baltimore County's victims of sexual assault. Since local sources of guidance or direction were unavailable, nor was there any precedent for an organization of this sort, my sole mandate consisted of a suggestion that I utilize a center operating in another county as my model to "help victims." My staff was to be hired from the CETA pool and the physical plant for the center was to be contributed by a local hospital. I had been a volunteer for a rape crisis group; my 2 day training

from them and my own first hand knowledge of victim needs were my only directives. No one I knew had ever started or run a rape center, the literature available was scanty at best, inapplicable at worst, and the director of the other rape center was not freely available, although she had been awarded a small grant to provide technical assistance on a local basis. The National Center for Rape Control and Prevention, to whom I made my very first call on my new phone, was not able to provide the hands-on assistance I needed.

So, functioning purely on intuition and determination, blissfully ignorant of any of the possible pitfalls, I developed procedures, begged and borrowed office furnishings, trained staff, and established rapport with and elicited the support of the community.

The local CETA organization had agreed to provide seven workers; they could not ensure that these individuals would have the educational level, the professional skills, and the intuitive concern, warmth and sensitivity that the crisis counseling positions required. Again, more through luck than through any conscious assessment of needs, we were able to develop a successful, serviceable organization.

A 24-hour-a-day hot-line has now been established and approximately 50 new clients a month receive counseling, support, hospital and/or court companionship. Community education and the training of police and medical personnel are on-going concerns.

Although our center has proven itself to the community, established its credibility and served the mis-used and the unhappy in a professional and caring manner, we have serious concerns about our ability to provide services past the end of this summer. The county has only been able to budget \$20,000 towards the center, and revised CETA policies are enforcing severe cutbacks in personnel. Workers lost through natural turn-over are not being replaced. And our attempts at finding other sources of on-going support have not yet been successful. The only Federal agency which addresses the issue of rape directly, the National Center for Rape Control and Prevention does not have any funds earmarked for direct service delivery; other agencies which are willing to underwrite primarily volunteer groups do not service the kind of 24 hour fully staffed organization our community's needs demand.

Only by becoming a delegate agency of the Community Action Agency (a CSA grantee) in our area do we have any hope of assuring our continued existence. The regional office of this agency has looked unfavorably on our grant proposal since we do not reflect a priority issue, and the matter is still being deliberated at the Washington level.

We have clients in serious need of counseling, support, and information: an adolescent impregnated by an employer; a four year old boy who has contracted genital herpes, an incurable disease, as a result of a sexual assault; an elderly home-maker

raped by a burglar. And there are many others. We cannot, in conscience, abandon these clients. It is our obligation to ensure that they receive the assistance that they need and deserve. But without Federal assistance, it is unlikely that we can keep our door open.

Our experience can serve as an example, as an indicator, of needs which affect not only us but centers nation-wide. Rape-related service needs fall into five primary categories; direct service delivery (establishing and operating rape crisis centers), evaluation and research, training and technical assistance, community education support, payment of medical costs, and the centralized coordination of rape-related services.

1 - Direct Service Delivery -

Centers like ours, in need of continued funding, and communities which still lack such facilities depend on external funding sources. The energy and effort which currently goes into securing continued support would be best re-directed and focussed on its direct object, the victim and her needs. Hot-lines, crisis-specific counseling, and referral information provided by skilled workers for whom rape is a priority---provision of these basic rights will cost us \$145,000 next year. With this amount, we will staff our center and establish three volunteer-run neighborhood centers, a necessity in a county where transportation is poor and where the rape victim is unlikely to own a car. In other areas, operating costs and the

specific services offered will vary; what does not change is the woman's or child's need for and right to friendly, non-judgmental support, well-informed referrals and skilled counseling.

2 - Evaluation and Research

If a center like ours is to continue to provide quality service, two basic requirements must be met: our own performance must be evaluated against our own pre-set goals and we must have information available about the efficacy of alternate approaches, about innovative techniques, and about the true nature of the problems that we deal with.

A number of examples arise. At our center, we tend to use individual rather than group therapy techniques with our clients, a procedure which stems more from a sense of its appropriateness rather than from any firm data. The questions are vital: which modality is most likely to benefit rape victims? How should we proceed if we are to serve our clients well? Another example: we observe that a large number of our clients are, in addition to being rape victims, prior incest victims. Is this coincidental? What significance does this have in terms of our crisis-counseling procedures, in terms of rape prevention techniques? To further ignore the untapped body of information which comes into rape centers on a regular basis would be a disservice to future clients. But research requires money and expertise not readily available to rape centers. Only through the continued sustained

Federal sponsorship of research programs can effective models for evaluation and study be developed.

3 - Training and Technical Assistance -

In my description of the early days of our center, I detailed the difficulties which I faced because of the lack of information and guidance. At that time, I needed hands-on assistance, either printed materials which addressed the issues I was dealing with in designing a new facility, or direct assistance in the form of a consultant familiar with the procedures. I have no doubt that there are directors of other centers who have faced similar situations and who would be--as I would be now--willing to share their expertise. Training of staff members and volunteers, is also an area of bewildering concern and, again, those of us in the field would benefit from technical assistance and from consulting materials. In other specific areas, center personnel would be well served by having access to training sources, for example, in particular therapy modalities, in grant proposal writing and in administration and supervision techniques. A central training program or the use of specialized consultants would provide much needed guidance in a new field which often lack experienced or skilled personnel.

3 - Community Education Support -

I am convinced that a large part of the obligation incurred by those who would provide rape-related services centers on issues of community education. Outdated and insensitive at-

tititudes towards rape are amazingly prevalent in most communities. Police and physicians must be sensitized in addition to school and social service personnel and clergy. Information must be disseminated about the critical need for medical assistance, especially among those segments of the population which are least likely to report to the police. Prevention information, too, is critical and, in our experience, eagerly received by the community. So great is this demand for education that the facilities of our center are often overtaxed. We cannot assign a worker solely to this task, since we are critically short-handed and perform even our primary functions with difficulty. In addition, the few films, pamphlets and other materials needed for this tasks further burden our meager budget.

The problem is compounded by the lack of good, problem-and age-specific films. For example, for the 6 to 10 year olds, whose vulnerability to rape is indicated by our statistical records, we have no appropriate printed material or films which alert them to possible danger without unduly alarming or misinforming them.

Funds for the special staffing of centers with community education personnel and for the development of appropriate, effective and attractive materials constitute a significant need.

4 - Payment of Medical Costs -

In states like Maryland, any costs for treatment are borne by the victim herself. Although the collection of evi-

dence may be paid for by the state, it is not unusual for our client to be held financially responsible for any treatment for injuries, venereal disease prevention, follow up medical care or needed psychological assistance. Although there is, in our state, a Criminal Injuries Compensation Act, it only provides payment for medical bills which exceed \$100, it usually requires the intervention of an attorney, and it does not reimburse the victim for costs incurred until 8 to 12 months after the event.

A woman already traumatized by the devastating experience of rape, should not have to incur the added burden of medical or psychological care.

5 - Centralized Coordination of Rape-related Services -

I have mentioned service-delivery funding, research and the development of training programs and materials as critical needs in this field. These would, of course, be administered centrally. But there are, in addition, a number of other services which are currently unavailable but which would be of significant value to centers like ours.

A quarterly journal which summarized the new knowledge in the field and a newsletter which offered legislative updates, information on new sources of funding, and current activities would prove invaluable to me and my staff in keeping us informed of issues in our field. The National Center is not currently authorized to pursue an endeavor of this sort, valuable as it would be.

A registry of rape-centers, particularly valuable in a society as mobile as ours; readily available statistical data on rates of incidence, vulnerable population, etc.; and the continuation of the clearinghouse service already provided are other services from which we would benefit greatly.

The responsibility towards the rape victim is a shared one. The community's part in facilitating her passage through the crisis period into re-integration is a vital one; local coordination is critical if the woman is not to be limited in her sources of support. But the efforts of the local community cannot answer the need alone. With Federal assistance the pregnant adolescent, the sick and frightened youngster, the young mother or senior citizen trying to deal with the trauma of rape can receive sensitive, skilled, and appropriate intervention at this most vulnerable time.

Senator KENNEDY. Dr. Burt?

Dr. BURT. Mr. Chairman, I would like first to describe some of my background which stimulated the research I have done, which is the primary reason for my being here. I have worked on crisis lines. I have been the cochairperson of a State task force on rape for the National Organization for Women in Minnesota, and have done quite a bit of training of community groups and community organizing around rape issues. I also have done public speaking and served on grants review panels for the National Center for the Prevention and Control of Rape.

But the primary reason that I am here is that I have done several pieces of research which relate to rape and rape attitudes, and which have some implications for the kinds of services and other activities which would be appropriate for the Federal Government to support or to fund.

My research primarily has concerned rape myths. In addition to recovering from the physical trauma and the terror of a sexual involvement, rape victims must recover from the psychological consequences of rape. Those people working with rape victims have come to realize that rape myths are some of the attitudes present in the population which makes this recovery the most difficult.

I can state for you several rape myths, but it is very easy, from my public speaking experience to draw these from any audience. They are: There is no such thing as rape; any healthy woman can resist a rapist if she really wants to; only bad girls get raped; men rape because they are sexually frustrated; women ask for rape by dressing provocatively or flirting; and women cry rape only when they have been jilted or have something to cover up, such as a pregnancy. There are also many rape myths expressed in quips or one-liners which their tellers assume to be humorous: You cannot thread a moving needle; rape is assault with a friendly weapon; a woman can run faster with her skirt up than a man can with his pants down; and seduction is for sissies, a he-man wants his rape.

All of these things end up being part of a complex of attitudes that make life very difficult for victims when they are victimized because they have the consequences of either denying that a rape has occurred or blaming the victim for her own victimization. The research that I did documented that many members of the general public do believe in these attitudes, and also that these attitudes are related to other attitudes that are not rape specific but are far more deeply embedded in our cultural context. These are things like sex role stereotyping, like a battle-of-the-sexes ideology which assumes that both men and women are largely out to exploit each other; that men are only out for one thing; that women are sly and manipulative—in essence, that neither sex can trust the other and that rape is assumed to be the extension of that kind of exploitive behavior; and the acceptance of interpersonal violence for getting what you want—it is OK to hit people if they do not deliver.

It is important, I think, to recognize that these attitudes—the violence attitudes in relation to sex, the sex role stereotyping—are very deeply embedded in our culture and make changing the rape specific attitudes very hard, because you not only have to change an isolated attitude, but you have to change something that is connected to a large number of other beliefs and values. Neverthe-

less, I think that the presence of this cultural context has been found by many people who have helped victims toward psychological recovery. I think it has implications for prevention and for amelioration for rape once it has occurred, which I would like to suggest to the committee. One of its implications is that these do seem to be in this country—and many other countries as well—a sex-violence-family syndrome which involves many things that are surfacing as social problems. The spouse abuse problem, the incest problem, the child abuse problem, and sexual assault of adult women all seem upon analysis to reflect back on the set of attitudes, cultural beliefs, and sex role stereotyping.

Consequently, it might be advisable to begin dealing with them as a set of interrelated problems at the Federal level rather than coming out with individual categorical grants to cover each of them and have each of those groups as interest groups fighting for the same dollars.

With respect to prevention, I think that the research I have done would suggest a very strong effort to develop curricula, for all grade levels, which deals with sexism, with stereotyping, with victim blame, but perhaps not the sexual aspects of our culture for very young ages. Particularly sexual manifestations could be included later, along with the nonsexual aspects, because inequality and disrespect between the sexes is responsible for a lot of the attitudes I'm talking about.

I would very strongly recommend, with the curricula and everything else in my testimony, that these things be done on a contract basis as opposed to the present grant kind of moneys which are being used right now, because the tasks are specifiable; you can name what you want. You can detail for a contractor what products they are supposed to deliver. My experience with the kinds of grants that come in and the kinds of products that result suggests that you can get a lot of what you want faster with the contract method.

The second thing that I would like to suggest in the way of prevention is that we need research to tell us who the sexual assailants are. We do not at the moment know that. We do not know whether the people who are caught, who end up in prison, such as compulsive multiple offenders, are the only rapists out there. We strongly suspect that is not true, but we do not know the distribution of who is assaulting whom, how often, what kinds of assaults they are, or the context in which they take place. It is fairly impossible to try to develop preventive strategies unless you know the scope of what it is you are trying to prevent. In addition to that general statement, I think that this should be done in a way that avoids the fight over what is a rape and what is not a rape, by trying to ascertain a range of potentially offensive sexual—behaviors everywhere from rape-murder to "forceful seductions" as defined by the assailant—to things like the use of economic threats, job loss, to gain sexual access, and not worry about where you are going to draw a line until you find out what is actually happening out there. Then start working on where you want to put your resources in terms of preventing the maximum amount of crime. We should not get into endless fights about what

is a rape and what is not a rape, or we will not end up with the information we want to know.

The third prevention relevant piece of information we need is the lifetime incidence of sexual assaults, their number or varieties, in our population. If we did, it would aid prevention efforts in a couple of ways. First of all, there is evidence that many offenders who become sexual assailants as adults have themselves been sexually molested as children. If we could target our treatment efforts, we would potentially have a much more focused way to attack the problem of who is going to attack whom when they get to be adults.

Second, and there is even less evidence on this, there is a sense among people who see sexual assaults that they have also been multiply victimized, or some percentage of them—if they have been victimized as children, first of all, recovery after the second attack is made greatly more difficult and, second, that some prevention efforts might be targeted at those groups which have, as a consequence of having been victimized, become more vulnerable to having it happen a second time.

Leaving prevention and getting into the question of how to ameliorate the effects of rape on the victim, I think again we need to focus on the sex-violence-family syndrome which we talked about, what kinds of services we want to provide and how we want to provide them. Obviously, it will be very nice to begin funding direct services. They are definitely in trouble and very hard to maintain with any continuity. So much depends on voluntary services and volunteers have a heavy burnout rate. They research points to the importance of teaching counselors to recognize and deal with the consequences of attitudes and values when the victim displays them. In my experience in dealing with victims, those reactions caused by negative attitudes toward rape give victims the most trouble. If the general public blames victims for being raped, the victims themselves were members of the general public before they became victims, and they are turning all of that upon themselves. Learning how to sort that out, how to live with their new ideas, and how to accept themselves without blaming themselves for what happened, is a major job for the victim.

In conjunction with what is necessary as a part of training for direct services, I think that again a purchasable or deliverable commodity is a package of training materials. There are two major audiences that need training. One of those audiences is the people who are already in direct service, like social workers, crisis line workers, doctors, people in emergency rooms, prosecutors, police, all of the people that are usually named when you talk about rape. They need packages of training materials that are adjustable to the in-service kinds of time they will have available and sensitive to the demands of their job in addition to the needs of the victim, so that the package actually makes sense to those separate audiences.

The second important audience to get at for training is the future professionals, or the future people who will have contact. Here you are talking about formal curriculum much more than for the inservice kind of training. But the schools that turn out the people who I mentioned above need a package of material that will help them train their up and coming professionals in ways to deal

not only with rape victims but all kinds of victims of the syndrome I have described, the sex-violence-family syndrome, sexual abuse and so on.

Third, I think that we need a very broad evaluation of direct services. Certainly if the Federal Government is going to be getting into the business of funding them, there ought to be a mandatory requirement to provide evaluations of their own services and, again, I think that the National Center for Prevention and Control of Rape should contract for a comparative evaluation of those services so that there is a set of measures, a way to say that this center is doing something and another center is not. They should include such things as the breadth of services offered, whether they are dealing only with rape victims, whether they are trying to deal with all people who have problems within the sex-violence-family syndrome, whether they are trying to do a little of everything. Evaluation should also look at the location of the services—whether they are independent agencies, whether they are a recognizable unit within the hospital or a community health center or whether they are the emergency room social worker that sees everybody who comes in, including rape victims.

One of the difficulties in knowing where to place direct service dollars is that there are a million different problems crying for attention. If you try to fund something special for every one of them, there is not enough money to go around. We don't know whether it is necessary to fund everything separately or whether people can indeed be trained to be sensitive to a number of problems at the same time. I think we need to know that to know where to put the money.

Finally, we absolutely need an accurate measure of how many rapes occur in a given period of time, in a given place. We know it does not come from police data. It does not come from LEAA studies. It should not be that hard to develop, if given certain specifications of what it is, and without it, it is very hard to say you have prevented anything. You are just guessing. So the final recommendation I would have is that again, on a contract basis, an attempt be made to develop a doable and an accurate measure of exactly how many sexual assaults occur.

Thank you.

[The prepared statement of Dr. Burt follows:]

POLICY IMPLICATIONS OF
RESEARCH ON ATTITUDES TOWARD RAPE

Testimony submitted to the U. S. Senate Committee on Labor
and Human Resources, Subcommittee on Health and Scientific
Research, Senator Edward M. Kennedy, Chairman.

June 11, 1979

Submitted by:

Dr. Martha R. Burt
The Urban Institute
Washington, D. C.

POLICY IMPLICATIONS OF
RESEARCH ON ATTITUDES TOWARD RAPE

Testimony submitted to the United States Senate, Subcommittee on Health and Scientific Research, June 11, 1979.

Outline

- I. Rape Myths
- II. The Cultural Context of Rape Myths
- III. Implications for Social Policy
 - A. Prevention
 - 1. Attitude change--school curricula.
 - 2. Who are the sexual assailants?--research.
 - 3. Lifetime incidence of sexual assault--research.
 - B. Amelioration
 - 1. Direct service.
 - 2. Training.
 - 3. Evaluation of service delivery.
 - 4. Accurate measures of sexual assault.

I. RAPE MYTHS

In addition to recovering from the physical trauma and the terror that a sexual attack involves, rape victims must recover from the psychological consequences of rape. The psychological recovery process, hopefully resulting in restored mental health, is most often longer and more tortuous than the physical recovery period. Activists concerned with rape and the victim's reactions to it have long maintained that beliefs and attitudes in American culture (and in other cultures as well) create conditions which make rape relatively easy and recovery from rape extremely difficult. Chief among the culprits in this cultural context are rape myths. A rape myth is a false or prejudicial belief about rape, rape victims, or rapists. Common rape myths include: 1) "There's no such thing as rape;" 2) "Any healthy woman can resist a rapist if she really wants to;" 3) "Only bad girls get raped;" 4) "Men rape because they are sexually frustrated;"

5) "Women 'ask for' rape by dressing provocatively or flirting;" and 6) "Women 'cry rape' only when they've been jilted or have something to cover up." There are also many rape myths expressed in quips or one-liners which their tellers assume to be humorous: 1) "You can't thread a moving needle;" 2) "Rape is assault with a friendly weapon;" 3) "A woman can run faster with her skirt up than a man can with his pants down;" and 4) "Seduction is for sissies, a he-man wants his rape." 

Because rape myths operate to deny that a "real" rape has occurred, or to shift the responsibility for the assault to the victim, they have many important practical consequences. Victims' actions in reporting assaults to authorities, seeking medical or counseling attention, and obtaining support from friends and family members depend on their own beliefs about rape. The more they accept the idea that women ask for and deserve to be raped, and that their own behavior is somehow responsible for their victimization, the less they will tell anyone, the less social support and assistance they will receive, and the less authorities will know about the true extent of rape in their community.

The effects of rape-supportive attitudes on friends and family members are twofold. With respect to victims, such potential support people may deny support and actually increase the victim's emotional trauma by questioning her behavior, her motives, and her responses, causing her to doubt the justice of her own complaint. They may impede law enforcement efforts by convincing victims that no one would believe their story or that the fact of victimization is so shameful that victims should not make it public by reporting to authorities. With respect to assailants and potential assailants, family and friends who hold rape-supportive beliefs may make excuses for actual assailants by blaming the victim, or by downgrading or denying that any serious injury was done to the victim (this is especially likely in date rapes and bar pick-up rapes).

Attitudes and beliefs need not actively encourage assault in order to be rape-supportive. All they need to do is passively permit, dismiss or deny the seriousness of an assault in the vast majority of real-life rape situations which do not fit our extreme cultural stereotype of a "real" rape. This provides potential assailants with the practical assurance that they can plan rape situations which contain little real danger of capture or conviction.

Finally, rapists themselves hold rape-supportive attitudes and use them to excuse or deny their behavior after the fact. Their attitudes may also serve as psychological releasers or neutralizers, allowing potential rapists to turn off social prohibitions against injuring or using others when they want to commit an assault.

My research demonstrated that belief in rape myths is widespread.

II. THE CULTURAL CONTEXT OF RAPE MYTHS

My research tested the assumption that rape myths do not exist in isolation, but rather form part of a complex web of attitudes which extend far more broadly than rape specifically. Other research had already indicated that sex role stereotyping and rape myth acceptance tend to go together (Feild, 1978). Feminist analyses of rape (Brownmiller, 1975; Clark & Lewis, 1977; Weis & Borges, 1973) maintained that other attitudes and beliefs about appropriate sexual role behavior, beliefs about the amount of exploitation to be expected in "normal" sexual interactions, and acceptance of violence or threat of violence by men toward women in sexual interactions and intimate relationships generally are also part of a pervasive ideology which effectively supports or excuses sexual assault. In my research I have called these attitudes Sexual Conservatism, Adversarial Sexual Beliefs, and Acceptance of Interpersonal Violence. They are explained at greater length in a paper I have appended to this testimony (Burt, in press). It is important to recognize the significance of hypothesizing

that the relatively specific and focused set of attitudes designated as rape myths are intricately embedded in a much larger attitude structure that includes such deeply held and pervasive attitudes as sex role stereotyping and feelings about sexuality. This may help to explain why rape myths seem relatively impervious to corrective facts and statistics, and even to contacts with rape victims (Burt, in press; Feild, 1978). It is easier to change an isolated belief than it is to change one which, if it changes, would entail changing many other interconnected beliefs and attitudes at the same time.

My research did find that a number of attitudes and other factors are significantly related to acceptance of rape myths. Specifically, the more one accepts interpersonal violence as a legitimate way of getting what one wants, the more sex role stereotyped one's attitudes, and the more one believes that all sexual relationships are fundamentally exploitative, the more one also accepts rape myths. In addition, the less well educated one is and the older one is, the more likely one is to hold conservative and rape myth accepting attitudes. These relationships are described in more detail in the paper already cited (Burt, in press).

III. IMPLICATIONS FOR SOCIAL POLICY

The results of my research coincide with my conclusions as an activist in the rape area, and both have some important implications for public policy. I will divide these implications into those which are relevant to prevention, and those which are relevant to amelioration of the impact of rape on its victims.

A. PREVENTION

1. Attitude change--Curricula, including materials for written, oral and audio-visual presentaion, and for student participation and discussion, should

be developed for all age groups in the public schools (K-12). These materials should be distributed nationwide, and should include teachers guides and materials specifically to help teachers with their own difficulties with this material. In all grades these curricula should focus on the restrictive and damaging consequences of sex role stereotypes, should examine the appropriateness of violence in interpersonal behavior, compared to other means of conflict resolution, and should foster personal autonomy and self-respect. In later grades curriculum content should discuss the ways these themes get played out in specifically sexual interactions. The material should include a consideration of the whole complex pattern of family rights, violence within the family (toward women and toward children), and sexual abuse within the family, in "romantic" relationships, and in other circumstances. Since all these things seem to be surfacing at the present time as social problems, and since much analysis of the phenomena seems to point to a common core of "violence-and-sexism-within-the-family-supported-by-societal-attitudes," it seems appropriate to begin to deal with them on a policy level as an interconnected set of problems. Finally, I think the appropriate governmental agency should proceed to acquire this curriculum material on a contract (request for proposal) basis, to increase the probability that it will be produced in conformance with particular desirable specifications.

2. Knowing the enemy--We cannot design adequate prevention strategies until we know who is committing sexual assaults, how often, and what kind. To be most useful for prevention, this information must come from the assailants. At present we do not know this information. We need research which will define the range of behaviors which might be called sexual assault, from rape-murders to "forceful seductions" to sexual compliance gained through the use of economic threats--independent of police or psychiatric sources of data. We need to know how the people who behave in these ways view their own behavior, and we need some way to

assess whether changing their view of it is likely to affect their doing it. At the rape-murder extreme, I would guess that such people would keep on committing such assaults no matter what they called them to themselves. However, behavior which the victim defines as sexually assaultive but which the assailant perceives simply as "the way the game is played" might cease if it were possible to change the assailant's definitions of appropriate behavior. At our present state of knowledge, all this is speculative because we do not have the first clue about the actual distribution of assaulters or types of assault. Again, this should be done on a contract basis since the product desired can be quite accurately specified. Even if it were done on a grant basis, the description of the grant program could be quite specific about the questions to be answered by the research.

3. Knowing the victim--We need to know lifetime incidence of sexual assault.

Lifetime incidence is relevant to prevention in two ways. First, Swift (1978) noted that males who are themselves sexually victimized as children seem to be particularly prone to victimize others sexually when they reach adulthood. Accurate information about which children are being sexually victimized would allow social programs to target such children for special efforts to prevent their becoming victimizers in the future. Second, anecdotal information from rape centers and other agencies which treat rape victims indicates that they see quite a number of multiply-victimized individuals. Often the first victimization incident occurred in childhood, and frequently within the family. They raise the question of whether particular sexual victimization experiences make a person more vulnerable to subsequent episodes, and also whether recovery from subsequent incidents becomes more difficult when a history of previous abuse exists. If research indicated that particular personal histories make individuals more vulnerable to sexual assault, prevention efforts could target such individuals for assistance. My preference for purchasing specifiable information through the contract mechanism

continues to be relevant in this recommendation.

B. AMELIORATION

1. Direct service--Direct services to rape victims are needed in a number of areas, among them counseling, medical services, legal services, transportation, emergency shelter, social services, and follow-up counseling and support. Since other witnesses will speak to these needs, I will not develop them further. However, I would like to mention that the rape myth acceptance and other attitudes which my research demonstrated do form a cultural context in which people understand rape in this country, are present in the victim's mind as well as in the minds of those with whom she must interact. Because she is likely to turn these attitudes against herself, in a self-punitive way, all people who expect to deal with rape victims should be attuned to what this looks like when victims do it, and why it happens. If rape victim support people do not themselves understand the cultural context which is making adjustment difficult for victims, they are unlikely to be able to offer much assistance when these problems surface.

2. Training--Training materials and curricula should be developed and distributed for two audiences: 1) people already seeing victims in their work, including crisis line workers, hospital social workers, police, prosecutors, doctors, mental health workers, etc., who require continuing in-service training; and 2) people presently in school studying to become the people in (1), who require systematic training in dealing with the whole complex of problems in the sex-violence-family syndrome. Training materials for both audiences must include a thorough discussion of the cultural context of rape and sexual assault, and must help the trainees discuss their own participation in this cultural context before they are turned loose to "help" others who have become the victims of the culture in becoming the victims of rape. This training material should be acquired

on a contract basis, and its adequacy should be demonstrated by the contractor as part of the contract.

3. Evaluation of service delivery--If the federal government is going to begin paying for direct services to rape victims, it should insist that goals and expected outcomes for these services be established, that these services be evaluated against the expected outcomes, and that this evaluation be done in a comparative way across service delivery agencies. To assure that this evaluative work gets done, and that it enables comparison among service deliverers, it should be contracted to researchers independent of the service delivery agencies, and acceptance of federal financial assistance should carry with it the explicit agreement to cooperate with this evaluation effort, and possibly to undertake meaningful evaluations independently. At a minimum, this evaluation should cover service outcomes, the effectiveness of treatment types, efforts to affect community attitudes, and the impact of organizational factors on service effectiveness. By organizational factors, I mean things like: 1) whether the agency is completely independent, attached as an identifiable unit to a multipurpose community agency, or completely integrated into the work of an agency, such as an emergency room social worker who sees everyone brought to the hospital, including rape victims; or 2) whether the agency specializes in rape only, combines several sex-violence-family syndrome support services under one roof (e.g., counseling for rape, spouse abuse, incest, and sexual dysfunction), or does a little of everything.

4. The ultimate dependent variable--We need to develop accurate ways to know how many sexual assaults have occurred in a given population during a given time period. Where Recommendation III.2. suggests information about assailants, and Recommendation III.3. suggests information about lifetime patterns of assault from victims, this recommendation suggests that at present, we can't even accurately report how many assaults of what type happened last week or last year in Washington, or anywhere else. Since the ultimate goal of much effort in the rape area is to reduce the actual incidence of sexual assault, it would help to have an adequate way to assess whether we are getting any closer to that goal or not.

Senator KENNEDY. That was very helpful information from both of you.

Let me ask, Ms. Lorton, what has been the reception by medical personnel and hospital personnel as well as those who have been involved in law enforcement?

Ms. LORTON. Initially, there was quite a bit of distrust, particularly on the part of the police. They saw crisis center workers as bleeding heart liberals, social worker type, and were very concerned about what this would mean in terms of investigation, would we try to convince the victim not to report, for example, or would we try to interfere with her testimony in any way. These are very serious concerns that the police had, and understandably so.

What has happened in the year and a half we have been there is that they have gained a sense of the real place that the crisis workers have in a police investigation. Right now, we are conducting training sessions on a weekly basis with every single policeman in the county. Medical personnel at our hospital have been very receptive and were from the beginning. Other hospitals did not respond exactly the same way perhaps because of lack of actual contact. In many hospitals there is a definite sense that victims do not need counseling. In fact, that is a direct quote, rape victims do not need counseling, and so the service is not a necessary one.

Obviously, I do not agree with that viewpoint, and our daily experience negates that.

Senator KENNEDY. Dr. Burt, you gave us a number of areas in which you are doing research—a number of areas and problems that those who are concerned about the public policy implications of rape and rape treatment should be aware of. You are not suggesting that we do not have enough information to date, that we do not know what the priority items are in sufficient detail to permit us to move ahead in an aggressive way, are you?

Dr. BURT. Mr. Chairman, I think that you could make some pretty good guesses based on the data we already have about what we should be doing. The answer to that depends on which of the particular pieces. I think we could surmise that when we find multiply abused women, they who need more help than possibly singly abused women, or if we find abused children that we ought to pay attention to them more because the payoff would be greater. We do not know how many there are and we do not know where to find them. When they show up at our centers, OK, we can pay attention to them. But we do not know the scope of the problem or how to target it. It was that kind of targeting information that I was suggesting. I am suggesting it because I believe that those are likely to be the major problems, and I certainly would support going ahead and treating such people when you find them. It is finding them that is difficult. We do not know how many assaults are happening. Nobody trusts the data that come in on the numbers of assaults. When they go up, you do not know whether it is because you have been doing a good job on community education and everyone is reporting them or whether these actually are more assaults. When they go down, you do not know whether you have scared everyone off. You have no way of assessing your actions at present.

Therefore, I would simply say we just do not know.

Senator KENNEDY. We had last year \$8 million authorized for the National Center for the Prevention and Control of Rape. The appropriation was \$5 million. The House Appropriations Committee came in with a \$1.5 million. So there appears to be a great deal of work to be done before we can expect to win the kind of approval for funding levels that are needed for a truly effective and comprehensive program. I do not know whether there are any intermediate steps that you would like to suggest.

Ms. LORTON. I would like to suggest the efforts of the national center must be continued, the kind of research that they are sponsoring. My suggestion is, however, that where the service provision is available, at the same time the research is being done—to address one and not the other would be to serve the victim—rather to serve the victim poorly in the long run.

Senator KENNEDY. Dr. Burt?

Dr. BURT. Certainly the amount of money available is not adequate for providing direct services at the present time. But I do think that the national center could specify exactly what they want when there is something they know they want, and doing that on a contract basis, no matter what the headaches are in getting through OMB, and seeing to it that the things we know are top priority are actually purchased and delivered, not left to the uncertain and unpredictable awareness of the people that submit grants.

Senator KENNEDY. I want to thank you both very much. I know Senator Mathias would want me to extend his good wishes. He is not a member of this committee but we work closely with him.

Next we will have Dr. Gary VandenBos of the American Psychological Association and the Association for the Advancement of Psychology.

I would also like to ask Dr. Lee Macht, professor and head of the Department of Psychiatry at Harvard Medical School, to come up.

We are going to run into a time problem with votes and also another scheduled conference.

We are glad to have both of you and we look forward to what you have to say.

STATEMENTS OF GARY VANDENBOS, PH. D., AMERICAN PSYCHOLOGICAL ASSOCIATION AND ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOLOGY; AND LEE MACHT, M.D., PROFESSOR AND HEAD OF THE DEPARTMENT OF PSYCHIATRY, HARVARD MEDICAL SCHOOL AT CAMBRIDGE CITY HOSPITAL, AND AMERICAN PSYCHIATRIST ASSOCIATION

Dr. VANDENBOS. Mr. Chairman, members of the committee, my name is Gary VandenBos. I am appearing here today on behalf of the American Psychological Association and the Association for the Advancement of Psychology. I am accompanied by Clarence J. Martin who is general counsel for the AAP.

Currently I serve as the director for Mental Health Policy for the American Psychological Association. I received my doctorate from the University of Detroit. In my testimony today I draw heavily on my 4 years experience as a community mental health center director in rural Michigan. I also draw heavily on research I have recently completed for two books now in press, "Psychology and

National Health Insurance" and "The Treatment of Schizophrenia: An Empirical Investigation with Suggested Clinical Applications."

Mr. Chairman, I need not reiterate the arguments in support of more and better mental health care. We support this bill but we believe it can be improved and, in that spirit, I would like to offer this testimony.

You already have my extensive testimony and I will be quite brief in summarizing.

The American Psychological Association and the Association for the Advancement of Psychology support this bill. We believe it can be improved. The bill must recognize the distinction between the unserved, the underserved and the inappropriately served. If not, we cannot have a comprehensive study.

As it relates to prevention, there must be stronger emphasis on primary and secondary prevention. Programs with children and also employee assistance programs should be the emphasis. A prevention center within NIMH would be useful to establishing a clear focus on prevention in mental health.

We believe that the health system and the mental health system must be linked. But, there needs to be an emphasis on fully trained mental health practitioners. We believe that the primary care provider initiative, as it relates to mental health, must be questioned.

We support the section on obligated service but would encourage that this section be amended to allow service in "targeted" research and training centers that are specifically focused on the priorities in the bill. We support the establishment of a division of minority concerns.

We certainly believe that the role of States must be increased to make the system more comprehensive. But to do that it is important to assure that the State governments work on an affirmative action basis not only as it relates to the traditional criteria but also to professional degrees and to community versus hospital orientation.

Patients' rights should be mandated as a part of this bill. We believe that it is important to include both freedom of choice in the selection of providers as well as establishing an advocacy services program.

I call your attention to the fact that stigma in many ways is decreasing. Federal policies, however, often support the development of a stigma, particularly the funding mechanisms. We feel that these should be corrected, and that the key for reimbursing mental health services is appropriate training, not professional degree.

The health care for all Americans bill should include realistic evaluation procedures. Such mechanisms can pay off in dollars and cents.

I want to draw your attention to one study that relates to stigma and availability of services. At the University of Michigan Survey Research Center, they conducted a study which was a replication of a 1957 study. In this they found that the percentage of the population, of the adult population, actually using professional mental health services between 1957 and 1976 doubled. The number of individuals seeking help from their family doctor or, as they are

now known, the primary care provider, decreased by 30 percent, while those seeking help from appropriately trained mental health professionals increased by almost 80 percent. As we move forward, linking mental health and health priorities and initiatives, it is important that we do not undo what we have done in the last 30 years.

The last point I would like to make is that there needs to be a responsible level of funding within this bill, particularly as it relates to titles I, II, and III, which are in the new initiatives in the bill. The level of funding is very inadequate.

Thank you.

[The prepared statement of Dr. VandenBos follows:]



ASSOCIATION for the ADVANCEMENT of PSYCHOLOGY

Testimony of
American Psychological Association
and
Association for the Advancement of Psychology
before the

Subcommittee on Health
Committee on Labor and Human Resources
United States Senate

June 11, 1979

on the subject of
Mental Health Systems Act
(S. 1177)

presented by
Gary VandenBos, Ph.D.

Mr. Chairman, members of the Committee, my name is Gary VandenBos. I am appearing here today on behalf of the American Psychological Association and the Association for the Advancement of Psychology. I am accompanied by Clarence J. Martin who is general counsel for the AAP.

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Mr. Chairman, I need not reiterate the arguments in support of more and better mental health care. We support this bill but we believe it can be improved and in that spirit I would like to offer this testimony.

DIFFERENT PROBLEMS NEED DIFFERENT SOLUTIONS

The President's Commission on Mental Health noted that different populations have different problems in access and quality of care. Some are unserved--most notably certain rural areas which lack any organized mental health services. Some are underserved--such as children, youth, elderly, inmates, and minorities. Some are inappropriately served--and while this may be the case with any subset of patients, it is particularly notable regarding women and minorities.

Many patients are currently inappropriately served, be it through inappropriate, unneeded and harmful hospitalization; minimal and inappropriate treatment within the primary care health system; or by services that are insensitive to socioeconomic or ethnic sub-cultural differences. Children, youth, and the elderly are often hospitalized and/or medicated inappropriately. Minorities often receive service unresponsive to their needs. Women are also frequently inappropriately served, the most notable example being overmedication.

The Mental Health Systems Act fails to clearly differentiate between these varying types of service delivery problems. In some cases it ignores the inappropriately served (for example, the inappropriately served are not mentioned in the definitions, especially in Section 3(9)); in other cases reference is made to "inappropriately served populations," but not all inappropriately served groups are mentioned (for example, women are not listed in Section 2(b)(2)); and in still other cases the unserved and the underserved are simply lumped together (for example, Section 402). Such a failure to differentiate among the varying types of problems obscures Congressional intent and the relative priority, and complicates

accountability issues that must be taken into account in trying to resolve the present inequities.

PREVENTION

The term "primary prevention" refers to intervention designed to build adaptive strengths, coping resources, and behavioral competencies in individuals and families. Such intervention occurs before the person develops problems, so as to prevent their development. Primary prevention approaches can be applied flexibly in a variety of situations. They are an especially attractive means to effectively and cost-efficiently reach vulnerably high-risk groups, such as the children of the chronically mentally ill, infants temporarily separated from their parents in the first year of life, and the infants of parents who themselves were physically abused as children.

Let me illustrate. Infants and their parents occasionally get separated for a month or two in the first year of the infant's life. This could be because of illness of the infant requiring hospitalization, or hospitalization of the parent (either father or mother), or for economic or legal reasons. The interaction developed in the first year of life between parents and child appears to have subtle but measurable effects on later emotional and physical health. As a group, infants who experience such separations have been shown to later have more physical health problems, have poor interpersonal skills, and have more behavioral problems. More research is needed to sharpen and clarify these findings and the causal factors. But even now, prevention can be helpful. Providing parents with information and a simple brief program of increased activity, play and touching between the parents and child facilitates interaction and psych-

ological development. Monitoring and follow-up will identify those few cases where more complicated psychological processes must be resolved through counseling or psychotherapy.

Prevention programs can also be targeted directly to the high-risk child, such as children of chronic mental patients or children from impoverished backgrounds. As a group, such children are more "socially immature" and have more behavioral problems. It has been found that a set of interpersonal cognitive problem solving (ICPS) skills consistently discriminate between such immature or poorer functioning children and more healthy or better functioning children. ICPS skills include the ability to "sense" problems, to identify feelings, to use alternative-solution thinking, and consequential thinking. ICPS skills can be thought of as mediating effective behavioral adjustment. Training programs have been developed to teach these skills to high-risk four-year-olds, via 46 "lessons" given over a ten-week period. The evaluation findings of these programs are exciting. Behavioral adjustment improves. The poorest functioning children improve the most, catching up with the better functioning children. And these improvements last over time and generalize to other settings, such as school and the home.

The term "secondary prevention" refers to early detection and treatment of mental health difficulties. The proposed CHAP legislation, which should definitely include emotional and behavioral problems, is an example of secondary prevention possibilities, particularly as they relate to adult populations. For example, it is frequently estimated that 70% to 80% of involuntary terminations of employment are the result of social ineptness and behavioral or emotional problems. Before the employee is fired, it is estimated that \$20 billion is wasted in lost production and

industrial accidents. Work setting-based mental health programs offer an opportunity to provide timely service that can prevent human suffering and save dollars, both for industry and the government. It is to the benefit of all parties for government and business to engage in a creative partnership.

The Employee Assistance Program of the International Paper Company is one such program. The local plant establishes a cooperating program with their local community mental health center. Referrals can be self-initiated or company-encouraged. For employee-initiated service, the employee assistance staff member simply serves as an information and referral resource. The company-initiated referral works as follows. First, the foreman notes job performance difficulties, such as absenteeism and poor work quality, which could lead to termination but could be the result of family or emotional problems. In such a situation, the foreman would discuss the job performance issues with the employee, and provide the information on counseling or other employee assistance services that might be helpful -- in other words, provide information and encouragement but not a formal referral. If work performance has not improved in a few weeks or several months, depending on the seriousness of the job performance problem, the foreman rediscusses the work performance problem with the employee and makes a formal referral (including letting the community mental health center know of the referral and the nature of the job performance problem). The employee is free to follow up on the referral or not, and the CMHC does not let the company know whether or not the employee followed through. The services at the CMHC are covered by the company health insurance plan. If the work problem continues and the company makes a decision to terminate the employee, the employee assistance staff member calls the community mental health center to see whether or not the employee is

being seen, and this limited bit of information is provided. If the employee is being seen, the company rethinks its decision, gets a limited release of information, and works with the employee and therapist.

Other companies, such as the Kennicott Copper Corporation, J.C. Penny and the Oldsmobile Division of General Motors, utilize slightly different models. The often conflicting needs for consumer choice and confidentiality, and early detection and intervention are preserved in a creative manner.

Corporate users of these programs have reported reducing medical and surgical cost by 55 percent, improving employee work attendance by 52 percent and reduced absentee-induced corporate cost by 74.6 percent for the treated employees.

Employment-based early intervention programs can be very effective. However, I wish to note that several factors must be closely attended to in developing such systems. First, attention must be given to possible abuses of confidentiality, but it is also necessary to provide limited information on referral follow-up to the employer. Second, screening and referral criteria must be sensitive to sex differences, socioeconomic factors, and ethnic considerations. For example, the alcoholism screening procedures used in most work settings are male-based, and females manifest alcoholism symptoms on the job differently than do males.

Prevention in mental health is a promising area. The Prevention Task Panel of the President's Commission on Mental Health provided an excellent review of the innovative and effective demonstration projects that have been completed. It is still too early to mandate prevention services in all community mental health centers, but sufficient progress and potential has been documented to warrant a concerted, centralized

effort to further developments and disseminate knowledge.

The current version of the Mental Health Systems Act is lacking in relation to prevention. I recommend: first, including in Title II the establishment of a Center on Prevention within NIMH, funded at \$10 million, to provide the needed national administrative and programmatic focus on mental health prevention; second, separate specific funding authorization, also at \$10 million, for State mental health prevention initiatives (including strong empirical evaluation); and third, a stronger emphasis on primary prevention with high-risk populations and truly innovative secondary prevention with targeted populations rather than the current focus on general public information and in-service training regarding general early detection and treatment.

MINORITY ISSUES

Minorities are underrepresented in the mental health professions. The mental health needs of minorities are underserved and often inappropriately served. The APA and AAP strongly endorse establishment of a Division of Minority Concerns within NIMH. Such a Division would serve to increase the representation of minorities both in mental health service and mental health research, to sensitize mental health training and research to unique needs and issues of minority group members, and to improve access and quality of care available to minority citizens.

In order to train high-quality minority mental health professionals, both service providers and researchers, I would note, however, that it is necessary to have a viable mental health training system. It is as important to the training of minority mental health professionals that the training system through which they pass is healthy, as it is to increase admission and support for minority students.

LINKING HEALTH AND MENTAL HEALTH

As we work to link health and mental health, and place mental health professionals in physical health settings to address the emotional needs of those with physical health problems, it will be necessary to alter current reimbursement mechanisms. Mental health providers, such as doctoral psychologists, are legally autonomous and independent health care providers. The present reimbursement mechanisms would not allow them to be reimbursed for their services in physical health settings and to patients with a primary diagnosis of a physical health problem. It is costly and duplicative and professionally unnecessary to have a physician, who is totally unfamiliar with mental health procedures, officially "supervise" and then bill for the treatment. Likewise, the health care data base, which is critical for planning and policy making, is distorted when physicians subcontract for independent mental health services, but then bill the insurance carrier as though they had provided the services themselves.

Reimbursement should be to the qualified professional rendering the service. This would place responsibility for patient care with the actual provider of care; it would eliminate the "middle-man" costs; and it would make the actual provider responsible for quality assurance and appropriateness-of-care reviews.

Section 404 of this bill concerns mental health services in ambulatory health care centers. As drafted, I would suggest it is not likely to increase the availability of mental health services in ambulatory health care settings, will lead to further maldistribution of mental health services, and will lead to the increased and inappropriate overmedicalization of mental health care. Such unintended consequences

could be avoided. I would suggest these changes:

First, making mental health entities the only eligible recipient of such grants (by deleting Section 404 (a) (2)), although the one exception might be that areas without an organized mental health service could receive a grant to employ mental health professionals, either medical or non-medical, to provide mental health services;

Second, modify 404 (c) to more clearly encourage the actual provision of mental health services in ambulatory care settings; and

Third, making the awarding of these grants subject to the same population and area priorities as other sections of the proposed Act.

Without such changes it can reasonably be expected that the majority of grants would go to physical health facilities rather than to mental health facilities. The resulting emphasis would be on costly medicine and medical care needs rather than mental health needs in general or the emotional and behavioral problems related to physical health care. In addition, rural and poor urban areas would not generally be the recipients of such grants because of their lack of resources for preparing grant applications and their inability to meet the comprehensive requirements. Further, the result would be increased consultation but not necessarily increased provision of services.

OBLIGATED SERVICE

The American Psychological Association and the Association for the Advancement of Psychology support the "payback" provisions of the proposed Systems Act (Section 633). Such obligated service in underserved areas is reasonable and appropriate, and should serve to increase access to service by rural, poor urban, and minority populations. We would, however, suggest a minor modification to this section. There is

an increasing recognition of the need to involve clinicians in research and training, particularly when those clinicians are knowledgeable about underserved and inappropriately served populations. Hence, we suggest adding a subsection stating that such obligated service could, upon request and approval, be spent in research or training in specifically targeted areas of research and training relative to the underserved and inappropriately served. This would help to expand the numbers of providers, both specialized and non-specialized, knowledgeable and informed about serving these populations. This could certainly help make dramatic strides toward understanding, and helping to correct, our chronic shortage of health and mental health professionals willing to serve these population groups and geographic areas.

The National Research Council commented on this problem in their 1978 Report on Personnel Needs and Training for Biomedical and Behavioral Research:

"When the NRSA Act required that a distinction be made between clinical training and research training, ADAMHA, which had long provided support for both types of training through NIMH, established guidelines by which existing awards could be assigned to either the clinical or the research training category "as the preponderance of evidence" from the grant applications suggested. Since that time, the agency requires applicants seeking training support to declare their intent to pursue research or clinical careers and, accordingly, assigns them to the appropriate program to support.

The effect of these actions on the development of a pool of clinician investigators in mental health research is not yet clear, although this assignment process appears to affect more significantly the acquisition of predoctoral research training support, especially

for predoctoral clinical psychologists.

As one ADAMHA official has pointed out:

The necessity of making such distinctions was, of course, related to the requirements of NRSA with respect to pay-back, limitation on the number of years of support, etc. We knew of no way to accommodate these legal and other DHEW policy requirements within undifferentiated....grants.

To clarify the relationship between NRSA program administration and the recruitment at the predoctoral level of clinicians for mental health research, the following assessments are provided for the fields of clinical psychology and psychiatry.

Clinical Psychology. Traditionally, predoctoral programs in clinical psychology have involved 4 to 5 years of study toward the Ph.D., during which time the individual has initially focused on acquiring those skills that characterize all doctorally trained psychologists.

Invariably these skills include a definitive immersion not only in the contents of one's specialty but also work in research methodology, advanced statistical and quantitative methods, statistical design, computer training, etc. These skills...are joined to active research participation during the predoctoral years...

What distinguishes these clinical psychology doctoral students from their nonclinical peers is the intensive exposure to various forms

of human service delivery, culminating in an internship period at institutions accredited by the American Psychological Association, at which time the clinical psychology student engages in the supervised performance of testing, diagnosis, and/or treatment of clients.

Since Ph.D. clinical psychology doctorates can either provide services or conduct research, with many actually doing both (NRC, 1975-77: 1977 report), the distinction between clinical and research training drawn by federal agencies for administrative purposes appears to some clinical psychologists to be artificial or, at best, arbitrary.

This is especially the case when entire training grant programs must be categorized, although the distinction is not entirely impossible to draw on an individual basis.

With respect to individual support, clinical psychologists have been supported as predoctoral NRSA fellows if they have been willing to declare their intention to pursue research careers. Indeed, in recent years about half of the fellowships awarded by the Psychological Sciences Fellowship Section of NIMH have been at the predoctoral level. Of these, about 40 percent are made for research training in the area of "maladaptive behavior and mental illness." About 35 percent of the total awards in this area have been made to predoctoral clinical psychologists.

In the view of many persons responsible for predoctoral training in psychology, the distinction between clinical and research training appears to be an impediment in the allocation of NRSA predoctoral institutional research training grants. As of FY 1978, no predoctoral institutional research training grants have been awarded to clinical psychology programs under the NRSA authority.

The Committee is aware of the fact that clinical psychology continues to be eligible for training support under both training authorities.

However, evidence reviewed in the past year suggests that the oversimplification of the content of clinical programs in order to qualify for training support may, in the long run, adversely affect the development of graduate training in clinical psychology.

Some clinical psychologists believe that this manner of implementing the distinction between research and clinical training will erode the research tradition in clinical psychology. They also believe that the distinction encourages the "professional degree" movement in psychology, a situation that in recent years has stirred much controversy within the psychology community.

The complexity of these developments suggests that a more extensive examination of the impact of the NRSA authority on research training opportunities for predoctoral clinical psychologists is required before a clear recommendation can be provided by the Committee.

Psychiatry. Physicians get little or no formal research training either at the predoctoral level or during their residencies. The Director of ADAMHA summarized the situation as follows:

We must acknowledge that the recruitment of physicians into research and academic careers occurs from a biased population. The vast majority of students who enter medical school do so with the intention of practicing medicine...It follows that psychiatry, along with other medical specialties, when recruiting for investigators at the postgraduate period, is recruiting among people who most likely entered medical school with a

particular objective in mind and have already made a tremendous investment in pursuit of the objective.

The National Institute of General Medical Sciences (NIGMS) some years ago established the Medical Scientist Training Program (M.D./Ph.D.), now under the NRSA authority, as a means to foster research careers early in the training of physicians. Occasionally, this program has provided research training for clinicians who subsequently conduct mental health research. However, there is no program of this type offered by ADAMHA at the present time.

Currently, research training in psychiatry under the NRSA authority is supported through NIMH programs in the biological sciences, social sciences, and "special areas." Interdepartmental grants are made in which departments of psychiatry are coequal to other participating departments. In FY 1977, support for 231 positions was provided through 51 new or continuing interdepartmental grants. However, only 44 of the 231 positions represented predoctoral awards, and a small fraction of these were made to individuals specializing in psychiatry. This suggests that medical students are not being recruited in significant numbers into research careers under the NRSA program.

It is not clear at this point whether the failure of the NRSA program to recruit physicians, including psychiatrists, into mental health research suggest the need for a targeted program such as the M.D./Ph.D. program mentioned earlier. The Committee noted that the Research Task Panel of the President's Commission on Mental Health (1978) has urged ADAMHA to establish a research training program of this kind in the near

future. The Committee will explore this and other alternatives to the recruitment of these clinicians in the coming year.

The Committee notes that the number of psychiatrists in the U.S. labor force actively engaged in research as a primary activity has remained steady in recent years at a level of only 1.8 percent (450 persons) of the active psychiatry labor force (AMA, 1975-77). The absence of significant expansion may be due to the fact that physicians who elect research careers are more likely to experience a significant net economic loss over a lifetime than are those who chose to enter private practice, although this loss is smaller in the medical specialties of psychiatry and pediatrics than in fields such as medicine and surgery (Scheffler, 1975).

The difference between salaries for clinical and residency training and NRSA stipends has also been cited as a disincentive to the recruitment of physicians for clinical research (NRC, 1975-77: 1977 report). While this may be an important factor, it does not entirely account for the lower recruitment rate from such medical specialties as psychiatry, since NRSA stipend levels are uniform for all M.D.'s.

With respect to nonphysicians, the Committee notes that nearly 60 percent of the 1971-75 clinical psychology doctorates surveyed in 1976 reported that they spent some portion of their total work time in research (NRC, 1975-77: 1977 report). While these figures are encouraging, the potential impact of predoctoral funding patterns discussed earlier suggests that the recruitment of investigators in this field warrants close monitoring."

THE ROLE OF STATES

State government should play a greater role in continuing mental

health. However, changes will be necessary at the state level if we are ever to have a genuine Federal-State-local mental health "system." State Departments of Mental Health originally consisted of the State Mental Hospitals, which had an orientation towards medicine and hospitalization. One of the prime contributions of President Kennedy's community mental health initiative was to recognize that mental health was a multidisciplinary field in which relevant training, not the field of professional degree, was the critical factor. Community mental health centers are currently directed successfully by clinical psychologists, psychiatric social workers, and psychiatric nurses as well as psychiatrists. The diversity of these professional perspectives has led to innovation, a broader range of services, and more comprehensive care.

There is a need to increase the role of state government in mental health, particularly community mental health, and it must be done in a way that ensures that a true multidisciplinary perspective is maintained, that a community perspective outweighs a hospital perspective, and that funding patterns approach program priorities. Towards accomplishing these goals, I suggest that an additional section be added to Title III of the proposed Systems Act. This proposed Section 303 would require that for States to qualify for grant under Title III they would have to observe affirmative actions principles at all levels of mental health administration with regard to field of professional degree and hospital/community orientation, as well as the traditional affirmative action criteria.

PATIENT RIGHTS AND ADVOCACY

In the mental health field there is increasing discussion of

patients' rights, confidentiality, commitment procedures, and advocacy. A comprehensive mental health systems act must attend to the linkage between the mental health system and the legal system. This aspect of the system has been neglected despite its massive impact on the lives of the patients involved. This lack of attention has led to brief diagnostic evaluations by medically-oriented psychiatrists, and the resulting poor "predictions" of dangerousness--to self and others--have received wide-spread attention. Whenever the wrong facts are considered, poor decisions and inappropriate and ineffective treatment will occur.

For citizens to be meaningfully involved in their own treatment, they need both access to relevant information and access to a range of services and service providers. Without these opportunities, there can be no real "right" or choice.

A "bill of rights" for present, former, and potential mental patients would increase access to and appropriateness of care and reduce stigma. An adequate advocacy package within the Mental Health Systems Act would be multi-faceted, including an internal system of patient protections, an external system to back it up by addressing system-wide neglects and/or abuses, and a "bill of rights" which includes the right to service and freedom of choice of treatment, practitioners, and services. A "bill of rights," and an advocacy system to back it up, are needed to provide at least the symbolic teeth to rectify present and past abuse and neglect.

STIGMA AND GOVERNMENT POLICY

The stigma attached to having a mental health problem or seeking mental health care is decreasing. A large-scale survey, a replication of a

1957 study, was recently conducted by the Survey Research Center of the University of Michigan. The samples of the two national surveys were independently selected using area-sampling probability methods to constitute representative cross-sections of persons 21 years of age or older living in private households.

They found that 60% of the respondents had either utilized mental health services or felt there were particular problems for which they might utilize such services. This represented a twenty percent increase in the number of persons who felt they might need and would utilize such services. The stigma related to acknowledging such needs and the use of such services is decreasing.

Continued effort to reduce such stigma is still needed. The Government itself frequently perpetuates stigma by restricting access to services through Medicare and Medicaid. The recently proposed Health Care for All Americans Act continues these stigma-producing policies. It is critical that Titles XVIII, XIX, and XX of the Social Security Act be modified to increase the "limits" on mental health benefits, to lower the required copayments for mental health services, and to provide consumer freedom of choice in practitioner and provider systems. I recommend that the Health Care for All Americans bill be similarly modified.

Health coverage, public or private, which includes arbitrary and discriminatory disincentives to mental health care tell the consumer that mental health problems (and care) are less "acceptable." Restricted mental health benefits encourage the translation of emotional distress into physical symptoms, which leads to costly utilization of inappropriate

and unavoidably ineffective use of general medical services and tests.

One feature of this Act, and current national policy, has the potential unintended consequence of encouraging this "somatization of emotional problems. This feature involves the emphasis on mental health training of primary care providers (c.f. Section 2(b)(4)). Primary care providers are oriented toward physical causes and medical treatments. There is little data to suggest that increased mental health training of primary care providers improves patient care. In fact, the increasing trend to overmedicate women suggests that while primary care providers may be more aware of mental health problems in their patients, they may also feel inadequate in treating those needs and, hence, overmedicate. An NIMH task force found that primary care providers spend an extra six minutes with patients they saw as "having an emotional problem," and I can tell you if that's all the time you spend trying to help a patient understand and change an emotionally painful problem or situation, you would not be very successful and you will be looking for anything which "gets the patient off your back."

There is another reason why the primary care provider initiative as it relates to mental health is a bad idea. It is regressive. It is a retreat into the inadequate and inappropriate system of mental health care we had 20 years ago. It also is actually the opposite of what consumers want. The University of Michigan survey I mentioned earlier found that the proportion of the adult population reporting actual use of professional help for a personal problem doubled between 1957 and 1976. The number of individuals reporting seeking such help from their family doctor (primary care providers) decreased by thirty percent, to a mere 21%. Those seeking

such help from appropriately trained mental health providers increased almost eighty percent, to 50%. The effect of our thirty-year effort to increase the number and quality of mental health services has been effective. The public knows and utilizes such services. I recommend the primary care initiative in mental health be eliminated from this Act, and the emphasis be on integrating a range of fully trained mental health providers into the physical health delivery system.

ACCOUNTABILITY AND HEALTH CARE

The citizens of our nation are entitled to accessible and high-quality health and mental health care at a reasonable cost. The major governmental responsibility should be to ensure a system of service delivery which is clinically effective and cost-efficient. Mental health coverage is an "insurable" benefit, and the provision of mental health services can reduce physical health costs. However, these facts will never be recognized given the way HEW funds services and evaluates services.

Well-designed and appropriately utilized evaluation programs should be the core of vital cost containment and quality assurance measures. A system of national health services must provide the best currently available treatment, yet it must be designed to facilitate innovation and incorporate change. This can be accomplished by a system which emphasizes a range of alternative services and modes of delivery, assesses their intended or unintended outcomes in a comparative manner, and uses the feedback to produce a change in the system itself. Such dynamic systems do not happen by accident, nor are they easily tacked on to existing systems.

A high-quality, rigorously-designed, outcome-oriented, integral system of evaluation is needed. First, an evaluation/accountability component must be an integral part of any national health care system. Second, such an evaluation unit must be relatively autonomous. Third, the head of the evaluation section must have an influential position within the health system and the ability to modify the system. Fourth, the priorities and goals in the national health insurance system must be prospectively articulated in measurable clinical/behavioral outcome terms. Fifth, such evaluation and research must be a continuous process. Sixth, the results must be publicly discussed, and when appropriate, the health care system changed. A properly designed and funded evaluation component would pay off in dollars and cents by continuing to fund only those services which are demonstrably effective and provided in a cost-efficient manner. I encourage you to consider such accountability mechanisms as you further refine this Act and other legislature initiatives.

FINANCING MENTAL HEALTH SERVICES.

Issues of financing for mental health services are so important as to effectively override most other policy decisions. For instance, it is the expressed intent of nearly every part of the mental health system--governmental or private--to promote deinstitutionalization and increase the use of ambulatory mental health care services. However, the reimbursement systems of Medicare, Medicaid, and many private insurance carriers unquestionably promote placing the mentally disabled in hospitals. This

pattern of reimbursements only fuels health care inflation, leads to inappropriate treatment of the patients, and restricts the availability of good mental health care.

Additionally, there is a lack of acknowledgement within the health insurance programs that appropriate mental health care can be provided by a number of qualified professional disciplines. In fact, the present reimbursement policies actually promote mental health treatment by largely unqualified general practitioners--through official recognition of the physician as the only reimbursable practitioner.

Studies of Community Mental Health Centers, Health Maintenance Organizations, and the Medicare program (through a test project in Colorado) have shown that insurance coverage for the services of psychologists is not only appropriate (in terms of quality of care) but also cost-efficient. We strongly support the recommendations of the President's Commission on Mental Health that mental health care reimbursement should be provided directly to the four core mental health professions--psychiatry, psychology, social work and psychiatric nursing. Underlying this recommendation is the explicit requirement that those practitioners to be reimbursed for their services are the practitioners specifically trained to provide mental health services.

We endorse, and encourage your consideration of the numerous bills before this Congress that would modify the Medicare and Medicaid programs to allow more rational mental health benefits and permit direct access for patients to the range of qualified mental health practitioners and organized providers of care. The provisions of these various bills would recognize Community Mental Health Centers and psychologists for

direct reimbursement; would increase or eliminate the annual dollar limit for coverage of mental health services; and would provide for equality of copayment requirements between mental health and physical health care services.

These changes would not only benefit the Medicare and Medicaid eligibles who deserve appropriate and accessible services, but would also be an important step toward rationalizing the mental health care system. Unless we change the financing priorities for mental health services, we cannot effectively change the way services are--or are not--delivered.

A RESPONSIBLE LEVEL OF FUNDING

The suggested initiatives of Titles I, II, and III could greatly improve the availability and quality of mental health care of those neglected by the mental health "system." While attention must be paid to ensuring that the new initiatives do not fragment comprehensive care, it is even more important that the funding authorization be set at a responsible level, one that allows these initiatives to be more than scattered "demonstration" projects. We recommend a funding level of between \$75 and \$80 million for Titles I, II, and III, and a funding level of \$340-\$350 million for Title IV. Thank you for the opportunity to offer these recommendations and for your consideration of them.

Senator KENNEDY. Dr. Macht?

Dr. MACHT. My full testimony is available for the record. I will try to summarize.

My name is Lee Macht. I am professor and head of the Department of Psychiatry, Harvard Medical School at Cambridge Hospital. I am here today as a member of the Board of Trustees of the American Psychiatric Association, a medical specialty society representing over 25,000 psychiatrists nationwide.

I am also from my native Massachusetts where we are in the middle of a major budget battle on the need for enduring Federal commitment as the vagaries of State politics sometimes invade the provisions of services.

In 1963 we looked to President Kennedy and worked closely with him to achieve our mutual objectives. We have worked closely with President and Mrs. Carter and with the President's Commission on Mental Health. We believe that this has been a significant development.

We note an ancient Chinese saying, "I curse you; may you live in an important age." Mr. Chairman, we believe we are mutually cursed that this is an essential, if not critical, time to begin to complete the unfinished work of the Community Mental Health development. We look to you and your colleagues in the Congress to carry the mantle and lead us even further on behalf of these most needy citizens.

We believe that the bill in its present form does not do justice to the magnitude of this problem and the crying need for its solution. We believe that the bill's legal funding will not significantly affect patient care in States and localities and that the inadequacy of the funding will not only fail to stem the tide of inadequate community care and the "dumping of patients," but will have a backlash effect in that the view will prevail that, even with Federal assistance, these clients will remain unserved or, at best, underserved.

Senator KENNEDY. You are accusing us of being stingy and little spenders. We are not accused of that very often.

Dr. MACHT. We are just asking for your help in getting us more money.

In addition to this bill, we would like to work with you in the reworking of medicaid, medicare, and social security disability, as well as the use of Housing and Urban Development dollars.

It is basically our belief that titles I through III in the current funding situation are so meager that they will, in fact, provide very little for very few.

We support the concept of comprehensive mental health services, particularly as they are linked to the care of the chronically ill and as they serve low income and minority groups. However, we also believe in increasing the flexibility of Community Mental Health Centers, and that many, many communities should be given the opportunity to begin somewhere, even with only one service, as long as that is linked, as the bill does, to the evolution of a comprehensive service system. We believe the major problem here is really the long-range funding of community services once the Federal dollars diminish or stop. Many States and localities are unwilling or unable to pick up these costs and, as you know, many

services are not reimbursable, albeit essential for comprehensive programs.

We strongly support the integration of mental health and general health and social services, especially in primary care settings, particularly neighborhood health centers. We note the absence here of integration language and programing for integration of services, for mental health in general hospitals, although we are in total agreement with the conceptualization of the money into neighborhood health centers.

We believe that the manpower section also raises major concerns. We strongly believe, although this might sound self-serving, that we should declare a manpower shortage in our specialty. We believe that psychiatrists should be trained and receive incentives to work in the priority areas that this bill defines.

We note the absence of an advocacy section in the bill and you know, Mr. Chairman, of our keen interest in that, in seeing that that is addressed. We believe that such an advocacy system should be balanced, providing equitable safeguards for providers, as well as clients, in the ultimate best health care interest of that person.

We further note the absence of adequate highlighting and funding of services for children. This might require a separate title so that it can be addressed more adequately and funded more appropriately.

We believe there is inadequate attention paid to the private sector, both organized settings and individual practitioners. Again, without being self-serving, private practitioners and facilities have, in many instances, been left out of the mainstream of the evolution of community mental health. We believe that this has tended to create a two-tier system of care.

We believe that this bill is so linked to third-party insurance for mental health services and to national health insurance that we must reiterate that any insurance system should provide for mental health care on the same basis and parity with physical health care.

We believe the bill does not address the major problem of community acceptance, including restrictive zoning laws for community residences. This must be addressed and research programs developed and performed on how to educate and change public attitudes if all our efforts are to really succeed.

Having presented major concerns with the content and specifics of this bill, let me reiterate that it does provide a major and significant framework and a bold articulation of public policy and priorities. The American Psychiatric Association applauds its intent and stands ready to work with you to work out the substantive content problems of concern. We believe that, given the leadership of the President and yourself and your commitment, that this bill, in revised form, coupled with changes in the entitlement programs and a national health insurance program with adequate mental health benefits will make a major and lasting contribution to the good of our fellow Americans.

Cursed to live in this important era, let us make the bold but necessary steps and not shrink back to safer asylums. The millions of mentally ill in our Nation demand nothing less than our best, and they should receive it. As a Nation, we cannot be too self-

centered or too poor in dollars or spirit to fail to care for those in greatest need among us, or to tolerate the shame of our State hospitals when we have the promise of building more decent, humane, growth-promoting community services. We join with you and the President in your efforts to make this vision a reality and to see things as they are and ask why but "dream things that never were and ask 'why not?' "

Thank you.

[The prepared statement of Dr. Macht follows:]

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TESTIMONY

of the

AMERICAN PSYCHIATRIC ASSOCIATION

before the

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

of the

SENATE LABOR AND HUMAN RESOURCES COMMITTEE

on

S. 1177

THE MENTAL HEALTH SYSTEMS ACT

presented by

Lee Macht, M.D.

June 11, 1979

Mr. Chairman and distinguished Members of the Subcommittee, my name is Lee Macht, M.D. I am Professor and Head of the Department of Psychiatry, Harvard Medical School at Cambridge Hospital. I also serve as a Member of the Board of Trustees of the American Psychiatric Association, a medical specialty society representing over 25,000 psychiatrists nationwide.

The American Psychiatric Association has a long and distinguished history of concern for the mentally ill in America. Founded by thirteen dedicated Hospital Superintendents during the eighteenth century, it has maintained a commitment and dedication to the seriously mentally ill.

Dr. Harry C. Solomon, our President in 1968, stated: "The large mental hospital is antiquated, outmoded and rapidly becoming obsolete. We can still build them, but we cannot staff them; and, therefore we cannot make true hospitals of them.... I do not see how any reasonably objective view of our mental hospitals today can fail to conclude that they are bankrupt beyond remedy. I believe, therefore, that our large mental hospitals should be liquidated as rapidly as can be done in an orderly and progressive fashion."

We continue to hold that view and believe that, despite the monumental steps forward, made by the 1963 legislation and the 1975 amendments in this field, that we are in the earliest stages of revolutionizing a mental health delivery system so that it meets the needs of our citizens, particularly the chronically mentally ill, children, the elderly and minority group members. In 1963, we looked to President Kennedy and worked closely with him to achieve our mutual objectives. His contribution was heroic and began us on his "bold new approach." We have worked closely with President and Mrs. Carter and with the President's Commission on Mental Health. This has been another critically significant development which moves us even

closer to our national goal of developing highest quality, accessible care for the mentally ill provided in the least restrictive setting and with dignity.

There is an ancient Chinese saying: "I curse you; may you live in an Important age." Mr. Chairman, we are mutually cursed that this is an essential, if not critical, time to begin to complete the unfinished work of the Community Mental Health development. It is critical because millions of Americans still receive limited, frequently sub-standard and at times, tragically, no care for their mental illness. This is especially true of the high priority groups, which this legislation addresses. It is a critical time because far too many Americans still have only the poorly custodial state hospital to turn to when in desperate need. It is a critical time because, much as in 1963, we have the opportunity to really make a difference for our generation and others to follow. Mutually cursed to live in this Important era, the President and now the Congress have made a significant step forward in attempting to embody in legislation the historic and highly significant work of the President's Commission. Mr. Chairman, we look now to you and your colleagues in the Congress to carry the mantle and lead us even further on behalf of these most needy citizens. The American Psychiatric Association believes that these citizens, long isolated and disenfranchised, doubly impoverished by economic circumstances and by disability deserve far more. We support the concept and framework of this bill as a major attempt to move us further out of the dark ages of our institutions and into the warm light of highest quality community care. However, we believe that the bill in its present form does not do justice to the magnitude of this problem and the crying need for its solution.

The bill takes as its centerpiece the care of the chronically mentally ill, as well as prevention. We fully support the outlines of these sections and their philosophy. We believe that they are essential in the delivery of services to those in greatest need. The bill, however, does not adequately emphasize the need for community support systems for the longterm patient in the Community. These are essential, both to maintain patients in the community and to foster their growth and development toward lives of independence and productivity. The bill does not adequately address the need for incentives for care of these patients and very seriously underfunds the needs of a community based system of care for these patients. We believe that the meager funding will not significantly affect patient care in states and localities and that the inadequacy of the funding will not only fail to stem the tide of inadequate community care and the "dumping of patients", but will have a backlash effect in that the view will prevail that, even with Federal assistance, these clients will remain unserved, or at best, underserved. Let us provide adequate resources, including major modifications in Medicaid, Medicare and Social Security Disability Insurance to underwrite the income maintenance as well as treatment costs for these individuals. Let us further include Housing and Urban Development dollars targeted to this population. Even with these sorely needed revisions in these funding sources and their priorities focused on this population, there is still great need for more dollars attached to this Title of the Act, especially for community support systems.

We believe that the major problem with Title II, Prevention, is that there is still not a national focus on this problem and also that critically needed outcome and evaluation research will be sorely neglected, as in other sections of this bill. We believe that this Title is also inadequately funded,

and that this underfunding, coupled with that in Title I, makes the problem especially severe in that this two-pronged effort, prevention and chronic care, will not really get off the ground to the great detriment of patients and of the whole Community Mental Health development.

We strongly support improving the administration of State Mental Health Services, but are concerned that this bill may add to the administrative and paper work burdens of already understaffed and underfunded State Departments of Mental Health. We strongly support the idea of performance contracts as a way of both assisting priority setting, maintaining activities, and influencing patient care. The states are very uneven in their abilities to administer, manage, plan and develop programs. They need massive assistance in these efforts and this bill only makes a minimal start in this direction.

We support the concept of comprehensive Mental Health Services, particularly as they are linked to the care of the chronically ill and as they serve low-income and minority groups. However, we also believe in increasing the flexibility of Community Mental Health Centers and that many, many communities should be given the opportunity to begin, somewhere, even with only one service, as long as that is linked, as the bill does, to the evolution of a comprehensive service system. We believe the major problem here is really the long-range funding of community services once the Federal dollars diminish or stop. Many states and localities are unable or unwilling to pick up these costs and, as you know, many services are not reimbursable, albeit essential for comprehensive programs. This problem is the essential one to be addressed and there must be a long-term Federal commitment.

We strongly support the integration of mental health and general health and social services, especially in primary care settings, particularly neighborhood health centers. We believe this is a major step toward making Mental Health Services relevant to people's needs, as they define the need for outside assistance. We note the glaring lack of the integration of Mental Health Services into general hospitals in this bill, as we believe that this is a major and crucial direction for in-patient, emergency and ambulatory care. We also note the crucial absence of Day Treatment (frequently linked to primary care settings) in this legislation. Also, we once again must call to your attention the major underfunding of this crucial section.

We believe that the manpower section also raises concerns. We strongly believe that Psychiatry is, and should be declared a manpower shortage specialty. Although this might sound self-serving, we are convinced that there is inadequate psychiatric manpower to fulfill the commitments of other sections of this Act and for state services. We believe that psychiatrists should be trained and receive incentives to work in the priority areas that this bill defines. We believe that the payback provision should apply equitably to other medical specialists as well, to address the problem of other shortages in medical manpower. We believe, of course, that any payback should only occur after the physician, or other practitioner, is fully trained.

We note the absence of an advocacy section in the bill and know of our shared keen interest with the Chairman, in seeing that this issue is addressed. We believe that such an advocacy system should be balanced, providing equitable safeguards for providers, as well as clients, in the ultimate best health care interest of that person.

We further note the absence of adequate highlighting and funding of services for children. This might require a separate title, so it can be addressed more adequately and funded more appropriately. The President's

Commission on Mental Health identified as many as 9,600,000 children suffering with mental, nervous or emotional disorders, with only 10 percent receiving treatment through existing programs.

We believe there is inadequate attention paid to the private sector, both organized settings and individual practitioners. Again, without being self-serving, private practitioners and facilities have, in many instances, been left out of the mainstream of the evolution of community mental health. This has tended to create a two-tier system of care, one for the rich and one for the poor, which is undesirable for all concerned. This could be addressed by this bill if it went further to provide adequate incentives to the private sector. We believe that in the public interest, we must recognize that the public mental health problem cannot be solved by the public sector alone, and that a viable partnership with the private sector must be forged with equity for all parties.

We believe that this bill is so linked to third-party insurance for mental health services and to national health insurance, that we must reiterate that any insurance system should provide for mental health care on the same basis and parity with physical health care. We believe the nation needs a new vision in the funding of chronic care, both for physical and mental health. While possibly beyond the scope of this bill, it does begin to be addressed here and should be pursued vigorously.

We believe the bill does not address the major problem of community acceptance, including restrictive zoning laws for community residences. This must be addressed and research programs developed and performed on how to educate and change public attitudes if all our efforts are to really succeed. Restrictive zoning laws will impede the whole community development and must be addressed nationally, in the states and locally. Our goal must be the real integration of former patients into our communities as good and participating neighbors.

Having presented major concerns with the content and specifics of this bill, let me reiterate that it does provide a major and significant framework and a bold articulation of public policy and priorities. The American Psychiatric Association applauds its intent and stands ready to work with you to work out the substantive content problems of concern. We believe that, given the leadership of the President and yourself and your commitment, that this bill, in revised form, coupled with changes in the entitlement programs and a national health insurance program with adequate mental health benefits will make a major and lasting contribution to the good of our fellow Americans. Any society should legitimately be measured, in terms of its social progress, by its response to those in greatest need. This could be a significant step forward for our nation. Cursed to live in this important era, let us make the bold but necessary steps and not shrink back to safer asylums. The millions of mentally ill in our nation demand nothing less than our best, and they should receive it. Even in an era of austerity, we must not lose our momentum in this area. As a nation, we cannot be too self-centered or too poor in dollars or spirit to fail to care for those in greatest need among us, or to tolerate the shame of our state hospitals when we have the promise of building more decent, humane, growth-promoting community services. We join you and the President in your efforts to make this vision a reality and to see things as they are and ask why but "dream things that never were and ask 'why not?'"

My testimony seeks to limit itself to the time requirements you have requested of witnesses, and I ask that a more detailed analysis and series of legislative recommendations, in conformity with my presentation today, may be submitted on behalf of the American Psychiatric Association for the hearing record and be included at the conclusion of my remarks.

Senator KENNEDY. Thank you very much. We had some interesting testimony, important testimony, about the problems of minorities.

What are each of your associations doing to try to bring more minorities into the profession and what are each of your associations doing to try to reach out to provide these services for minority groups?

Dr. VANDENBOS. The American Psychological Association has a very large minority fellowship program funded by NIMH in which we have very creatively taken and expanded the amount of money in that grant that is—the number of people in that grant.

Senator KENNEDY. What are we talking about?

Dr. VANDENBOS. In terms of the number of people?

Senator KENNEDY. Yes; you can provide it for us.

Dr. VANDENBOS. I will. In terms of women, we have an office of woman affairs within our central office, a very active committee involved in developing a number of projects. However, I would say the focus of the women issue is probably less well developed than minority issues.

Senator KENNEDY. Will you provide for us some additional information on both of those points? Maybe we will write you a letter to specify the types of information we want and make it part of this record.

Is this Office for Women's Affairs, is that to bring women into the profession or to provide social services for women?

Dr. VANDENBOS. The Association per se is not a service organization. However, we do advocate on behalf of increasing the number of women within psychology. Also they advocate increasing materials related to women's issues within the core training programs of the profession. We also advocate for increased appropriate services to women.

Senator KENNEDY. Do you have a program to increase, for example, women in the field of psychology?

Dr. VANDENBOS. Yes.

Senator KENNEDY. Do you want to describe it briefly and can you tell us how successful it has been?

Dr. VANDENBOS. In the sense of saying that we have a formal program that is funded, we do not. In the sense that women represent very large percentages of the field—

Senator KENNEDY. What percent do they represent, say, in psychology?

Dr. VANDENBOS. I would say 40 percent in the clinical area. I am not sure overall, my colleague, Nancy Russo, who directs that program is here.

Dr. RUSSO. Women are 28 percent of psychologists that are members of APA. APA's Women's Programs Office, the Administrative Office that I head, has a dual purpose. One, to increase the status of women in the profession of psychology, and the other is to use the profession of psychology to advance the status of women. We have also an office of minority affairs which has a similar mission. We do not have as many minorities as women in psychology and we are not large offices, but we do have a coordinated effort so we can maximize the small resources we do have.

Senator KENNEDY. If you have 28 percent in terms of women, do you know what it is in terms of minorities?

Dr. RUSSO. It varies by minority. The figures for APA membership are 1.1 percent black, 0.4 percent Hispanic, 0.7 percent Asian and 0.1 percent American Indian.

Dr. VANDENBOS. The percentage of minorities in terms of the last time we did a study is relatively low. The total minority percentage was around 6 percent in data, that is 3 years old. However, our data in terms of the number of people in graduate training are significantly higher. I think about double that.

Senator KENNEDY. If you can just provide it for us.

Just on that point, Dr. Macht?

Dr. MACHT. We will provide the actual data. We have a much better track record in attracting women into our profession, about 30 percent of our profession. Our profession has traditionally not attracted minority group members, and I think there is an effort currently to try to do that more. But, in the face of decreasing numbers of people going into psychiatry—whereas, 10 or 15 years ago, 10 or 15 percent of the medical school graduates were going into psychiatry, today only 4 or 5 percent go into psychiatry. So we are maintaining a major battle in attracting new people.

I think the problem begins much earlier in terms of work we have done and begins to recruit minorities even at the high school level and get them interested in pursuing careers either in psychology or psychiatry, that the problem begins in high school as to what career choices are made. I think there are many obstacles. I think at this point economics, rather than opportunity, is the obstacle in going into the medical profession.

Senator KENNEDY. Perhaps you can provide some additional information.

[The following was received for the record:]

AMERICAN PSYCHOLOGICAL ASSOCIATION
1200 SEVENTEENTH STREET, N.W.
WASHINGTON, D.C. 20036

Telephone: (Area Code 202) - 833-7600

June 21, 1979

The Honorable Edward M. Kennedy
Chairman, Subcommittee on Health and
Scientific Research
Committee on Labor & Human Resources
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

This is to provide additional information for the record on a series of issues, per your request, following my testimony on June 11 regarding the proposed Mental Health Systems Act. It will address the training of minority mental health professionals, the training of women in psychology, industrial-based mental health programs, and mental health services for children and youth.

TRAINING MINORITY PROFESSIONALS

In 1978, the American Psychological Association established a Minority Affairs Program Office. It is housed in the APA Central Office and is entirely supported with Association funds. The APA Minority Affairs Office functions in close collaboration with an 11-member committee composed of distinguished ethnic minority psychologists from throughout the United States. The primary objectives of this new effort are to increase the scientific understanding of those aspects of psychology that pertain to culture and ethnicity, to increase the quality and quantity of educational opportunities for ethnic minorities in psychology, and to promote the development of culturally sensitive models for the delivery of psychological services. In addition, the Minority Affairs Office serves as a clearinghouse for the collection and dissemination of information relevant to or pertaining to ethnic minority psychologists and students.

The American Psychological Association has operated a Minority Fellowship Program in Psychology since 1974, when it received an initial grant from the NIMH Center for Minority Group Mental Health Programs. In addition, APA has made financial contributions of approximately \$30,000 per annum to the program since its inception, not including indirect support costs. The initial NIMH grant provided

\$75,000, \$150,000, and \$225,000 in trainee support for the second, third and fourth years of the grant respectively, and decreasing amounts in the fifth and sixth years. The grant allowed support for trainees in research or clinical fields. In 1977, an additional three-year grant to support clinical trainees was awarded. Both grants terminate in FY '80, although renewal proposals have been submitted.

Over the five award years, the APA Minority Fellowship Program has received over 6000 inquiries, resulting in nearly 3000 applications. Applications are reviewed in terms of the applicant's capacity to pursue and complete doctoral work. Virtually all of the applicants are qualified, as reflected by the fact that over 90% ultimately are admitted to graduate programs. The Minority Fellowship Program, however, identifies "highly qualified" individuals to become "finalists" in the consideration for receiving a fellowship. Over the five award years almost 500 individuals have been so selected and fellowship awards made to 222 persons, a figure which represents about 8% of the applicant pool. Fifty new fellowships will be awarded in 1980.

The first nine graduates from our program obtained their Ph.D's in 1978. Twelve more are expected to graduate in 1979. These numbers should dramatically increase in 1980 and 1981. Graduate training in psychology is a five or six year enterprise, so, with the phasing-in of the initial awards of traineeships, the real impact of graduating doctoral students will be seen in the seventh and eighth year of the Minority Fellowship Program--assuming that our grant is renewed.

The APA program is cost-efficient. Through cost-sharing or matching arrangements, the APA Minority Fellowship Program is able to match every dollar of financial support to Fellows with \$1.13 from host graduate institutions. Considering the total net stipend support to Fellows, the administrative costs are only 11.4 percent.

Moreover, the Minority Fellowship Program effects university training programs far beyond simply supporting a given student. The MFP director communicates regularly with psychology department chairs and faculties, and regularly visits graduate psychology departments across the country on behalf of the MFP Fellows. The director counsels and advises admissions committees on appropriate and inappropriate selection criteria. Program consultation concerning the implications of the Bakke Decision has been provided, and curriculum consultation regarding the training of ethnic minority psychologists and placement assistance has been given.

These activities aid in developing a climate favorable to recruiting and training ethnic minority students. Psychology departments participating in the Minority Fellowship Program have a higher percentage of minority students than the national average, even though the department may only have two or three actual MFP Fellows.

The APA MFP has maintained close contact with its Fellows. Professional and personal support is provided, not just financial support. This has helped Fellows to complete their training and to form mature and accurate judgements of where and how to begin a professional career. The program's job locator and newsletter has assisted in the development of a network of academic institutions and public and private mental health facilities involved with minorities, and a national cohort of ethnic minority psychologists. Such regular contact and involvement with the Fellows aids the retention of ethnic minority students.

Finally, the APA program has developed rosters of undergraduate ethnic minority students that are circulated to graduate departments for recruiting purposes. The director makes annual visits to summer research institutes where primarily Black undergraduates spend two months between their junior and senior years learning about psychology and conducting research projects. The director visits undergraduate Black colleges and arranges meetings with ethnic minority undergraduate psychology majors during site visits to graduate departments. All of these activities are part of the identification and recruitment effort necessary to increase the pool of minority graduate students in training. These activities are a side-benefit of the basic program. The operation of the Minority Fellowship Program of the American Psychological Association is a model for such programs.

The Minority Fellowship Program has increased the "consciousness" of graduate psychology departments about minority issues and the need for minority professionals. It has begun to make inroads into the problems of availability of well-trained ethnic minority psychologists. But it is only a beginning. Stable support for 10 to 15 years is needed.

In 1977, approximately 5% of psychologists were members of ethnic minorities. Data from the Earned Doctorate Survey of the National Academy of Sciences (1978) show that 7% of the persons earning their doctorate in psychology in 1976-77 were ethnic minorities. A 1976-77 survey of 103 graduate departments with an APA-approved doctoral clinical program found that 10.7% of the students were ethnic minorities. By contrast, a sample of 25 graduate departments involved with the APA Minority Fellowship Program found that 15.1% of the students were ethnic minorities. This demonstrates the direct and indirect impact of the APA MFP efforts.

These figures suggest that advances are being made. From a figure of only 5% in the professional pool, to 7% of recent doctorates, to 11% in training demonstrates a clear positive trend. It will obviously take some time for the pipeline to empty into the professional market with sufficient impact. Provided national policy and priorities continue to support these efforts, significant positive effects will be clearly demonstrated over the next 10 to 15 years. The federal commitment is critical. Although the American Psychological Association has been able to magnify the effect of the federal support, both directly and indirectly, it could not significantly increase the present minority participation level without federal backing.

We need Congressional support of these efforts. Support for training in general has been in disfavor, and the beginning gains in relation to minorities may be jeopardized. The 1980 funding for the APA Minority Fellowship Program was recently cut by \$90,000. The fate of the grant for 1981 and beyond is unknown. New minority research fellowships have not been allowed for the last two years; a grant for minority research fellowships was approved by NIMH, but unfunded.

We encourage you to insure that this initiative is not damaged by contradictory policy and program initiatives. The President's Commission on Mental Health has clearly documented the need and importance of minority professionals. We recommend that you support the NIMH training budget, specifically instruct the NIMH not to cut minority (clinical and research) training funds, and specifically direct NIMH to support the five minority fellowship programs in a stable manner with slightly increasing funds.

WOMEN

In 1970, the Council of Representatives of the American Psychological Association established an eight-member task force to prepare a position paper on the status of women in psychology. The Task Force set for itself the goal of furthering the major purpose of APA--to advance psychology as a science and as a means of promoting human welfare--by making recommendations to ensure that women would be accepted as fully enfranchised members of the profession. Among the activities of the Task Force was the collection of information to document the status of women in our profession. A membership survey was conducted, and the final report of the Task Force, in 1973, provided documentation of the disadvantaged status of women in psychology.

In 1972, The Task Force became a continuing Committee on Women in Psychology (CWP) which reports to APA's Board of Social and Ethical Responsibility. CWP has been the catalyst for a variety of subsequent efforts to eliminate sex bias, including Task Forces on Sex Bias and Sex Role Stereotyping in Psychotherapeutic Practice (under the Board

of Professional Affairs), Sexism in Graduate Education (under the Education and Training Board), and Sexist Language in APA Journals (under the Publications and Communications Board). In 1973, the Division of the Psychology of Women (Division 35) was established to promote the research and study of women and to encourage the integration of this information about women with the current psychological knowledge and beliefs in order to apply the gained knowledge to the society and its institutions.

The Women's Program Office was established within the Central Office of the American Psychological Association in 1977 as a reflection of the importance of devoting specific attention to the needs of women. The Program is located within the Office of Programs and Planning. In addition to women's concerns, the Office of Programs and Planning encompasses ethics and social responsibility, professional affairs, scientific affairs, education and training, accreditation, international affairs, and human resources. It produces technical and analytical reports in these areas as one means of providing the sound information necessary to the APA governance structure, to its membership, and to government agencies.

The Women's Program of the American Psychological Association has a dual mission. First, it has the responsibility of monitoring the status of women in psychology, serving as a focal point for the Association's efforts to insure equality of opportunity for women psychologists. Second, it is charged with monitoring governmental actions and organizing information from psychologists on public policy issues affecting the lives of women. The office activities fall into scientific, clinical, educational, and public interest areas. In addition to providing staff support for the Committee on Women in Psychology (CWP), the Women's Program serves as a resource on women's issues for all other relevant units of the APA Governance Structure, and as a coordinator of their efforts that specifically relate to women's concerns.

A few illustrative activities of the Women's Program Office in 1978 are: (1) Scientific--a) organizing and disseminating information on the status of women scientists and professionals in psychology, b) participating in an AAAS-NSF sponsored Conference on Women in Scientific Research, including publicizing that conference in the Monitor and developing interest in the implementation of its recommendations, c) organizing a workshop on the politics of federal funding for regional association meetings, d) stimulating testimony on legislation dealing with women in science, (2) Clinical--e) facilitating implementation of the Report on Sex Bias and Sex Role Stereotyping in Psychotherapeutic Practice, f) participating in the work of the Subpanel on the Mental Health of Women of the President's Commission on Mental Health, presenting the report of that body to the Commission and organizing the dissemination

of the summary report, g) organizing information on women as providers of mental health services, (3) Educational--h) developing "Issues for Women in Psychology" pamphlet, i) developing an "Interviewing Women Candidates" brochure to help employers implement nonsexist interviewing practices, j) stimulating symposia in regional and national meetings that highlight employment issues for women in psychology, and (4) Public Interest--k) working with the Federation of Organizations for Professional Women to build coalitions with other women's caucuses and groups to help advance the status of women in all of the professions, and l) serving as a resource on public interest issues related to women. Issues of current special interest include reproductive freedom, affirmative action, domestic violence and the Equal Rights Amendment.

According to the National Research Council, in 1977 there was an estimated 295,800 Ph.D. scientists and engineers in the United States who had received their degrees between January, 1934 and July, 1976. 280,200 were still in the labor force. About 10%, or 30,500, of this doctoral population were women. Although psychology comprised only 10.3% of the doctoral population, it had the largest proportion (24%) of women. The relatively higher proportion of women in psychology compared with other sciences, however, does not hold across a fine field classification. The proportion of women in all fields of psychology, except for psychometrics, has increased since the 1960-1969 decade, but sex segregation is still marked.

Twenty-five percent of the 40,000 doctoral psychologist APA members are women. Data from the Earned Doctorate Survey of the National Academy of Sciences (1978) showed that 36.5 percent of the individuals earning their doctorates in psychology in 1976-1977 were women. A 1976-1977 survey of 103 graduate departments with an APA-approved doctoral clinical program found that 46.5 percent of the students, clinical and non-clinical, were women. These figures suggests that women currently represent a substantial proportion of psychology's pool of human resources and that that proportion is increasing.

While equal opportunity in education and training should not be neglected, the expanding number and proportion of women in psychology's workforce demand attention to employment issues. For example, a closer look at the employment status of 1977 doctorates in the specialties of clinical, counseling, and community psychology finds that 85.6 percent of the men are employed full-time compared to 69.9 percent of the women. The unemployed/seeking employment rate for women is 2.1 percent compared to 1.4 percent for men. Twenty percent of the women in that sample, compared with 7.2 percent of the men, are employed part-time.

These statistics could reflect a lack of full-time opportunities for women and/or exploitive personnel practices that enable institutions to reduce budgets by minimizing personnel benefits. They could also reflect a responsiveness to women's desires to combine home and career values through part-time work. Proper evaluation is needed to develop programs that will address barriers for women in the various settings. However, personnel policies that provide proper benefits for part-time workers are needed to ensure that part-time employment is not a means of exploiting women in the guise of responding to their preferences.

Salary differentials persist, and vary by employment sector. Data from the 1976 APA Human Resources Survey on the salaries of doctoral health service providers in psychology employed in a range of settings reveals that men earn more money than women in all settings. The differential was \$2400 in community mental health centers. The employment practices that produce salary differentials have not been adequately explored and data are needed. Mechanisms to ensure that health service providers receive equal pay for equal work will help to eliminate sex differentials in salary. Ensuring equal pay for equal work must be supplemented by equal access to promotion and broader and more responsible career opportunities. Career development and affirmative action programs are needed to equalize opportunity in the administration of mental health services.

INDUSTRIAL-BASED MENTAL HEALTH PROGRAMS

Several industry-based mental health intervention and referral programs were described in my testimony that related to secondary prevention efforts. You requested suggestions about how to address such initiatives legislatively. I suggest a sub-section of Title II authorizing funds for joint industry-community mental health programs. Such grants would be given to community mental health centers to cover the administrative costs of coordinating the programs. The actual direct service or treatment would be covered by the company's health insurance plan. It should not be necessary to provide companies with either a tax writeoff or to subsidize their share of the cost of such programs. The direct real savings that result from such programs save companies considerable money. Corporate users of employee assistance/mental health programs have reported reductions in medical and surgical costs of 55 percent, employee work attendance increases of 52 percent, and reductions in absentee-induced corporate costs of 74.6 percent. It is clearly to the company's financial advantage to provide such programs.

Community Mental Health Centers do not need to be funded for the direct service that they supply to the referred employees. Most corporations that are large enough to be interested in such an employee-assistance/mental health program also have good mental health coverage. The regular health insurance plan should cover services provided by the mental health center.

The inclusion of mental health benefits within the company's health insurance plan, and reimbursement to community mental health centers, should be a requirement for corporate participation in the program. Hence, such a joint industry-CMHC program would be able to provide service without any direct treatment cost to the government. Only the administrative costs related to coordinating the program need to be funded.

Depending on the size of the catchment area of the Community Mental Health Center, such grants to support industry-based mental health programs would require an estimated \$5000 to \$20,000 per year. You might wish to meet with representatives from some of the corporations which have used such programs. The Kennicott Copper Corporation, J. C. Penney, and the Oldsmobile Division of General Motors have utilized such programs and rigorously evaluated them. I encourage contact with individuals currently involved with such programs to gain further information on their operation and cost-saving features.

CHILDREN

The President's Commission on Mental Health placed major emphasis on the need for improved and expanded services for children and adolescents. This population is strikingly underserved. The Mental Health Systems Act does not adequately address the "system" problems related to the delivery of mental health services to children and youth. In draft versions of the Mental Health Systems Act attention was given to some of the special needs of children and adolescents. However, as the bill was introduced these sections were collapsed into other sections, often inappropriately, and the emphasis on services to children and adolescents was downgraded. We encourage you to amend the Act to make at least a partial response to the mental health needs of children and youth.

We recommend that a separate section be included under Title I addressing the mental health needs of severely disturbed children and adolescents. The emphasis should be on service delivery, not administration. Section 102 already provides support to state departments of mental health for administration, and it is expected that these administrative funds would include the improved organization and operation of mental health services for children and adolescents. The focus of the new section should be an outpatient mental health service, including intensive outpatient treatment in acute situations to prevent hospitalization, and follow up treatment for children, adolescents, and their families after hospitalization.

Prevention efforts were encouraged in my original testimony. Title II should clearly emphasize primary prevention with children. This should be clearly stated in Section 201. Sub-sections (1) and (3) should either

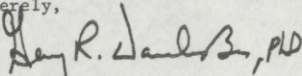
be eliminated or acknowledged to be minor efforts. The activities in Sub-section (4) should be eliminated from the grant program and the duties assigned to a Center for Prevention in NIMH. Sub-section (5) should be expanded, with the emphasis on primary prevention with children and industry-based/school-based targeted secondary prevention.

We recommend that Section 602 specifically state that state mental health plans must assess mental health resources for children and youth, explicitly state conclusions about the adequacy of the available resources (and/or recommendations for increasing each resources), and make a clear statement of the relative priority of improving the availability and quality of mental health care for children and youth.

Attention to these points will provide the structure for improving the availability and quality of mental health care for children and adolescents. Children and youth are currently underserved and, in most areas, inappropriately served. By failing to be responsive to the emotional/behavioral problems of children and youth, later problems and costs of dealing with the mental health problems of an older population are compounded.

Thank you for the opportunity to testify at the June 11 hearing on the Mental Health Systems Act, and for this opportunity to provide additional information for the record. We look forward to working with you to create a system of health/mental health care which is fully responsive to all health needs of all Americans.

Sincerely,



Gary R. VandenBos, Ph.D.
Administrative Officer--Mental
Health Policy

GRVB:dp

MINORITY FELLOWSHIP PROGRAM

ANNUAL REPORT FOR 1977-78

Prepared for

The Board of Directors

AMERICAN PSYCHOLOGICAL ASSOCIATION

August 26, 1978

This Report was written by Dr. James M. Jones, Director, Minority Fellowship Program

I. Introduction

The Minority Fellowship Program (MFP) has completed the 1977-78 year, the fourth full year of operation, with notable success. Much of this success is the coming together of programs and initiatives of the first Director, Dalmas Taylor, who envisioned a dynamic program of Fellowship support, ethnic advocacy, and academic/training consultation. The past year has shown great advances in each of these areas, as well as expanded new programs and activities which I have initiated.

The MFP was initially funded in 1974 for a period of six years. During that six year funding cycle, APA was expected to fund a total of 30 ethnic minority students for a maximum of three years each in the amount of \$7500 (including all tuition, fees, travel, and stipend) per Fellow. With the aid of an additional grant for clinical training awarded in September 1977, and a successful program of cost-sharing with host graduate institutions, we expect to have 145 active Fellows in 1978-79. In addition, we have 17 Fellows who already have been supported for three years (of whom 5 have obtained the Ph.D.), 4 who received support for less than three years and have completed their doctoral work, 3 who have been supported but have withdrawn from graduate school (none of them for academic reasons), and 3 who have been terminated from the program (only one for academic reasons). Thus a total of 172 ethnic minority graduate students have received support from MFP over the past four years, nearly a sixfold increase from the original projections.

Two things are important to note about these numbers. First, MFP has contributed a smaller percentage of the total financial support package than the grant called for. This is not a decrease of MFP involvement, rather, should be seen as leveraging the grant dollars for maximal impact. The average support package for Fellows for 1978-79 is full tuition and fees and a maintenance stipend of \$3900. The range of institutional support is from a minimum of full tuition and fees, to a maximum of full tuition, fees and \$2,000. In two instances, CUNY Graduate Center in New York and UCLA, the combined package is for full tuition and fees and \$5,000. It should be noted that these institutions have the second (CUNY has 11 Fellows) and fourth (UCLA has 7 Fellows) largest number of Fellows. Table 1 lists the institutions and the number of Fellows at each. One can see that in addition to the schools mentioned above, only Michigan (with 16 Fellows) and the University of Maryland (with 9 Fellows) have a critical mass of MFP Fellows. In both institutions, cost-sharing packages have been established and serve to guide recruitment and support of ethnic minority students.

The average tuition and fees for MFP Fellows is \$2500. This includes reduced tuition for advanced students, and smaller fees for in-state residents at state institutions. The average total stipend award is \$3900, while the average MFP contribution is \$3,000. Considering the 145 Fellows for the coming academic year, we have an estimated total of \$928,000 in fellowship

TABLE 1:
AREA BREAKDOWN OF FELLOWS AND INSTITUTIONS
1977-1979

AREA I		AREA II		AREA III	
Institutions	No. Students	Institutions	No. Students	Institutions	No. Students
*Arizona State	2	Illinois/Champaign	5	Adelphi	2
U of Arizona	1	Urbana		Boston U	7
Berkeley	4	*U of Illinois/CC	1	*Catholic U	1
*CA Grad Inst	1	Indiana	2	Clark	2
*CSPP/Fresno	1	Louisiana	1	Columbia Teachers	1
CSPP/LA	1	U of Miami	1	CUNY	11
*Colorado State	1	*Michigan State	2	*Fordham	1
Davis	4	U of Michigan	16	George Washington U	2
Denver	2	*Montana	1	Howard	3
Hawaii	2	Nebraska	3	U of Maryland	9
New Mexico	5	North Carolina	4	*U of MA/Amherst	3
Oregon	2	Oklahoma State	5	New York U	3
Stanford	5	*Texas Tech	2	Penn State	4
UCLA	7	U of Texas	8	*Pittsburg	3
Utah	2	U of Virginia	2	*U Rhode Island	1
*Washington State	2	*Washington U/St. Louis	2	*Rochester	2
U of Washington	2		TOTAL 55	Rutgers	3
Wright	3			*SUNY/Albany	1
	TOTAL 47			U Tennessee	2
				Yale	1
				TOTAL	62

*Institutions having MFP Fellows for
the first time in 1978-79

support of which \$435,000 is contributed by MFP and \$493,000 is contributed by host institutions. Thus for every MFP dollar contributed to the support of our Fellows, host institutions are contributing \$1.13, for a matching rate of 113%. This figure represents both the effectiveness of the MFP field activities and influence on graduate institutions, and the cooperation of those institutions in the support of graduate training in psychology for ethnic minority students.

The second point to note is that MFP provides a significant percentage of training input to its Fellows. I will talk at greater length later about the annual site visit activities, but they represent consistent and important contact between the Fellows and representative ethnic minority professional psychologists. In addition to the annual visits, summer programs, financial support for attending conventions during the year, an informative Newsletter, job placement, internship placement, and the sponsorship of an Orientation session at the annual meetings of APA provide additional relevant support.

In each of the areas noted above, the year has been successful. The following report will elaborate on the dynamics of the program outlined above, as well as special activities sponsored by MFP and discuss plans for the coming year.

II. Status of Fellows

Over the past four years some 172 ethnic minority students have received support from the Minority Fellowship Program. During academic year 1977-78 there were 106 active Fellows. With 56 new awards for 1978-79, and the passage of 17 Fellows from the program by virtue of the three year support limitation, we will have 145 active Fellows for 1978-79. Comprehensive Award data are presented in Table 2.

The stated purpose of the Minority Fellowship Program is to increase the numbers of PhD-trained ethnic minority psychologists. The ultimate consequence of that training is presumed to make a substantial and conspicuous impact on the ethnic minority communities which Fellows represent as well as the profession of psychology. There are a number of ways in which this impact can be realized including direct mental health service delivery, teaching and research, administration and advocacy, and involvement in the professional associations of both APA and ethnic psychology associations. The present section will summarize some of the activities and accomplishments of MFP Fellows over the past year.

A. Fellows Earning the Ph.D.

During the past year 9 APA Minority Fellows earned the Ph.D. Table 3 gives the names of these fellows, their speciality area, dissertation titles and current employment. It should be readily apparent that the training and subsequent placement of these new PhD's is consistent with the stated purposes of the

TABLE 2: COMPREHENSIVE AWARDEE DATA

Distribution by Sex by Ethnic Group

Ethnic Group	Year	Females	Males	Total
		N (Row %)	N (Row %)	N
Black	75-76	13	1	14
	76-77	18	5	23
	77-78	12	7	19
	*78-79	<u>21</u>	<u>8</u>	<u>29</u>
	TOTAL	64 (74%)	21 (26%)	85
	Column %	(56%)	(37%)	(50%)
Hispanic	75-76	4	2	6
	76-77	1	5	6
	77-78	11	10	21
	*78-79	<u>13</u>	<u>7</u>	<u>20</u>
	TOTAL	29 (55%)	24 (45%)	53
	Column %	(25%)	(42%)	(31%)
American Indian	75-76	-	3	3
	76-77	1	-	1
	77-78	-	2	2
	*78-79	<u>1</u>	<u>1</u>	<u>2</u>
	TOTAL	2 (25%)	6 (75%)	8
	Column %	(1.7%)	(10.5%)	(4.6%)
Asian American	75-76	3	2	5
	76-77	6	-	6
	77-78	7	2	9
	*78-79	<u>4</u>	<u>2</u>	<u>6</u>
	TOTAL	20 (72%)	6 (23%)	26
	Column %	(17%)	(10.5%)	(15%)
	TOTAL	115 (67%)	57 (33%)	172

*These figures include only the clinical students to whom awards have been made. An additional 24 students are non-clinical finalists and await notice of a supplemental award from NIMH for funding.

TABLE 3: MEP FELLOWS EARNING PH.D. IN 1977-78

NAME	ETHNICITY/ SEX	GRADUATE INSTITUTION	SPECIALTY AREA	DISSERTATION TITLE	CURRENT POSITION
Paulette Hines	B/F	University of Delaware	Social	Differential Components of Self-Esteem in Black and White Adolescents.	Clinical Psychologist Rutgers Community Mental Health Center
C. Diane Howell	B/F	University of California, Berkeley	Clinical	Black Concepts of the Ideal Black Woman	Staff Psychologist/ Post-Doctoral Intern Pacific Psychotherapy Clinic
Anna Gonzalez	H/F	University of Texas (Austin)	Counseling	Research Approaches to the Dynamics of Ethnic Minority Personality	Research Associate Hogg Foundation for Mental Health
Melba Vasquez	H/F	University of Texas (Austin)	Counseling	The Effect of Psycho- social and Cultural Factors on Academic Achievement and Persis- tence/Attrition of Chicano College Students	University Counseling Center Colorado State University
L. David Jacobs	AI/M	University of Utah	Social	Across Cultural Validation of a Contin- gency Model of Leader- ship	Research Analyst White Cloud Center
Anthony Brown	AI/M	City University of New York (CUNY)	Educational Psy.	An Examination of Age, Sex, and Cross-Cultural Differences in Cooper- ation and Competition, and the Relationship of the Two Variables to School Achievement	

TABLE 3: MFP FELLOWS EARNING PH.D. IN 1977-78 (CONTINUED)

NAME	ETHNICITY/ SEX	GRADUATE INSTITUTION	SPECIALTY AREA	DISSERTATION TITLE	CURRENT POSITION
Harriet McCombs	B/F	University of Nebraska	Social	Psychological Reactants and the Motivation to Escape Freedom as Functions of Perceived Competence	Assistant Professor Wayne State University
Joyce Jones	B/F	University of Nebraska	Clinical	Black Self Concept Development	Assistant Professor University of Tennessee (Knoxville)
Deborah Coates	B/F	Columbia University Teacher College	Measurement	Dimensions of Maternal Care and Cognitive De- velopment in Infancy and Early Childhood: A Longitudinal Analysis	Research Associate National Academy of Science - Committee on Testing Ability

program. The full gamut of service delivery, research, teaching, administration is represented among these recent graduates. They also represent involvement with ethnic psychology associations as Dr. Howell has been elected the Western representative to the Association of Black Psychologists (ABPsi), and Dr. Jacobs is the coordinator of the roster of the Network of American Indian Psychologists.

Five of these Fellows will be presenting their dissertation research at the annual APA Convention in Toronto in a symposium sponsored by the Minority Fellowship Program and endorsed by APA's Board of Social and Ethical Responsibility, Education and Training, and Scientific Affairs.

It is anticipated that another 20 MFP Fellows will be earning their Ph.D. degrees during the coming academic year. It is exciting to watch a program begin to realize its goals. The membership of ethnic minority psychologists in APA is estimated to be between 1-2% (between 400 and 800 members). With the inclusion of MFP Fellows alone, this percentage could be increased by another half percent. With other activities of the MFP and contact with non-Fellows who are working toward the PhD, the figure could well be at least twice as high.

B. Fellows' Publications.

The record of the graduating Fellows has been matched by others who continue to receive support. During the past year, several of the Fellows have had research and other articles

published. Table 4 lists representative publications by MFP Fellows. It should be noted that this is not an exhaustive list as several fellows have works in progress that will be either submitted for journal publication, or will appear in edited volumes. It should be clear, however, that the Fellows are active and able to communicate their ideas, training and experience to the professional community.

C. Appointment of New Fellows, 1978-79

As in previous years, there was a considerably larger number of qualifiable ethnic minority applicants than we could support.. It can be seen in Table 5 that during the four years in which awards have been made, 1,735 students have applied to the program for support, of whom 172 (9.9%) have received awards. The number of applicants has declined from an average of about 500 during the first two years of the program, to a little over 350 during the last two years. This is understandable since each year 90% of the applicants fail to receive awards. They comprise a growing pool of students who are frustrated in their efforts to obtain MFP support. Thus, while we are pleased with the progress of Fellows in the program, we must note that the unmet need remains high.

Table 6 lists all of the applicants who received awards in clinical psychology for academic year 1978-79. Of the 56 new awardees, 17 (30%) are entering doctoral programs for the first time. The clear majority of new awardees (70%) were already enrolled in graduate doctoral programs when they applied for support. The MFP objective is to increase the numbers of

TABLE 4: PUBLICATIONS OF MFP FELLOWS, 1977-78

NAME	INSTITUTION	PUBLICATION
Darlene DeFour	U of Illinois	"Does Television Violence Enhance Program Popularity? <u>Journal of Personality and Social Psychology</u> , March 1978.
Shelvy Keglar	U of Indiana	"Incidence of Depression in Alcohol and Drug Abuses", <u>Alcoholism Digest</u> , July 1977.
Clive Kennedy	U of Washington	"Affirmative Action in Psychology, 1977", <u>Professional Psychology</u> , In Press, 1978.
Suzanne Randolph	U of Michigan	<u>Like Me, Like You</u> . Series (10) Teacher Guides for Films on Handicapped Children. <u>Encyclopedia Britannica Educational Corp.</u> , 1977.
Joseph Smedley	Howard University	"Evaluative Race-Class Stereotypes as a Function of Class of Subjects," <u>Journal of Personality and Social Psychology</u> , April 1978.
Aline Nishihara	U.C.L.A.	"Psychology in Action: National Asian American Psychological Training Conference," <u>American Psychologists</u> , July 1978.
Harriet McCombs	U of Nebraska	" <u>Researching Black Women Through Law</u> ," <u>Black Women's Studies</u> , Vol. 12, 1978.
Victoria Moseley	Boston University	"Presignalled Behavior as a Predictor of Signalled DRL Performance.", <u>Bulletin Psychonomic Society</u> , Vol. 10, 1977.
Paulette Hines	U of Delaware	"Ethical Concerns in Family Therapy" <u>Professional Psychology</u> , In Press, 1978.
Steven Lopez	U.C.L.A.	"Clinical Stereotypes of the Mexican American." In J.L. Martinez (Ed). <u>Chicano Psychology</u> , New York: Academic Press, 1978.
Mitzi Tanaka	U.C. Berkeley	"Changing Perspectives in the Study of Children: Comparison Between Research and Popular Literature." <u>Psych. Reports</u> , Vol. 41, 1977.
Victoria Binion	U of Michigan	<u>A Descriptive Comparison of the Family of Origin of Women Heroin Users and Non-Users</u> , In Press, NIDA Government Publications.
Stanley Nakashima	U of Utah	<u>Organizational Preparedness for Change. Behavior Research Methods and Instrumentation</u> , In Press.
Jacqueline Rodriguez	U of Michigan	Locus of Control in Mexicans and Chicanos: The Case of the Missing Fatalist; <u>Journal of Clinical and Counseling Psychology</u> .

TABLE 5: COMPREHENSIVE APPLICANT DATA, 1975-1978

ETHNIC BACKGROUND	SEX		TOTALS
	FEMALE	MALE	
<u>Black</u>			
1975-76	185	145	330
1976-77	230	149	379
1977-78	137	90	227
1978-79	136	94	230
TOTAL	688	478	1,166
<u>Hispanic</u>			
1975-76	41	71	112
1976-77	36	46	82
1977-78	42	40	82
1978-79	50	50	100
TOTAL	169	207	376
<u>Native American</u>			
1975-76	1	7	8
1976-77	5	3	8
1977-78	1	3	4
1978-79	3	7	10
TOTAL	10	20	30
<u>Asian American</u>			
1975-76	20	30	50
1976-77	20	20	40
1977-78	24	14	38
1978-79	21	14	35
TOTAL	85	78	163
<u>TOTALS</u>			
1975-76	247	253	500
1976-77	291	218	509
1977-78	204	147	351
1978-79	210	165	375
TOTAL	952	783	1,735

TABLE 6: 1978-79 FELLOWS IN CLINICAL PSYCHOLOGY

NAME	SEX	ETHNICITY	GRADUATE SCHOOL	UNDERGRADUATE SCHOOL
• Alford, Linda	F	B	University of Virginia	Fisk University
• Apodaca, Christine	F	H	Univ of New Mexico	Univ of New Mexico
• Arenas, Silverio	M	H	Washington State	Pan American Univ
• Bayard, Mary Louise	F	H	U of CA at Los Angeles	U of CA at Santa Barbara
• Belgrave, Jeffrey	M	H	City Univ of New York	St. John Vianney
• Branch, Curtis	M	B	Pennsylvania State	Johnson C. Smith Univ
• Brown, Frederica	F	B	Adelphi	Howard University
• Bruguera, Mark	M	B	Colorado State	U of CA at Santa Cruz
• Chao, Gloria	M	H	Boston University	Stanford University
• Chavez, Chris	F	AA	U of Texas at Austin	Univ of New Mexico
• Coleman, Marion	F	B	Univ of Pittsburgh	Hampton Institute
• Comeslast, Dayle Marie	F	AI	University of Montana	University of Montana
• Dames, Kenneth	M	B	City Univ of New York	John Jay of Criminal Justice
• Echols, Eva	F	B	Howard	Spellman College
• Freire, Evelio	M	B	City Univ of New York	New York City Comm Col
• Garcia, Deborah	F	H	University of Denver	University of Arizona
• Garrison, Carolynne V.	F	H	Arizona State	San Diego State
• Gilbert, Anita	F	B	Wright Institute	U of CA at Riverside
• Glover, Ollie	M	B	Boston University	California State/Hayward
• Gong, Susan Mae	F	AA	University of Pittsburgh	U of Pacific at Stockton
• Goodwin, Beverly	F	B	U of CA at Berkeley	Pitzer College at Claremont
• Gray, Charles	M	B	New York University	Morehouse College
• Hendricks, Jeanell	F	B	University of Nebraska	College of Virginia Islands
• Hinkle, Phil	M	B	City Univ of New York	University of Wisconsin
• Huergo, Mayra	F	H	University of Michigan	Univ of Puerto Rico
• Ino, Steven M.	M	AA	Boston University	U of CA at Berkeley
• Jung, Rita	F	AA	Univ of Rhode Island	U of CA at Berkeley
• Landrine, Hope	F	B	Michigan State	Westminster College
• Landrum, Joycelyn	F	B	Oregon	Spellman College
• Lee, Wanda	F	AA	New York University	Stanford University
• Lugo-Frey, Damaris	F	H	CSP/ Berkeley	City College of New York
• Maduro, Eugenia	F	H	George Washington U	California State Univ
• Martinez, Eddie	M	H	Fordham	U of Southern California/LA
• Martinez, Teresita	F	H	U of Mass/Amherst	St. Peter's College
• Mattei, Maria	F	B	University of Maryland	Univ of Puerto Rico
• Moorman, Deborah	F	B	Catholic University	State U of New York/Buffalo
• Morote, Gloria	F	H	Oklahoma State	George Washington Univ
• Proctor, Noble	M	AI	Arizona State	University of Tulsa
• Reese, Finetta	F	B	U.S. International Univ.	U of CA at Los Angeles
• Rhodes, Lenora	F	B	Rutgers	San Diego State College
• Russell, David	M	B		Swarthmore College

TABLE 6 (continued)

NAME	SEX	ETHNICITY	GRADUATE SCHOOL	UNDERGRADUATE SCHOOL
•Saavedra, Ramon	M	H	Washington State	University of Puerto Rico
•Searcy, Mary	F	B	University of Rochester	Fisk University
•Soto, Jose	M	H	University of Nebraska	Inter-American U of PR
•Spruill, Edith	F	B	University of Georgia	University of DC
•Stovall, Carole	F	B	University of Maryland	Park College/Missouri
•Tate, Cynthia	F	B	State U New York/Albany	Fisk University
•Turrietta, Margaret	F	H	CSPP, Fresno	Marquette University
•Villar, Ivis	F	H	City Univ of New York	Brooklyn College
•Warrior, Jackie	F	B	Oklahoma State	NE Oklahoma State Univ
•Wilkinson, Jean	M	B	Michigan State	Michigan State University
•Wilkinson, Lenore	F	B	Pennsylvania State	Mount Holyoke College
•Williams, Carmen	F	B	Pennsylvania State	Univ of North Colorado
•Wright, Chris	F	B	Univ of CA at Davis	California ST/Sacramento
•Yee, Leung	M	AA	Univ of CA at Davis	Oregon ST U/Corvallis
•Zavala, Iris	F	H	U of Massachusetts/Amherst	Inter-American U of PR

• These fellows are entering doctoral programs in 1978-79 for the first time.

NOTE:

- * 39 of these fellows were enrolled in their current doctoral program during the past academic year.
- ** 17 are enrolling for the first time this fall
- ** 11 of these fellows obtained their B.A. degrees at Black Institutions.
- *** 5 obtained their B.A. degrees from Universities in Puerto Rico.
- *** 39 of these new fellows are females
- *** 17 of the new fellows are males
- **** The Ethnic breakdown of new fellows is as follows

Black	28	Asian American	6
Hispanic	18	American Indian	2

trained minority psychologists which, in principle, means getting more such students into the educational system. I will return to this issue in a later section.

It should also be noted that 11 of these new awardees earned their B.A. degrees at predominantly black undergraduate institutions, and 5 earned their undergraduate degrees in universities in Puerto Rico. This is important since these institutions are often not included in the distribution of resources and information. The fact that 16 of the 56 new awardees (28%) went to predominantly ethnic minority undergraduate institutions indicates the ability of these institutions to train students well, and the MFP ability to reach these students.

The breakdown of awardees by sex shows a majority of women 39 (70%). Overall female applicants were somewhat more numerous than males (56% to 44%), however there was a greater tendency for females to apply in clinical psychology and since this is the only area for awards this year, they are somewhat over represented relative to the overall applicant pool.

The distribution by ethnicity falls closer to the distribution of applicants with 28 Black awardees (50%), 18 Hispanic (32%), 6 Asian Americans (11%) and 2 American Indians (4%).

There were another 28 applicants who were included in the list of finalists but who, because they were not pursuing clinical degrees, could not be funded. Table 7 lists these non-clinical

TABLE 7: 1978-79 NON-CLINICAL FINALIST'S

Name	Sex	Ethnicity	Under Grad. Sch.	Grad. Sch.	Specialty
ALLEN, Donald	M	B	Rider College	WA U/St. Louis	Social
BARONA, Andres	M	H	Texas A&M U.	U of Texas	Sch. Psy.
BARRERA, Adriana	F	H	Texas A&I Univ.	Texas Tech. U	Social
BROOM, Michael	M	B	Morgan State	John Hopkins U	Experimental
BURTON, Rodney	F	B	Federal City College	U of Michigan	Hmn. Develop.
ENG, Ricardo	M	AA	Suffolk Univ.	U MA/Amherst	Biopsych.
GISCOMBE, Katherine	F	B	U Michigan/AA	U of Michigan	Organizational
HALLSTORKS, Robin	F	B	Morgan State	Ohio State U	Developmental
HILTON, William	M	B	Morgan State	CUNY	Environmental
HOUSTON, Archester	M	B	Abilene Christian U	Oklahoma State	Social
INOUE, Arlene	F	AA	UC-Berkeley	Stanford	Educational
JOHNSON, Michael	M	B	Morehouse College		Social
LITTLEJOHN, Valaida	F	B	Syracuse Univ.		Developmental
MARTINEZ, Laura	F	H	IntramERICAN U	Ill/Champaign	Educational
MONTEIRO, Kenneth	M	B	Dartmouth Col.	Stanford	Cognition
PARHAM, Patricia	F	B	Smith College	U of Texas	Community
PEREZ-Ginart, David	M	H	St. Peter's Col.	Rutgers	Sch. Psych.
RAMIREZ, Julio	M	H	Fairfield U	Clark U	Physiological
ROYALE, Gene Issac	M	H	San Francisco ST	UC-Santa Cruz	Social
SANCHEZ, Dolores	F	H	San Francisco ST	U San Francisco	Edu. Psy
SANTOS, Maryann	F	H	City Col. NY	U Texas/Austin	Sch. Psych.
SIMMONS, Linda	F	B	Swarthmore College	Harvard U.	Physiology
SMITH, Myrtle	F	B	U of Cincinnati	Peabody Col.	Developmental
TAYLOR, Marsha	F	B	Sweet Briar College	Cornell U.	Child Develop.
TAYLOR, William	M	B	Pomona College	Stanford Univ	Experimental
THOMAS, Shelley	F	B	U of Maryland	U of Michigan	Social
TRUJILLO, Robert	M	H	CA, Los Angeles	U of Michigan	Community
WILLIS, Benjamin	M	B	Harvard	Stanford	Social
ZAKS, Vivian	F	H	San Francisco State	UC-Santa Cruz	Social

14 Males
14 Females

Black 16
Hispanic 11

Asian American 1
American Indian 0

finalists. We are still awaiting word from NIMH on a supplemental request that would enable us to fund these students. In the absence of that authorization, we must reluctantly become a Fellowship program for clinical training only.

III. MFP Advisory Committee Activities

As in the past, the work of the Advisory Committee has been a major component of the overall outreach efforts of the Program. Three members of the committee ended their tenures, Dr. Albert Yee, Chair, Dr. Margarita Garcia and Dr. Gary France. Drs. Yee and Garcia were on the Committee for three years and contributed substantially to the formation of MFP policy and the implementation of MFP programs. Dr. France was only a one year appointee.

At its June meeting, the Board of Directors approved three persons as replacements for the above Committee members. They are Dr. Reiko Homma True, Mental Health Consultant, Dr. Jose Bauermeister, Chairman of the Department of Psychology at the University of Puerto Rico, Rio Piedras Campus and Dr. L. David Jacobs, Research Associate at the White Cloud Native American Research and Development Center, and former MFP Fellow at the University of Utah. We are pleased to have these new members who have already demonstrated a commitment to psychology as a profession and to making it work for their respective ethnic constituencies. Dr. Robert V. Guthrie in his second year on the Advisory Committee was elected to the Chair.

A. Site Visit Activities

During the past year the MFP program of site visits to campuses was the most active it has been. During 1976-77, there were approximately 28 universities in the site visit itinerary. Last year, the number rose to 44. Since it was my first season as Director of the program, I was surprised at the various reactions we received during our visits. In some cases, we were received as "Feds" or carpetbaggers come to meddle in department affairs. In others, we were received as a cost-inefficient entourage with little purpose. I should add that in these cases, the dynamics of the visit and the problem solving and mutual beneficial discussions led to a complete reversal of that view. In other cases, we were welcomed as sources of technical assistance for local departmental problems of recruitment, curriculum, faculty-student conflict, financial negotiations with administration officials, and a source of information about Federal programs of potential benefit to the department and/or university.

Site visits are intense, exhausting, exhilarating and in most cases very productive. The primary benefactors are MFP Fellows. The visits reinforce their status as APA Fellows, and further gives them an advocate and supporter in their programs. It can also serve to identify problems the Fellow is having and many solutions emerge from such visits.

As was shown earlier in this report, the financial contributions to the support of MFP Fellows is 113% from host institutions.

I am convinced that this degree of cooperation is only possible because of the face to face contact site visits make possible, and the resultant rapport and understanding that follows.

As the number of schools continues to grow, the importance of the Advisory Committee members in the site visit schedule grows correspondingly. Last year, I visited every institution but 4. That schedule was nearly impossible and this year we expect over 15 more schools. It is, therefore, important to have committee members who are dedicated and willing to make the sacrifice to participate in these visits.

During July, the Advisory Committee held a retreat meeting for the first time. This meeting served as an orientation to the program for new members, and an opportunity to discuss general issues of concern to the program which regular meeting agendas never were able to accommodate. One of the major outcomes of that meeting was a decision to increase our emphasis on supporting students entering PhD programs. During the past year, some 70% of new awards went to students already enrolled in doctoral programs. Reversing this trend, the Advisory Committee has set a goal of 70% new doctoral enrollees for 1979-80 awards. In order to accomplish this we will make more recruitment trips to undergraduate psychology departments (primarily but not exclusively predominantly black institutions), and during regular site visits, we will encourage the presence of undergraduates for seminars and group discussions about our program, psychology as a profession, and graduate opportunities.

To facilitate the goals of greater involvement of undergraduates, we are developing a symposium format for site visits. This format is envisioned as a presentation-discussion session in which site visitors will present a body of information and lead discussions of relevant topics such as minority recruitment, financial support, curriculum, intern placements, faculty hiring etc. These are issues discussed in the past, but never formally coordinated for the benefit of the broader psychology community.

One of the goals of site visits is to collect data from each department concerning recruitment, faculty hiring, curriculum and student issues as they reflect ethnic minority concerns. The data from the past year's visits is currently being analyzed, but some preliminary information is available. A summary of preliminary data is contained in Appendix A. From a sample of 12 institutions, there were a total of 15,147 applicants to graduate school of whom 9.8% were ethnic minorities. The acceptance rate for minority applicants was 20.2%, while for majority applicants, it was only 8.5%. This can be seen as an affirmative action measure and suggests that these institutions are attempting to meet the need and their commitment. Looking further we see that about two-thirds of minority applicants accepted actually enroll (compared to about 50% of majority applicants).

While the recruitment and enrollment statistics look good, the attrition data are not as strong. Nearly one quarter (24.4%) of minority student enrollees either withdraw or transfer, and

another 5% were terminated. The corresponding figures for whites were 17.7% withdrew or transferred and .84% were terminated. These data suggest that while programs are becoming more successful at getting minority students enrolled, they have not made the adjustments in tutoring, advising, curriculum and counseling that is needed to increase the rate of successful completion of the program. A major role played by MFP during site visits is in just this area of support- counsel and guidance. It is rarely a matter of ability, but more often a matter of effective communication and reasonable flexibility.

On the basis of responses from 23 institutions, reflecting 2,960 graduate students, nearly half (46.8%) are in clinical psychology, followed by 14.6% in experimental, 9.8% in social and 8.2% in developmental. These aggregate figures correspond to the figures for white students very closely since they comprise 85% of the total sample. Minority students deviate somewhat from these percentages in that they are overrepresented in clinical psychology (62.8%), and social psychology (12.6%), and underrepresented in experimental (5%) and developmental (6.3%)

Data from 26 universities were obtained concerning 1,099 faculty appointments. Of these positions, 38.6% were at the level of Professor, 18.2% Associate, 19.2% Assistant, and 24% Adjunct or part-time. Ninety-three percent of these positions were identified as majority persons, and 6.5% as ethnic minorities (.2% were foreign). The distribution by faculty status showed that

ethnic minority faculty were somewhat overrepresented at the level of Assistant Professor, and underrepresented at the levels of Associate (11.1%) and Professor (27.8%). One marked deviation occurred within the ethnic minority groups where Asian-American Professors accounted for 62.5% of all Asian-American faculty positions.

This overall faculty profile suggests several things. One, there is a definite need for more ethnic minority faculty; two, promotion patterns are slow for ethnic minority faculty, and three, there is a need to encourage more ethnic minority students in graduate school to consider academic positions among their career choices. In order for that to be feasible, the promotion pattern as well as salary range would have to be improved.

Among other issues discussed at the retreat meeting were ways to increase the number of non-clinical applicants and the comparability of their chances in competition with clinical applicants. This objective remains tenuous, however, considering the status of grant funds for non-clinical training.

B. Director's Activities

In addition to the extensive travel associated with regular site visits, I made several recruitment trips to other institutions. Among these trips were Atlanta University Center (Morehouse, Spelman, Morris Brown, Clark), Tennessee State and Fisk, University of Pittsburgh, University of Massachusetts (Amherst),

summer Institutes for minority undergraduate seniors at the University of Delaware and University of Georgia. I also made promotional presentations at the Southeastern Psychological Association Meetings in Atlanta, and the Association of Black Psychologists Annual Convention in St. Louis. I also spent some time touring the facilities at the Westside Community Mental Health Center in San Francisco and the McHarry Community Mental Health Center in Nashville. Both are important internship facilities for ethnic minority students. I made a formal presentation to the review panel for the Office of Education's new Fellowship Program for Minority training, and also provided technical assistance to the director of that program in setting evaluation criteria. Another major block of time and energy was spent coordinating the planning and implementation of the Dulles Conference of Ethnic Minority Psychologists.

The major regret I have is that there is not enough time to do all that needs to be done. As I travel the country and observe the numbers of ethnic minority students who desire training in psychology, the positions which require such trained professionals, the unresolved issues of faculty recruitment, curriculum development, data collection and research priorities, I can only feel that more could and should be done. Hopefully the development of the proposed Office of Minority Affairs in Central Office of APA will serve to lessen the gap, and the increasing numbers of well trained ethnic psychologists will further reduce it. I am pleased with what the Minority Fellowship Program has accomplished, and am eager to see it continue and do more.

IV. MFP Special Activities

It has always been the philosophy of the Minority Fellowship Program that making financial awards to ethnic minority students was not sufficient to meet the existing need for comprehensive training. We have already discussed the variety of programs that are regularly followed in the context of Fellowship support. In addition to these programmatic activities, a number of other ancillary efforts are maintained.

A. Job Locator

Every year numerous job openings are sent to the attention of the MFP office. These positions range from academic to research to service delivery and in each instance specify a desire to attract ethnic minority applicants. In the Winter issue of the MFP Newsletter, VARIABILITY, four full pages of position openings were given. The MFP office maintained an up-to-date file of minority PhD psychologists and circulated this list along with resumes, where possible, to interested prospective employers. It should be noted that this effort was not restricted to MFP Fellows alone. With additional clerical and administrative help during the coming year, we hope to expand on this practice. With a larger number of our Fellows completing their degrees and looking for positions, it will become a necessary and natural extension of our programmatic thrust.

B. Summer Internships for MFP Fellows

For the third consecutive year, MFP Fellows spent two months during the summer working in the offices of Ethnic Minority Congressmen. This experience is important as a way to learn more about how psychology and psychologists can affect the legislative process (and ways in which it can't as well). We had a very energetic group this summer and in addition to their time in congressional offices, they spent a day at NIMH meeting with key staff and learning about how it operates, a day at the Urban Affairs Institute at Howard University, a Research and Development Center funded by the Minority Center at NIMH; and a day at APA Central Office learning more about that structure and some of the things that happen there. During the remainder of the summer, they worked at their assignments, with the exception of bi-weekly seminars at APA.

In addition to the Congressional placements, Fellows spent time at R&D centers conducting research, writing proposals and learning about these Center activities. Table 8 summarizes all of the summer placements. One student spent the summer working with the Coalition of Spanish Speaking Mental Health Organizations (COSSMHO); and one worked with a private contract research firm doing program evaluation. The composite experiences were important as an extension of their formal academic training.

C. Dulles Conference of Ethnic Minority Psychologists

The Minority Fellowship Program organized and convened a Conference of Ethnic Minority Psychologists in May 14-17, at

TABLE 8: SUMMER INTERNSHIP PROGRAM
1978

Name	Institution	Program Assignment
Hortensia Amaro	UCLA	Fordham University
Crystal Archable	U. of North Carolina	Howard University
Connie Chan	Boston University	Senator Daniel K. Inouye, D-HI
Kermit Crawford	U. of Virginia	Congressman William Clay, D-MO
Lotus Dix	CUNY	Mark Battle and Co.
Antonio Lopez	CSPP-California	Spanish Speaking Mental Health Center at UCLA
Suzanne Randolph	U. of Michigan	Congressman John Conyers, Jr., D-MI
Juanita Reaves	Howard U.	Howard University
Michael Rodriguez	U of New Mexico	Congressman Henry B. Gonzalez, D-TX
Ronald Suarez	U of Michigan	National Coalition of Spanish-Speaking Mental Health Organizations (COSSMHO)
Donna Taylor	Washington U.	Fanon Center
Cynthia Telles	U of Boston	Spanish Speaking Mental Health Center at UCLA
Belen Zayas	NYU	Congressman Robert Garcia,
Christine Hall	UCLA	Navy Personnel Research & Development
Donna Nagata	U. of Illinois	Asian American Mental Health Research Center

the Marriott Hotel at Dulles Airport. The Conference was funded jointly by the Center for Minority Group Mental Health Programs at NIMH and the Board of Social and Ethical Responsibility at APA. The primary purpose of the conference was to explore ways in which ethnic minority representation and involvement in APA could be increased. Meeting in ethnic caucuses and with APA officers and staff including President-elect Nick Cummings and Executive Officer Chuck Kiesler, one major recommendation emerged from the conference; that a Board of Minority Affairs be established at APA with a corresponding Office. At the June meeting of the Board of Directors, this proposal was made formally with an interim proposition that an Ad Hoc Committee of Minority Affairs be appointed to explore the most appropriate mechanism for such a Board. Further, it was voted that an Office of Minority Affairs be established and a senior staff person be hired to Supervise the work of that Office and provide the administrative support for the Ad Hoc Committee.

The MFP has over the past four years served as such an Office and to some extent, the program's Advisory Committee has served as such a Board. However, neither the Program nor the Committee is a permanent APA structure and should the program not be needed in 1980 when the current cycle expires, there would be no explicit functioning body at APA to tend to these affairs. As I indicated earlier, there is considerably more to do than MFP alone can handle. While most of the Boards and Offices in APA do receive inquiries relevant to minority concerns,

there is no formal oversight responsibility and many things slip through the cracks. Much is directed to our office for handling where it is queued up behind other program matters with higher priority. It is envisioned that when the MFP no longer exists at APA, the initiatives for minority actions and concerns will be well handled by the emerging Board/Office structure developed by the Dulles Conference.

D. MFP Activities at APA in Toronto

The Minority Fellowship Program has planned three formal activities for the Toronto convention.

1. Symposium: Dissertation Research of Ethnic Minority Fellows in Psychology

Five Fellows who earned their Ph.D's during the past year will be presenting their dissertation research. This is the first year in which this is possible. The purpose of the symposium is to develop a sense of the kind of research areas and paradigms minority doctoral candidates are using and to put these works into the public domain.

2. MFP Orientation for New Fellows

In parallel with the symposium of graduating Fellows, we will host an orientation for new Fellows during the convention. We anticipate approximately 70 Fellows will attend among whom will be 40 new awardees. The session will include brief remarks by the Executive Officer, President and President-elect, Central Office staff, and a representative of the Minority

Center of NIMH. The national network of Fellows is a very strong and positive force which when coupled with those presenting their dissertations and those entering graduate school for the first time, provides a solid kind of socialization experience.

3. Symposium: Criteria for Admissions of Minority Students to Graduate School

In part as a result of the discussions we have had with admissions committees during our site visits and in part in anticipation of some of the questions raised by the Bakke decision, we are sponsoring a symposium to consider basic issues of admissions criteria for minority graduate students and their implications for affirmative action. A cross section of psychologists representing diverse research, administrative and ethnic backgrounds was selected to participate in this symposium. The goal is to develop some basic guidelines for continuing an aggressive and successful recruitment program for the training of ethnic minority psychologists, and to preempt the cautious retrenchment that might follow from some interpretations of the Bakke decision. We hope to produce a document from the symposium that can be used as a guide to some of the issues that are germane to graduate psychology department's admissions procedures and criteria.

V. Prospects and Projections - 1978-80

The past year produced advances in many areas, most of which have been discussed. There are three major areas of concern that will dominate the focus of MFP activities in the coming year.

1. The political climate of Special Minority Programs and Structures

Three events occurred during the past year which have potential implications for the Minority Fellowship Program. The first was the decision in support of Bakke's claim for admission to UC Davis Medical School. A number of people see this as a direct attack on affirmative action in general, and special programs in education in particular. As subsequent Supreme Court decisions suggest, the Bakke decision was not as conservative as many felt, and further, a how to do it model (the example of Harvard University Medical School) was given in the decision. In my judgment, the consequence is likely to be that those departments and universities that have no commitment to affirmative action and fail to recognize the importance of including ethnic minority students in their programs, will have an easy and ready excuse for their inaction. Programs that choose to continue to be (or become) active in the recruitment of ethnic minority students can do so without fear of legal sanctions. One effort MFP will make during the coming year is to advise programs on how to continue aggressive recruitment policies, and how to evaluate admissions criteria so that they can get the job done legally and fairly.

A second major event was the President's Commission on Mental Health Report. That Report recommended, among other things, expansion of the Minority Fellowship Programs. I have already sent a brief perspectus to the Minority Center outlining ways

in which the program could be expanded to address the remaining unmet needs of ethnic minority students and communities. I hope that the Implementation Task Force will make specific and effective recommendations that would provide financial and legislative support for all of the MFP's. I will make whatever contributions I can to that process during the coming year.

There was a Senate Bill offered by Senator Daniel Inouye (proposed in the House by Representative Stokes and Garcia as H.R. 12102) proposing that the Center for Minority Group Mental Health Programs be elevated to the status of a Division within NIMH. The bill did not come before either the House or Senate during the 95th Congressional Session hence will likely be reintroduced next year. It is entirely possible that the status of the Minority Center (as either a Center or Division) may have implications for the renewal prospects of our program. We will watch these developments carefully and provide whatever information will be useful in hearings on the Bill that will reflect the importance of continued support for our program. There is reason for concern since the supplement request though approved has not been funded. The financial situation is poor at NIMH and we feel that the expanded budget Divisional status would bring to the center would greatly improve our chances for renewal as well as for receiving funds for non-clinical training.

2. Focus on Undergraduate Recruitment

As mentioned earlier, the Advisory Committee has decided to try to reverse the trend toward greater support of graduate

student applicants by concentrating on reaching undergraduate students. In my opinion this means not only making sure that MFP brochures and applications get to them, but promoting the notion of career possibilities in psychology. One of the things that is most striking when I talk to undergraduates is how little information they have concerning graduate study and the range of career choices to which they lead.

It appears that perhaps the counseling of undergraduate psychology majors is inadequate. Among the possibilities for meeting this goal might be a centralized graduate application process (this is currently done for Black student's applying to medical school), regional conferences for ethnic minority undergraduates in their junior year, continued cooperation with Summer Institutes for Black undergraduates, and use of MFP Fellows to counsel and guide undergraduates in consideration of psychology careers. The coming year will be spent exploring these possibilities.

3. Development of Office of Minority Affairs at APA

As of this writing, the Board proposal for an Office of Minority Affairs awaits approval by the Council of Representatives. Assuming that approval will be forthcoming, one of the important tasks during the coming year will be to facilitate the coordination of the Ad Hoc committee activities and to help initiate the new Office staff to the issues of minority affairs. This will require ultimately turning over some of the materials that have been flowing through the MFP office.

During the past year, MFP attempted to make more contact with the ongoing Board and Committee activities within APA by assigning Advisory Committee members as liaisons to relevant groups such as the Accreditation Committee and the Testing Committee. Because of the extensive responsibilities with our own program, it was not easy to maintain that contact. With an Ad Hoc Committee and Office, it will be possible to do a better job of it and hopefully to make more substantial contributions to the work of these committees.

Conclusion

I have enjoyed my first year as Director of the program. It has proven considerably more challenging than I anticipated and correspondingly more rewarding. I have found the cooperation from Central Office staff, Advisory Committee members, department faculty, university administrators, Fellows, and Board of Directors members to be consistent and very positive. I thank you all. I believe the program works and look forward eagerly to the coming year.

APPENDIX A

MINORITY FELLOWSHIP PROGRAM

Summary of Faculty and Student Data
Reported by Participating Programs
Through the Departmental Questionnaires

The departmental questionnaire is designed to obtain qualitative data concerning the graduate psychology programs at host institutions and basic quantitative data on minority representation in the student body and on the faculty of these programs. Of the programs that received the questionnaire a total of 28 responded with varying degrees of completeness. The omissions and discrepancies in the data supplied seem to be due primarily to carelessness in preparation. It would be desirable to make some attempt to correct this problem in future studies in order to increase their reliability. Responding institutions and the usability of data supplied are summarized below:

<u>Institution</u>	<u>Faculty</u>	<u>Student Area</u>	<u>Student Enrollment</u>
<u>Area I</u>			
Arizona	+	+	0
Berkeley	+	+	0
Davis	+	+	+
Denver	+	+	+
Hawaii	0	0	0
New Mexico	+	+	+
UCLA	+	+	0
Utah	+	0	0
Washington	+	0	0
Wright Institute	+	0	0
<u>Area II</u>			
Illinois	+	+	+
Louisiana	+	+	+
Miami	+	+	0
Michigan	+	+	0
Nebraska	+	+	+
North Carolina	+	+	0
North Texas State	+	+	0
Oklahoma	+	+	0
Wayne State	+	+	+
<u>Area III</u>			
Adelphi	+	+	+
Boston	+	+	+
CUNY	0	0	0
Clark	+	+	+
Howard	+	+	+
NYU	+	+	0
Penn State	+	+	+
Tennessee	+	+	0
Yale	+	+	0
TOTAL USABLE RESPONDENTS	26	23	12

GRADUATE STUDENT RECRUITMENT (Item B.1.a.)

The twelve responding programs provided a sample of slightly more than fifteen thousand students for the three year period beginning in 1975. Applicants were reported as minority or majority for each of seven phases in the application/attrition/graduation process: application, acceptance, enrollment, withdrawal, transfer, termination and graduation. These seven categories were reduced to five by combining withdrawals and transfers and eliminating the graduation category. The data for graduates was omitted because it was not clear in all cases whether the response indicated the number of students who graduated during the year in question, regardless of application year, or the number of students admitted during the application year in question who have since graduated. In most instances the response in this category should have reflected only a small number of graduating transfer students since the average time to completion of the Ph.D. was reported as being longer than three years. However several responses indicated a substantial number of graduates.

The enrollment and attrition of applicants (Table 1A) is represented by the percentage of applicants in a given phase with respect to the number who completed the previous phase. This data is presented for each year and for the three year period and provides a means for comparison of the attrition rates of minority and majority applicants.

The ethnic distribution of applicants (Table 1B) shows the percentage of minority and majority applicants in each phase for the same periods as above.

ENROLLMENT PROFILE BY SPECIALTY AREA (Item A.4.b.)

A sample of approximately 3,000 students representing twenty three programs was grouped according to specialty area (Clinical, Developmental, Experimental, Social and Other) and ethnicity (Caucasian, Afro-American, Native American, Asian-American and Hispanic). The distribution of students by specialty area (Table 2A) was constructed by calculating, for each ethnic group, the percentage of students enrolled in a given specialty area with respect to the total number of students in the ethnic group. This distribution facilitates the evaluation of specialty area preference within each ethnic group as well as the comparison of ethnic groups with respect to specialty area preference.

The ethnic distribution of students (Table 2B) was constructed in an analogous manner to Table 2A and provides a measure of minority group representation within each specialty area as well as in the entire student body.

FACULTY PROFILE (Item A.6.b.)

The faculty data obtained from twenty six programs are grouped according to ethnicity (as above) and faculty status (adjunct and tenure track (assistant professor, associate professor and professor)). The Ethnic distribution of faculty (Table 3A) is simply the composite base data converted to percentages of the total faculty (minus foreign faculty) or 1,099.

The ethnic distribution within status groups (Table 3B) and the status distribution within ethnic groups (Table 3C) were constructed in an identical manner to that used to construct Tables 2B and 2A respectively and yield similar information concerning the faculty sample.

TABLE ENROLLMENT & ATTRITION OF
1A: APPLICANTS

AREAS I-III (n=12)		Applicants	% Appl'ts Accepted	% Acceptance Enrolled	% Enrolled who withdrew or Transferred	% Enrolled who were Terminated
1975	Minority	493	18.9	64.5	33.3	10.0
	Majority	4,774	8.9	51.6	6.8	1.4
	Total	5,267	9.8	53.9	22.2	3.2
1976	Minority	558	20.4	68.4	29.5	5.1
	Majority	4,868	7.9	50.3	20.8	.52
	Total	5,406	9.2	54.4	23.3	1.8
1977	Minority	441	21.3	67.0	9.5	0.0
	Majority	4,033	8.9	77.8	12.7	.51
	Total	4,474	10.1	55.3	12.0	0.0
1975 to 1977	Minority	1,492	20.2	66.8	24.4	5.0
	Majority	13,655	8.5	51.3	17.7	.84
	Total	15,147	9.7	54.4	19.4	1.9

TABLE
1B: ETHNIC DISTRIBUTION OF
APPLICANTS

AREAS I-III (n=12)	Applicants	App'l's Accepted	Acceptance Enrolled	Enrolled who withdrew or Transferred	Enrolled who were Terminated
1975					
% Minority	9.4	18.0	21.5	32.3	66.7
% Majority	90.6	82.0	78.5	67.7	33.3
Total	5,267	518	279	62	9
1976					
% Minority	10.3	23.0	28.9	36.5	80.0
% Majority	89.7	77.0	71.1	63.5	20.0
Total	5,406	496	270	63	5
1977					
% Minority	9.9	20.7	25.1	20.0	0
% Majority	90.1	79.3	74.9	80.0	0
Total	4,474	454	251	30	0
1975 to 1977					
% Minority	9.8	20.5	25.1	31.6	64.3
% Majority	90.2	79.5	74.9	68.4	35.7
Total	15,147	1,468	800	155	14

(23 RESPONDING INSTITUTIONS)
TABLE 2A: DISTRIBUTION OF STUDENTS BY SPECIALTY AREA

	Clinical	Developm'l	Experimental	Social	Other	Group Total
Caucasian	43.8	8.6	16.4	9.3	21.9	2,500
Non-Caucasian	62.8	6.3	5.0	12.6	13.3	460
Afro-American	64.7	7.1	2.7	12.2	13.3	255
Native-American	70.6	0.0	11.8	17.6	0.0	17
Asian-American	52.5	8.5	10.2	15.2	13.6	59
Hispanic	62.8	4.6	6.2	11.6	14.8	129
Total	46.8	8.2	14.6	9.8	20.6	2,960

TABLE 2B: ETHNIC DISTRIBUTION OF STUDENTS WITHIN SPECIALTY AREAS

	Clinical	Developm'l	Experimental	Social	Other	Group Total
Caucasian	79.1	88.1	94.7	80.1	90.0	84.5
Non-Caucasian	20.9	11.9	5.3	19.9	10.0	15.5
Afro-American	11.9	7.4	1.6	10.6	5.6	8.6
Native-American	0.9	0.0	0.5	1.0	0.0	0.6
Asian-American	2.2	2.1	1.4	3.1	1.3	2.0
Hispanic	5.9	2.4	1.8	5.2	3.1	4.3
Total	1,384	243	432	291	610	2,960

TABLE 3: FACULTY STATUS VS ETHNICITY (n=26)

3A: ETHNIC DISTRIBUTION OF FACULTY						
Ethnic Grouping	Adjunct	Assistant	Associate	Professor	Total Tenure Track	Total Faculty (%)
Caucasian	22.4	16.8	17.5	36.8	71.1	93.4
Non-Caucasian	1.6	2.4	.73	1.8	4.9	6.6
Afro-American	1.1	1.5	.55	.73	2.7	3.8
Native-American	0.0	.46	.09	.18	.73	.73
Asian-American	0.18	.09	0.0	.45	.56	.73
Hispanic	0.36	.36	.09	.45	.91	1.3
Total	24.0%	19.2%	18.2%	38.6%	76.0%	100.0%
						1,099*

3B: ETHNIC DISTRIBUTION WITHIN STATUS GROUPS						
	Adjunct	Assistant	Associate	Professor	Total Tenure Track	Total Faculty
Caucasian	93.2	87.7	96.0	95.3	93.5	93.3
Foreign						.2
Non-Caucasian	6.8	12.3	4.0	4.7	6.5	6.5
Afro-American	4.5	7.6	3.0	1.9	3.6	3.8
Native-American	0.0	2.4	.5	.47	.96	.73
Asian-American	0.8	.47	0.0	1.2	.72	.73
Hispanic	1.5	1.9	.5	1.2	1.2	1.3
Total	264	211	200	424	835	1,101

3C: STATUS DISTRIBUTION WITHIN ETHNIC GROUPS						
	Adjunct	Assistant	Associate	Professor		
Caucasian	24.0	18.0	18.7	39.3		
Non-Caucasian	25.0	36.1	11.1	27.8		
Afro-American	28.6	38.1	14.3	19.0		
Native-American	0.0	62.5	12.5	25.0		
Asian-American	25.0	12.5	0.0	62.5		
Hispanic	28.6	28.6	7.1	35.7		
Total	23.9	19.4	18.2	38.5		

*There are 2 foreign faculty members (see Table 3B), making a total of 1,101.

APA Boards and Committees wishing to address issues of expanded educational opportunities and representation for minorities.

Fellowships are granted through a cost-sharing arrangement with graduate departments to cover tuition, allowance for books, and materials, a living maintenance stipend, and other related expenses. Individual fellowships are awarded for one year and are renewable for two additional years.

Eligible applicants for this Program include, but are not limited to, American citizens and permanent visa residents who are Black, Hispanic, Asian American, and American Indian.

The Program is open to beginning or continuing full-time students in Ph.D. programs in psychology. New students must apply to a graduate program of their choice and qualify for entrance.

The Program is aimed at providing support to students who have a demonstrated commitment to the field of psychology. The criteria for awarding the fellowship are *Academic ability, Interest in behavioral science and mental health issues, and Motivation (AIM).*

Application forms can be obtained by writing to:

Dr. James M. Jones, Director
APA Minority Fellowship Program
1200 Seventeenth Street, Northwest
Washington, D.C. 20036

MINORITY FELLOWSHIP PROGRAM
AIMED AT SUPPORTING EDUCATIONAL
OPPORTUNITIES IN PSYCHOLOGY



American Psychological Association
1200 Seventeenth Street, Northwest
Washington, D.C. 20036

Ethnic minority psychologists are underrepresented among:

- Psychology Graduate Students
- Psychology Faculties
- Mental Health Service Providers
- Social and Behavioral Researchers
- Community Mental Health Providers
- Membership of APA

The Table below shows that while ethnic minorities constituted over 16% of the 1970 population 18-24 years of age, the cohort of earned doctorates for 1976-77 showed only 6.7% ethnic minorities. These data based on the 1970 Census and the Earned Doctorate Study of the National Academy of Sciences (1978) help document the problem.

Table 1. Earned Doctorates (1976-1977) by Ethnicity and by Specialty

Specialty Area	ETHNICITY					
	Amer. Indian	Black	Hispanic	White	Total	
Clinical/Counsel	10	47	23	1047	1136	
Developmental	1	4	1	185	192	
Education/School	1	3	5	250	264	
Exper./Comp./Psy.	3	4	7	434	451	
Industrial	1	1	3	71	77	
Social/Person.	1	4	0	230	247	
Psychometrics	1	2	0	14	20	
General Psych.	4	17	4	249	280	
Total	22 (.8%)	90 (3.3%)	39 (1.4%)	480 (93%)	2664	
% of U.S. Population age 18-24 (1970 Census)	.4%	.7%	11.5%	4.9%	82%	100

The underrepresentation of ethnic minorities in psychology has important implications for the credibility and utility of developments within the field. Psychology is involved in the advancement and synthesis of information about human and animal behavior. A partial outgrowth of this effort is the promotion of human welfare and social programs. When ethnic minorities are not involved in asking the questions, framing the hypotheses, and interpreting the results, the body of knowledge is truncated because the full range of possibilities have not been considered. The AIM of the Minority Fellowship Program is to support full participation by ethnic minorities in the dynamic development of psychology both as an art and a science.



The Minority Fellowship Program in Psychology, funded jointly by the National Institute of Mental Health (NIMH), and the American Psychological Association (APA), was established in 1974 to improve and enlarge upon educational opportunities in psychology. As of 1978-1979 academic year one hundred seventy-two students have been supported by the program and nine have obtained Ph.D's.

The thrust of the support from this program is two-fold: Technical Assistance and Fellowships.

Technical assistance in the area of behavioral science and mental health issues relative to ethnic minorities is provided to:

faculty and students wanting to engage in research that has implications for ethnic minority issues.

college administrators and department chairs requiring information and specific techniques for recruiting and retaining minority students and faculty.

department faculty wanting to evaluate their graduate psychology program to determine whether the contributions and perspectives of minorities are adequately represented.



AN EXPERIMENT IN EDUCATIONAL INTERVENTION

by James Jones

Despite the fact that the Minority Fellowship Program has been more successful than the authors of the original grant ever imagined, it nevertheless faces an uncertain future. There is a real possibility that the program either will be terminated when its current funding authorization expires in 1980, or that it will be modified in such a way that the very factors responsible for its success will be eliminated.

The program has brought many more minority students into psychology training than had been expected, in large part because APA sponsorship has given the program added leverage, stretching available dollars to the limit. However, there are rumors of continuing questions on the part of the funding agency, the National Institute of Mental Health, as to the program's cost-effectiveness, its ability to meet the mandate of substantially increasing the pool of trained ethnic minority psychologists, and the appropriateness of funding such a program through a professional association rather than by funding universities directly.

It may be time to marshal some facts in the name of advocacy and self-defense. Among them are the following.

Cost: Through cost-sharing or matching arrangements, the MFP is able to match every dollar of financial support to fellows with \$1.15 from host graduate institutions. Further, the cost of administering approximately \$434,000 in fellowship stipends is approximately \$106,000 or 19.6 percent. If we consider the total net stipend amount including institutional contributions, we have an 11.4 percent administrative cost.

Need: Over the past five years, about 1,732 ethnic minority applicants have sought support and 172 actually have been supported. As of last September, nine had completed their PhDs and were gainfully employed in a capacity commensurate with their training and consistent with the goals of the program. This year, some 145 fellows will receive support, and 15 are expected to complete their degrees during the 1978-79 academic year.

Performance: Several fellows have published articles over the past year (a partial count shows over 20 published articles in major journals such as the *Journal of Personality and Social Psychology*, *Journal of Professional Psychology*, and *Psychonomic Science*). In addition, fellows have made presentations at regional psychology meetings and at the APA convention in Toronto, organized major conferences, worked on internships, written book chapters and engaged in other professional activities.

New awards: The coming year will show 56 new awardees all of whom are in clinical psychology (see table). A supplemental request to NIMH to support doctoral training in non-clinical psychology has been approved

The Minority Fellowship Program

A Status Report

and recommended for funding but no funds have been made available. There are 26 finalists in non-clinical areas awaiting funding opportunities.

An educational intervention

The Minority Fellowship Program has proved to be far more than a narrowly targeted activity. It has demonstrated its worth as an educational intervention, and those being educated are not only the minority fellows. The numbers game is only the first step. Left there, the intervention gets bogged down in discussions of affirmative action, quotas and a whole panoply of issues which assume the benefits all go to only one direction—to the ethnic minority student. In fact, the program is an intervention in the broadest sense. Recruitment, retention, graduation and placement of students, consultation and teaching assistance to psychology departments and partnership in funding are all as-

pects of the intervention. Last spring, as a direct consequence of MFP intervention, five finalists in the competition were admitted to doctoral programs. The cases differed widely but had the common thread that attention and more careful scrutiny of the application materials, and the additional incentive of MFP financial support, led to a decision to admit. In one case, we intervened at the point at which a letter of rejection was being prepared. The letter was being prepared by the admissions office and stated simply that there were no longer any slots and the applicant should reapply next year. Since that sounded like an administrative turned out more than a review and rejection, we pursued the case. It turned out that the applicant had originally gone to the wrong department where it sat for several weeks. When it was finally forwarded to the appropriate department, it was too late to be considered. When the student's

application materials were reviewed carefully and the applicant was interviewed by telephone, the student was admitted and is now enrolled on a full-time basis with adequate financial support. The dean even agreed to make additional money available. Without the MFP follow-up, the student undoubtedly would have received a "try again next year" letter and might never have gotten back into the system.

Left to their own devices, graduate departments, in general, have not been able to develop adequate holistic programs of identification, recruitment, retention, graduation and placement of ethnic minority students. There have, of course, been some notable exceptions; among them the University of Michigan (which has over 85 ethnic minority students enrolled on a full-time basis), the University of Pittsburgh which has successfully committed itself to 30 percent enrollment of black graduate students; the Graduate Center at CUNY, where the minority program has 11 fellows; and the University of Washington, where a determined commitment of the late Ned Wagner has been responsible for ethnically diverse student and faculty. This is not an exhaustive list, and places more isolated without geographical or financial pull also have made valiant efforts (for example, the University of Georgia and Penn State).

In general, a strong graduate program in psychology manifests some or all of the following major characteristics: *commitment* to include ethnic minority students in the program; *provision* of support and necessary flexibility and understanding to work toward the successful completion of the PhD degree; the presence of a *critical mass* of students and faculty (with faculty this may be, and in fact often is, as few as one); a belief and concern for *cultural diversity* as a goal both demographically and substantively in the conceptual foundations of theory and research; a diversified *curriculum* which reflects the substantive work of ethnic minority psychologists, as well as pedagogic techniques that may facilitate learning in culturally diverse students. Rarely are all of these factors present in a single department.

MFP intervenes at multiple levels. The targets include potential ethnic minority applicants, enrolled students and MFP fellows, department faculty, admissions committees, departmental administrators and university officials including deans. Affirmative action concerns are the focus even in personnel. The initial goal is to develop a working relationship. Once this relationship has been established, MFP becomes a resource to any faculty, university administrator or minority student.

In one case, after a site visit, the department chairperson took a faculty poll to determine the level of commitment to recruitment and admission of ethnic minority students, active search of the minority faculty and so on. The results showed that the overall commitment was not as great as expected. However, they also suggested reasons why some faculty and students who served on

special ethnic minority committees felt their work was not adequately supported and appreciated. Since our visit, the department has managed to enroll several minority students, invited a minority psychologist to give a colloquium and generally has improved its record.

In another instance, MFP intervened to help a department set contractual guidelines for completion of required work for a fellow who had been given too much leeway and too little guidance. On another occasion, we helped a fellow with her dissertation research design, giving more assistance, she said, than she had received from her faculty advisers during the whole semester.

In our view, better techniques for recruitment of ethnic minority students have been developed, and programs are becoming more flexible in admissions criteria to improve the admission rate. There is still work to be done, but the basic mechanisms are there. MFP facilitates the recruitment process by circulating lists of all our applicants entering PhD programs. The list gives names and addresses, specialty area and undergraduate GPA. This pool, coupled with Educational Testing Service locator names, a growing process of active recruitment by graduate advisors and special committees (such as the Racial Justice Committee at Pittsburgh) are responsible for the improved record.

What is now needed is serious and careful attention to the substance of training and the content of curriculum, including placement in appropriate clinical and counseling settings, appropriate training in research methods and theory construction, and access to adequate career counseling.

An example will help illustrate. At one major university, black graduate students prepared the position response which said students should first concentrate on learning psychology. After mastering basic psychology training, they were advised, they could focus on the specialties of black aspects of psychology.

If we conceive of psychology broadly to be the study of the human condition by people who share in that condition, then a general psychology can be no more or less than the sum total of human experience. To segregate out the black experience or the Chicano experience or the experience of any people who experience from general or basic principles is to sterilize the profession. Once this relationship has been established, MFP becomes a resource to any faculty, university administrator or minority student.

The MFP office is open and accessible to anyone. In addition to the office, there is a nine-member advisory committee which makes the extensive site visit schedule possible and enables the office to bring multiple ethnic perspectives to each department situation as well as to help encourage you to use us.

Jones is the head of APA's Minority Fellowship Program.

New Minority Fellows

NAME	UNDERGRADUATE SCHOOL	CURRENT ENROLLMENT
Afford, Linda	U. of Virginia	U. of Virginia
Aponte, Christine	U. of New Mexico	U. of New Mexico
Arnes, Silvio	Pan American U.	Washington State
Bayard, Mary Louise	U. of Calif. at Santa Barbara	U. C. L. A.
Belgrave, Jeffrey	U. John Vabney	C. U. N. Y.
Breikh, Curtis	Johnson C. Smith U.	Pennsylvania State
Brown, Frederick	Howard	Adelphi
Burgess, Marie	U. of Calif. at Santa Cruz	Colorado State
Chai, Boris	Stanford	Boston U.
Chen, Chris	U. of New Mexico	U. of Texas at Austin
Coleman, Martin	Hampton Institute	U. of Pittsburgh
Combs, Deyla Marie	U. of Montana	U. of Montreal
Davis, Kenneth	John Jay College of Criminal Justice	C. U. N. Y.
Echols, Eric	New York City Community College	Howard
Ferns, Edwin	C. U. N. Y.	C. U. N. Y.
Garcia, Deborah	U. of Arizona	U. of Denver
Gentile, Carolyn Y.	San Diego State	Arizona State
Gilbert, Anita	U. of Calif. at Riverside	Wright Institute
Glover, Orlis	California State/Fullerton	Wright Institute
Gong, Susan Mae	U. of Pacific at Brooklyn	Boston University
Goulden, Beverly	Wright College of Cincinnati	U. of Pittsburgh
Gray, Charles	Morehouse College	U. of Calif. at Berkeley
Hendricks, Kenneth	College of Virgin Islands	Boston U.
Hinkis, Phil	U. of Wisconsin	U. of Nebraska
Hunt, Mary	U. of Puerto Rico	C. U. N. Y.
Ino, Steven M.	U. of Calif. at Berkeley	U. of Michigan
Jung, Eric	U. of Calif. at Berkeley	Boston U.
Landrum, Hope	Westminster College	U. of Rhode Island
Leahy, Jennifer	Spelman College	Chicago
Lea, Wendy	Berkston	Chicago
Logg, Fay, Camilla	California State/San Jose	CSP/UC
Martinez, Eddie	U. S. C.	George Washington U.
Martinez, Teresa	St. Peter's College	Portland
Miles, Marla	S. U. N. Y. Buffalo	U. of Massachusetts/Amherst
Moskowitz, Deborah	S. U. N. Y. Albany	U. of Maryland
Moskowitz, Deborah	U. of Washington	Catholic U.
Proctor, Nicole	U. of Texas	Oklahoma State
Rhodes, Phyllis	U. of Illinois	U. S. International U.
Rhodes, Lamara	San Diego State	Rutgers
Rodriguez, Ramon	U. of Puerto Rico	Washington State
Sato, John	Inter-American U. of Puerto Rico	U. of Rochester
Sprull, Edith	U. of Rio	U. of Nebraska
Tan, Cynthia	Park College/Wisconsin	U. of Georgia
Tan, Cynthia	U. S. C.	U. of Maryland
Tan, Cynthia	U. S. N. Y. Albany	CSP/UC
Villar, Iris	Marquette	C. U. N. Y.
Wick, Susan	Emory College	Michigan State
Wilkinson, Jane	N.E. Oklahoma State U.	Oklahoma State
Williams, Laniro	Michigan State	Pennsylvania State
Williams, Carmen	U. of North Carolina	Pennsylvania State
Wright, Chris	California State/Sacramento	U. of Calif. at Davis
Yee, Leung	Queen's University	U. of Calif. at Davis
Zarek, Irit	Inter-American U. of Puerto Rico	U. of Massachusetts/Amherst



THE AMERICAN PSYCHOLOGICAL ASSOCIATION

Announces

FELLOWSHIPS FOR STUDENTS SEEKING
THE PH.D. IN PSYCHOLOGY

PURPOSE: The fellowship program is designed to enhance minority participation in psychology by increasing the supply of doctorally trained psychologists whose interests lie in the area of racial and ethnic minority issues. This is accomplished by providing fellowships for deserving graduate students. In addition, the Minority Fellowship Program develops information and specific techniques that could be employed by universities to attract and retain minority students, informs undergraduates on opportunities for graduate education and employment, and evaluates the effectiveness of graduate education in relation to minorities.

ELIGIBILITY: American citizens and permanent visa residents especially, but not limited to those who are Black, Hispanic, Native American, Japanese, Chinese, Korean, Filipino, Samoan, Hawaiian, and Guamanian.

This program is open to students beginning or continuing study in Ph.D. programs in psychology departments. New students must qualify for acceptance at graduate institutions of higher learning and express a commitment to research and involvement in minority issues in mental health and behavioral sciences. Potential for success in graduate studies and financial need will be considered.

AWARDS: Are granted through a cost-sharing arrangement with graduate departments to cover tuition, allowance for books and materials, a living maintenance stipend and other related expenses.

Individual fellowships are awarded for one year, renewable up through two additional years.

APPLICATION: Application forms can be obtained by writing to:

DR. JAMES M. JONES, DIRECTOR
APA MINORITY FELLOWSHIP PROGRAM
1200 17th STREET, N.W.
WASHINGTON, DC 20036

DEADLINE DATE: January 20, 1980

PLEASE POST

Senator KENNEDY. Can you tell us, Dr. VandenBos, you mentioned encouraging employee assistance programs, which we certainly agree with, through legislation to stimulate programs in the private industry.

Do you have any suggestions on that?

Dr. VANDENBOS. In mentioning that in my testimony, the specific thing I was referring to is the fact that within the prevention section I would hope that there would be a greater emphasis on primary and secondary prevention. The employees assistance programs are a type of secondary prevention. So, changing the emphasis within that section, I think, is the most important. How one would activate such a program would depend on regulation. But, I think, in part, it could be done because of the fact that it is to the company's interest. One could provide limited funding to support the administrative structure of it, and the insurance benefits which exist in many of the insurance programs would be able to cover the actual cost of the service.

Senator KENNEDY. One of the areas we are concerned about in health insurance, as well as this program, is the issue of reimbursement, and perhaps, Dr. VandenBos, you might just reiterate your own position about reimbursement for psychologists under medicare.

You know the concern that many of us have about the inadequacy of State laws in terms of control, licensure, monitoring, and quality controls. Do you want to review that with us for a minute or two?

Dr. VANDENBOS. Obviously we support the inclusion of psychologists for reimbursement. But that is really part of a broader policy. We feel that the reimbursement for mental health services should be based on relevant training in the delivery of those services, not on the basis of simply a particular professional degree. We think that is the most important critical step. We, in fact, support reimbursement for appropriately trained psychologists, psychiatrists, psychiatric social workers, and psychiatric nurses.

As it relates to the licensing law, psychologists are, although we recently got sunseting in one State, licensed in all 50 States plus the District of Columbia. As you know, we are included in many Federal programs. As it relates to specifically identifying psychologists who are qualified to provide health care services, there is also a national register of health service providers in psychology which requires State licensure at the level of independent practice, requires a doctorate degree, and requires appropriate supervised experience within the field of 2 years duration.

Senator KENNEDY. Dr. Macht, I would be interested in your reaction to this earlier response about reimbursement and the issue of quality control. Your testimony points to reimbursement of psychiatrists under medicare and medicaid. I believe, personally, that that should be done, but there will be some references to the Finance Committee on that issue. Nevertheless, what is your position and the position of your society in terms of the psychologists, given what we have heard from Dr. VandenBos?

Dr. MACHT. Our major concern is that one segregates the cost for a therapy or treatment portion of a patient's treatment from the support cost; namely, housing and income maintenance and suste-

nance. And as one looks particularly at the issue of care of the chronically ill, that there has to be a whole new restructuring of the way which we fund that care, with medicare or medicaid or eventually national health insurance taking the treatment dollar with the other social services and support systems underwriting the cost of the rest of the community care.

We believe that there should be equity in terms of the kinds of services that are provided under any of these entitlement programs or national health insurance, a coverage of physical and mental illness. I do not know if society has a particular position at this point on the kind of provider that should be reimbursed.

Senator KENNEDY. Should psychologists be reimbursed at the rate of a psychiatrist if they are equally trained?

Dr. MACHT. I would think that our society would probably say not. Whether they should or not is a question that has to be decided in terms of looking at the views of the various specialty associations as one looks at the kind of training, the kind of experience and what it is that one is buying.

Senator KENNEDY. What is your opinion?

Dr. MACHT. My personal opinion?

Senator KENNEDY. Yes.

Dr. MACHT. My personal opinion is that one should be reimbursed on the basis of experience and training, and that that ought to be looked at in some kind of fashion that is not related to the kinds of particular discipline that one comes from but rather to the background and experience that one comes from. That is not an opinion of the organized society, however.

Senator KENNEDY. Dr. VandenBos, is there anything you would like to say?

Dr. VANDENBOS. We certainly support parity because we believe reimbursement should be on the basis of training.

Dr. MACHT. I would like to also mention the issue of whether services are provided within the context of an organized care setting, another issue in terms of reimbursement.

Senator KENNEDY. We want to thank you both very, very much. We will get back to you in terms of these recommendations. The staff will be in touch with you in terms of the various language changes.

At this point I order printed all statements for those who could not attend and other pertinent material submitted for the record.

[The material referred to follows:]

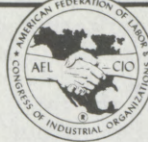
AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

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815 SIXTEENTH STREET, N.W.
 WASHINGTON, D.C. 20006

(202) 637-8000

June 26, 1979

Honorable Edward M. Kennedy, Chairman
 Health and Scientific Research
 Subcommittee
 Labor and Human Resources Committee
 United States Senate
 Washington, D. C.

Dear Mr. Chairman:

Over twenty years ago former President John F. Kennedy called attention to the plight of the mentally ill confined in large mental health hospitals. He called for the creation of 2,500 community health centers. Today, there are only 700 such outpatient facilities in operation. Clearly, there is still a long way to go if institutionalized patients are to receive adequate mental health care on an outpatient basis.

The AFL-CIO, therefore, welcomes the initiative of Rosalynn Carter in reviving the nation's attention to the plight of the mentally ill.

However, the bill, S. 1177 only provides \$46 million for many activities including planning for deinstitutionalization, staff training, prevention, community services including outreach services and upgrading of mental health workers.

Unfortunately, the history over the last twenty years indicates that, in spite of claims of success in reducing the number of patients in public mental health care facilities from 428,000 in 1969 to only 146,000 in 1978, over 300,000 mentally ill have been reinstitutionalized into profit-making nursing homes, boarding houses and other accommodations ill-suited to caring for the mentally ill. That this forcing of public patients onto the private sector saves money is doubtful. Most of such patient-stays are paid for by Medicare, Medicaid, welfare and Supplemental Security Income.

Moreover, as the patient census in public hospitals has declined, trained mental health workers have been discharged without adequate provisions for their reemployment.

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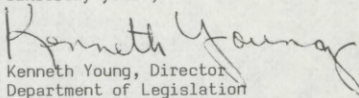
In other words, not only are patients left without adequate provisions for continuing treatment, but experienced mental health workers in short supply are also discarded.

Unfortunately, S. 1177 does little to improve care for the chronically ill or for poverty and minority population groups who are underserved by the private psychiatric establishment. The bill does not:

- * Provide adequate funding to develop new outpatient facilities and services for the mentally ill.
- * Provide for the upgrading of state mental health facilities which are the only institutions providing care for the chronically ill and dispossessed of our society.
- * Protect current employees of state institutions displaced if the trend toward institutional cutbacks and closures continue.
- * Impose tighter cost and quality controls upon private providers including community mental health centers.
- * Amend the Medicare, Medicaid and Supplementary Security Income Program to conform with the goals of the bill.

It is the position of the AFL-CIO that deinstitutionalization should not take place unless comprehensive outpatient mental health services have been fully developed in any given community. Unless the bill incorporates the points enumerated above, the AFL-CIO cannot support this legislation.

Sincerely yours,


Kenneth Young, Director
Department of Legislation



AFSCME®

American Federation of State, County and Municipal Employees
1625 L Street, N.W., Washington, D.C. 20036
Telephone (202) 452-4800
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May 31, 1979

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Honolulu, Hawaii

Maynard White
Houston, Texas

Stuart Shapiro, M.D.
Subcommittee on Health & Science
120 C Street, N.E.
Room 308C
Washington, D. C. 20510

Dear Stuart:

Attached are the documents Senator Kennedy requested on employee protections for mental health workers.

Thanks very much for your help on these issues. We'll be working with you every step of the way.

All the best,

Robert E. McGarrah, Jr.
Assistant Director
Department of Public Policy
Analysis

in the public service

October 18, 1977

The Honorable Joseph A. Califano, Jr.
Secretary of Health, Education and Welfare
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Califano:

Thank you for your letter on Operation Common Sense. We agree with your objectives to streamline and to reduce excessive government regulations.

We are concerned, however, that in at least two instances affecting mental health and mental retardation employees, HEW has avoided its statutory obligations to issue timely detailed regulations. Specifically, the Department has chosen to follow the previous Administration's policy of refusing to issue regulations to protect employees affected by state government deinstitutionalization of the mentally ill and retarded.

The Developmental Disabilities and Bill of Rights Assistance Act of 1975 (P.L. 94-103) provides state grants for deinstitutionalization of the mentally retarded. The same legislation also specified in Section 133(b)(29) that the Secretary issue regulations for employee protections, including retraining and job placement. Rather than issue detailed regulations, however, HEW merely restated the statutory language as regulations 42 Fed. Reg. 5283 (January 27, 1977). Guidelines to implement the regulations, according to the Developmental Disabilities Office, have been "in preparation" for the last two years.

As a result of HEW's failure to tell the states which protections are required by the statute, state plans and state actions to deinstitutionalize the mentally retarded have completely ignored employee needs. Considerable employee dissatisfaction and resistance to deinstitutionalization has resulted from HEW's inaction.

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The other example of HEW inaction also involves deinstitutionalization. In this case, the Special Health Revenue Sharing Act of 1975 (P.L. 94-63) amended the Public Health Service Act to require that HEW mental health grants support deinstitutionalization. HEW has failed to issue regulations since the statute was enacted. As a result, non-supervisory mental health workers have suffered. States have failed to provide protections for their employees in their plans submitted for annual HEW funding. HEW has blithely funded state efforts, despite injuries to employees.

In each case, concise, detailed regulations would have contributed substantially toward the Congressional objectives of deinstitutionalization and employee protection. Rather than excessive regulation, HEW has failed to adequately and promptly regulate state action.

HEW's Operation Common Sense should see to it that proper regulations not guidelines are issued when needed and required by statute. An important opportunity to streamline governmental regulations must not serve as an excuse to avoid necessary regulation.

Thank you for your attention to this important matter.

Sincerely,

Jerry Wurf
International President

JW:rmj

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES ADMINISTRATION
ROCKVILLE, MARYLAND 20857

BUREAU OF COMMUNITY HEALTH SERVICES

MAR 10 1978

Mr. Jerry Wurf
International President
American Federation of
State, County and
Municipal Employees
1625 L Street, N.W.
Washington, D.C. 20036

Dear Mr. Wurf:

This is in further response to your letter about the portion of Public Law 94-63 which deals with mental health grants to support deinstitutionalization and its effect upon employees.

The law requires that each State mental health authority provide the Secretary with an assurance that fair and equitable employee protection plans will be developed and carried out. The law also requires that there be review of State compliance with such assurance. To determine compliance, the Department's Regional Offices annually review for the Secretary the activities undertaken by the States.

In our opinion, the statutory standard of "fair and equitable arrangements" is sufficient for the Regional Offices to make the necessary judgments regarding State compliance.

We have not been aware of problems or injustices to employees affected by deinstitutionalization which require promulgation of detailed regulations for their resolution. (In this context, it should be noted that the employee protection plan applies only to employees affected by deinstitutionalization carried out under the section 314(d) requirements, and that it does not apply under other deinstitutionalization programs.)

We would appreciate any information you can give us on specific injustices to employees caused by State noncompliance with this Act.

If we find that the current implementation of the Act is inadequate and that detailed regulations are needed, we would consider their issuance.

Edward D. Martin

Edward D. Martin, M.D.
Assistant Surgeon General
Director

December 5, 1978

The Honorable Joseph A. Califano, Jr.
Secretary of Health, Education
and Welfare
Hubert Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Mr. Secretary:

The American Federation of State, County and Municipal Employees represents approximately 225,000 institutional mental health workers throughout the United States. We have long been concerned about the adverse effects of deinstitutionalization upon mental hospital patients and our members. Accordingly, we were greatly encouraged by the enactment of the Special Health Revenue Sharing Act of 1975. The Act required that deinstitutionalization grants to states not be made until the Secretary of Health, Education and Welfare received assurances of state efforts to protect and retrain affected employees. That provision, included in the Community Mental Health Centers Extension Act of 1978, P.L. 95-622, as Section 314(g) (2) (D) (iv), has been virtually ignored; state mental health plans with little or no protections for employees are routinely approved and state programs promoting deinstitutionalization are funded accordingly.

Enclosed you will find a report which documents the inadequacy of the Department's policy on employee protections for mental health workers. The report proves that, contrary to the Department's opinion as expressed by Assistant Surgeon General Martin in his letter to me of March 15, 1978, the Statute alone, without regulations and HEW enforcement, is insufficient protection for mental hospital employees. As a result, states blatantly ignore employee protections requirements.

A commitment by the Department to develop standards and criteria by which the Regional Offices may judge and approve state plans is a necessary step in guaranteeing the success of the employee protection provision of

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P.L. 95-622. Similarly, consultation with the Department of Labor, as called for in the Act, must be part of the process by which these standards and criteria are developed. Your immediate action in this area is required, especially in light of forthcoming mental health legislation implementing recommendations of the President's Commission on Mental Health.

Sincerely,

Jerry Wurf
International President

JW:sk

Enclosure

cc: Dr. Edward D. Martin



THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D.C. 20201

MAR 28 1979

#79-6544
4/5/79 No response
necessary.

file
Mental Health

79 MAR 29 AM 36
EXECUTIVE OFFICE

Mr. Jerry Wurf
International President
American Federation of State,
County, and Municipal Employees
1625 L Street, N.W.
Washington, D.C. 20036

Dear Jerry:

Thank you for your letter concerning implementation of the employee protections for mental health workers contained in Section 314 of the Public Health Service Act.

I apologize for the delay in responding to your letter, but we have been struggling to resolve the important problems you raise. In considering these questions, we have now found it necessary to seek a full General Counsel review of several legal issues as well as additional analysis by the National Institute of Mental Health. I have directed my staff to forward to me immediately a report on the issues that have been raised, and I will write again soon.

Sincerely,

Joseph A. Califano, Jr.

November 9, 1978

I. THE PROBLEM: HEW'S FAILURE TO IMPLEMENT AND ENFORCE CONGRESSIONALLY MANDATED EMPLOYEE PROTECTIONS FOR MENTAL HEALTH WORKERS

Despite the 1975 congressionally mandated employee protections for institutional mental health workers affected by deinstitutionalization, HEW has virtually ignored the statute, P.L. 94-63,* by refusing to issue necessary regulations and failing to enforce the statute.

The need to provide adequate protections for mental health workers was dramatically demonstrated by the number of hospital phasedowns and closures which took place throughout the United States in the 1970's. In Massachusetts more than 800 AFSCME members have been affected, as have some 500 in Washington; in Ohio almost 400 workers lost their jobs in state hospitals; at facilities which were phased down or closed in Michigan there were approximately 300 affected AFSCME members employed, almost half of whom were laid off; similar actions in Indiana and Minnesota involved another 350 members. It should be pointed out that these figures only include workers who belong to AFSCME and do not address the probably more severe situation of those who either do not have effective union representation or have no union at all. Furthermore, there is reason to believe that the problem will be more severe in the future, as states respond to the prevalent mood for reduced spending, especially in the area of social services.

II. THE LEGISLATION AND CONGRESSIONAL INTENT

- A. The Health Revenue Sharing and Health Services Act of 1975
Congress recognized that these disruptions in the labor force

*Although the statute was amended by the Community Mental Health Centers Extension Act of 1978, S. 2450 (not yet signed by the President), deinstitutionalization and employee protections requirements were retained. The provisions at issue will now appear at Section 314(g)(2)(D)(iv) of the Public Health Service Act as soon as S. 2450 is signed by the President.

were an undesirable by-product of the shift to community-based care which the federal government was funding. Accordingly, the Health Revenue Sharing and Health Services Act of 1975, P.L. 94-63, was amended to include provisions which were, in the words of the Act's sponsor, Senator Edward Kennedy, "simply designed to protect the interests of employees who might be displaced from their jobs directly or indirectly...." (Congressional Record, 94th Congress, 1st Session, April 10, 1975, p. S 5707.) These protections, contained in P.L. 94-63 as Section 314(d)(2)(D)(i)(II), were intended to facilitate planning, provide for more rational deployment of hospital personnel and inject a greater degree of equity into the treatment of mental health workers. Instead, administrative neglect has rendered them meaningless, victims of almost total non-enforcement by officials of the Department of Health, Education and Welfare.

According to the Health Revenue Sharing and Health Services Act of 1975, P.L. 94-63, the Secretary of Health, Education and Welfare shall make grants to state authorities only after a state has provided "assurances satisfactory to the Secretary" that:

(II) the state mental health authority will establish and carry out a plan which shall include fair and equitable arrangements (as determined by the Secretary after consultation with the Secretary of Labor) to protect the interests of employees affected by actions designed in subclause (I),* including arrange-

* This subclause deals with provisions of state mental health plans designed to eliminate inappropriate placements in institutions, ensure that appropriate noninstitutional services are available and improve the quality of care within institutions.

ments designed to preserve employee rights and benefits and to provide training and retraining of such employees where necessary and agreements under which maximum efforts will be made to guarantee the employment of such employees.

(Section 314(d)(2)(D)(i)(II) of the Public Health Service Act)

B. Legislative History of the Act

Clearly, Congress intended an active effort by the federal government to protect employees affected by adjustments in the mental health system, just as it had aided employees who were adversely affected when changes in other industries were carried out under the aegis of federal law.* (House of Representatives Report No. 94-192 by the Committee on Interstate and Foreign Commerce on the Health Revenue Sharing and Health Services Act of 1975, 94th Congress, 1st Session, May 7, 1973, p. 22.)

The Commerce Committee report on H.R. 4925 leaves no doubt in its discussion of employee protection provisions that the Department of Health, Education and Welfare was expected to draft and implement regulations which would provide for effective employee protections. The report contains at least two specific instances in which it assumed that additional regulations would be promulgated by the Department:

The Committee expects the Secretary to develop standards and criteria by which these plans may be judged ... and approved. (H.R. Report No. 94-192, p. 22.)

The Committee also expects that, to the extent practicable, in carrying out his responsibility

* Precedents cited by the committee in support of legislative protections for employees include railway legislation, the Urban Mass Transportation Act and the Juvenile Justice and Delinquency Prevention Act. (H.R. Report No. 94-192, p. 22)

with respect to this provision, the Secretary will rely on the expertise developed by the Department of Labor in connection with enforcing similar labor protective arrangements under other laws. (H.R. Report No. 94-192, p. 22.)

Indeed, the latter expectation, that the Department of Labor be consulted for the purpose of helping the Secretary carry out his legal responsibility, is also stated in the employee protection provision of P.L. 94-63.

III. HEW'S REFUSAL TO IMPLEMENT THE PROVISIONS OF THE ACT

A. The Department Claims That Regulations Are Unnecessary

The position of the Department of Health, Education and Welfare is that the legislative mandate can be adequately implemented without the promulgation of any regulations by the Department. HEW's current procedure, which calls for the annual review of state employee protection assurances and compliance with such assurances to be conducted by the Department's Regional Offices, is supposedly designed to guarantee state conformity to the provisions of 314(d). According to Dr. Edward D. Martin, Assistant Surgeon General and Director of the Bureau of Community Health Services (Health Services Administration), the Department's official position is that the present procedure, although it provides no guidance to the Regional Offices as they act on the Secretary's behalf other than the statutory language of 314(d), needs no revision:

... the statutory standard of "fair and equitable arrangements" is sufficient for the Regional Offices to make the necessary judgments regarding state compliance.

(Letter to Mr. Jerry Wurf, President of AFSCME,
March 15, 1978)

This statement, while revealing a truly inspiring faith in the ability of the Regional Offices to divine the determinations of the Secretary, flies in the face of both legislative expectations and current practice.

Unfortunately, an examination of selected mental health plans, inquiries concerning methods of evaluating these plans within the Department of Health, Education and Welfare and discussions with those most familiar with patterns of state plan review all point towards the same inescapable conclusion: The Secretary has, in effect, abdicated his duty to enforce the congressionally mandated labor protective arrangements. This abdication of duty includes both the failure to require that states submit plans for such arrangements as a prerequisite for federal grants under 314(d) and the failure to monitor state plans and activities in order to ascertain that those arrangements have been carried out and adhered to.

In fact, all available evidence suggests that the statutory standards have not provided Regional Offices with a sufficient basis for judgment. Discussions with personnel at both the Central and Regional Office levels indicate that enforcement of state compliance with requirements is wholly inadequate, as is the monitoring of enforcement efforts. Furthermore, HEW, despite instructions contained in the Act, has virtually ignored the Department of Labor in its rejection of employee protection regulations.

B. States Routinely Fail to Include Required Items in State Plan, Even Though Such Failure Should Result in a Loss of Federal Funding

Mr. William Moses, Social Science Analyst in the Office of Program Development and Analysis (NIMH) analyzed the 54 comprehensive state plans submitted for FY 1977, the first year of the ten-year plan period. While Moses' survey provides some evidence of how cavalierly requirements are treated by both states and the Regional Offices they deal with, it does not do full justice to the inadequacy of the current Regional Office review procedures: it fails to indicate the specificity of sophistication with which an issue is addressed by the state in question; nor does the survey give any indication of state compliance. In other words, the inherent bias of the survey is that it weighs satisfactory and unsatisfactory state plan provisions equally, so long as they appear in the document. In the case of employee protections, the plans often contain no more than a paraphrase or even a direct quotation of guideline language.

For the United States as a whole, more than 40 percent of the items required by the guidelines were allowed to be ignored by the states.

C. The Regional Offices Have Permitted the Systematic Exclusion of Employee Protections and Related Items from State Plans

In order to assess the adequacy of Regional Office review, a telephone survey was conducted during the month of August. The

respondents were, for the most part, project officers for particular states. They were directly involved, therefore, in the process of state plan approval. The officers contacted were asked about the procedures that their Regional Office used when approving mental health plans and updates. The four regions contacted contain some of the most populous states in the nation as well as those with the largest number of AFSCME-affiliated mental health workers.*

All of the respondents cited the May 1977 Interim Edition of the Guidelines for the Preparation of State Plans for Comprehensive Mental Health Services as the criteria which officers used in reviewing state plan compliance with statutory employee protection provisions. (The Interim Guidelines apply to the fiscal year 1977 five-year plans as well as to subsequent years. A Review and Progress Reports outline applies only to the fiscal years 1978 and 1979 updates.)

The following people were contacted:

Region I (Mass., R.I., Conn., N.H., Ver.):
 Mrs. Ernestine Kiano, Rhode Island State Project Officer
 Dr. T. Leon Nicks, Massachusetts State Project Officer
 Region II (N.Y., N.J., P.R., V.I.):
 Mr. Ronald Moss, Mental Health Officer
 Region III (Pa., Md., Del., D.C.):
 Mr. John Wells, Pennsylvania State Project Officer
 Dr. Nathan Seldin, D.C. State Project Officer
 Dr. Howard Kroll, Maryland State Project Officer
 Region V (Tn., Mich., Ohio, Wisc., Minn., Ind.):
 Mr. Kenneth Watanabe, ADAMHA, Mental Health Consultant

The employee protection provisions are contained in the third part of the Guidelines' "Manpower" section:

- (1) Plan includes summary of manpower by major job categories:
 - a. 5-year projection;
 - b. considers changing requirements.
- (2) Plan describes state taking (sic) to maintain adequate supply of personnel needs.
- (3) Special attention to employee rights affected by deinstitutionalization with specific procedures designed to:
 - a. preserve rights and benefits;
 - b. training and retraining;
 - c. assure maximum effort to guarantee employment.
- (4) Summary of state efforts to meet employee needs identified from past years.

(Moses Checklist)

Of these nine items, the mean for all 54 state plans was 3.91. Almost 57 percent of the items relating to manpower needs was missing from the comprehensive plans.

More than one-half of the required material concerning employee protections was omitted from the reports. No particular item was significantly more neglected than any other, indicating a rather uniform level of indifference to the various questions raised by the issue of protections for mental health workers:

<u>Item</u>	<u>No. of State Plans Including Item</u>
3	27
3a	25
3b	30
3c	25

Even more pronounced is the failure of states to discuss items which cannot be dismissed with unsubstantiated or uninformative statements such as, "The Department will assist displaced employees in securing similar employment in other agencies or within the mental health delivery system, if possible," (North Dakota, emphasis added), or "we do not foresee any sizeable reduction in the work force now employed at the ten state hospitals... . We anticipate that the reduction in staff from the existing authorized complement will be minimal." (Minnesota)

In the case of almost all the "Manpower" items not dealing with employee protections, even fewer states provided the information required. In fact, there was an apparent inverse relationship between the number of states replying to a particular item and the effort which a thorough response would have required: only 14 states included in their five-year plan a five-year projection of personnel needs; 12 out of 54 plans summarized state efforts to meet the employee needs identified from the previous year. The absence of these portions from the plans reinforces the superficial nature of other portions and raises some very basic questions about the adequacy of whatever employee protections may be present: How can a state discuss training and retraining programs or guarantees of employment with any credibility if it has neither projected its personnel needs nor reviewed its efforts to deal

-10-

with similar needs in the past? The fact that Regional Offices have approved these plans, incomplete as they are, is another indication that more direction must be provided from the Central Office if the decentralization of authority is to proceed properly and effectively.

- D. The Review Procedure Fails to Assess the Adequacy of Protections or State Compliance with the Assurances Contained in the Plans

The wide range of provisions which are considered acceptable by Regional Offices also illustrates the necessity of providing departmental guidance beyond the statutory language. While every respondent to the telephone survey indicated that draft state plans are subjected to "outside review" upon their receipt by the Regional Office (in Region III this seems to be the practice for the five-year plan and not the Review and Progress Reports), none had included in a review group anyone whose primary interest was employee protections. The exclusion of this interest from this and other steps in the review process is evident in the approved plans: not only do they contain language which runs counter to the expressions of legislative intent, they cannot even be squared with the statutory standard of "fair and equitable arrangements," despite the vagueness of that phrase.

Within the Regional Offices themselves the AFSCME survey did not reveal a single instance in which a staff person was involved with monitoring employee protection provisions and compliance with those provisions on an ongoing basis. In Region I, Dr. Leon

Nicks (Massachusetts) incorrectly thought that the Regional Office's Office of Civil Rights was involved in monitoring employee protections. In Region II, Mr. Ronald Moss would not approximate how much of the monitoring process involved questions of employee protections, although we were later told that it was not clear if the reviewers have ever questioned employee protection language in draft plans. In Region III, Dr. Wells (Pennsylvania) estimated that employee protections accounted for "maybe 1 percent" of the time his office spent on state mental health plans. In Region V, we learned from Mr. Watanabe that monitoring of employee protections only occurs when it is incidental to some other issue which his office is looking into.

The employee protection provisions of state plans often merely restate problems faced by institutional employees rather than providing employees with much needed protections. For example, the State of Florida indicates in its mental health plan that if an employee does not accept an employment offer, even if the offer involves a transfer of over 50 miles, a demotion or a reduction in pay, by a given date, the employee will be laid off and "the Department will consider the agency's obligation fulfilled." Similarly, we learn that "Maine is not in a position to guarantee state jobs to all who might be displaced." The State of Montana in its 1978 Review and Progress Report provides perhaps the most vivid evidence of why criteria for what constitutes "fair and equitable arrangements" need to be provided before protections can be enforced by the Department

of Health, Education and Welfare: "Legislative funding . . . has been less than expected, resulting in some staff layoffs at the state hospital." There is no indication of how many employees lost their jobs, what retraining options were considered for them, whether, or to what degree, their benefits were jeopardized and whether, or by what means, they have been guaranteed new positions.

E. The Lack of Well-Defined Standards and Criteria Is Exacerbated by the Failure of HEW to Review the Regional Offices' Performance

First, neither Regional Offices nor the states are required to forward state mental health plans to the Central Office of the National Institute of Mental Health in Rockville. Those that are sent may be sent to Rockville any time before or after their final approval, with or without an explanation of the plan's status (approve, approve with conditions, disapprove pending revision) or any conditions imposed. As Lamar Neville of the NIMH Community Support Branch explains, officers may sometimes express their views on a particular issue in a state plan during totally informal "negotiations," in which case no written explanation may be forwarded because none exists. Neville also mentioned that when certain conditions are met or states claim to have met them, there is no assurance that either final approval or the supplemental information provided for the approval will be communicated to the Central Office.

The inability of the Department of Health, Education and Welfare to assess how well Regional personnel are exercising the authority delegated to them appears even more obvious when one realizes that while methods of evaluation between regions vary greatly both quantitatively and qualitatively, no explanation of review procedures or resources devoted to a review need to be forwarded to the Central Office. Hence, one cannot tell whether plans have been subjected to extensive external evaluation, review by Regional Office staff or simple exchange of reports among the officials of several states. This is especially important with the passage of time because, as one State Project Officer observed, the annual "update is considerably more informal each year" with informal negotiations between Regional Office staff personnel and state officials replacing review by outside consultants as a mode of plan evaluation. (Dr. Nathan Seldin, D.C. State Project Officer, conversation with B. Rasmussen, August 10, 1978.) The quantitative differences, in terms of the time spent reviewing plans, also show great variance, ranging from offices "spending one-half day or one day on a plan to moving it by in one-half hour or forty-five minutes." (Neville conversation with E. Wolf, September 13, 1978.)

IV. CONCLUSION

The Secretary of HEW must establish standards and criteria to assist Regional Offices in the evaluation and active enforcement of employee protection provisions.

If the Secretary does not fulfill his responsibilities as set forth in 314(d), the situation with regard to employee protections in state plans will not improve. Even with adequate regulations, there is no guarantee of improved review, but at least there is a chance. It will take a major effort to overcome the existing perceptions of the Regional Office about the low priority of employee protections. The need for direction from the Secretary stems from the longstanding insensitivity to the needs of nonprofessional and paraprofessional workers on the part of the federal mental health establishment. As one NIMH employee familiar with the state plan review procedures explained when asked why employee protections were given such short shrift, "the Regional Offices do not pay much attention to the things which the NIMH does not consider important." (Conversation with E. Wolf, September 18, 1978.)

Department of Public Policy Analysis
November 9, 1978

Attachment:

Excerpt on Employee Rights from the "Manpower" section of the May 1977 Interim Edition of the Guidelines for the Preparation of State Plans for Comprehensive Mental Health Services.

Employee Rights:

Provisions must be made for the establishment of fair and equitable arrangements to protect the interests of employees affected by actions designed to reduce the number of persons in State institutions, to develop noninstitutional services and to improve the quality of care in State institutions. Some of these actions will result in a reduction in the number of employees at a particular location, while others will result in functionally different or qualitatively more difficult job assignments. Specific procedures must be established and identified in the State Plan which are designed to (1) preserve employee rights and benefits, (2) assure maximum efforts to find employment for such personnel and (3) provide for training and retraining, where necessary. The description of protective arrangements shall include specifications of arbitration procedures to be used for the resolution of conflicting claims and disputes which might arise. These provisions shall be developed as a result of negotiations between appropriate State authorities and employee representatives.

To document implementation efforts, an annual estimate shall be given of the number of employees whom it is anticipated will be affected by programs which foster deinstitutionalization, non-institutional services and improved institutional care. These employees should be further categorized to identify those for whom assignments will be available at comparable levels using existing skills, those who will need additional training and those for whom placement will be a problem because of relocation or skill factors. Each year a summary shall be presented of the State's efforts to meet the employee needs identified in the previous year, and of outstanding disagreements with employee representatives.



AMERICAN HOSPITAL ASSOCIATION

444 NORTH CAPITOL STREET, N.W., SUITE 500, WASHINGTON, D.C. 20001 TELEPHONE 800-368-5858
WASHINGTON OFFICE

**STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
BEFORE THE SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
OF THE
SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES
THE MENTAL HEALTH SYSTEMS ACT
S.1177**

June 29, 1979

The American Hospital Association (AHA) is pleased to present its views and recommendations on the Mental Health Systems Act. The AHA represents over 6,100 member hospitals and health care institutions, and over 30,000 personal members. The Association's Psychiatric Services Section consists of 2,750 institutional members, 70 percent of which are general hospitals.

In late 1978, the AHA established the Center for Mental Health and Psychiatric Services to serve both its psychiatric services section and the Association's membership in general. The Consulting Director of the Center is Harold Visotsky, M.D., Professor and Chairman of the Department of Psychiatry and Behavioral Science at Northwestern University Medical School. Among the functions of the Center are the representation of all institutions that provide psychiatric services (including inpatient, outpatient, partial hospitalization, emergency, and home care services); assistance to community general hospitals in the interest of effective and cost-efficient delivery of psychiatric services through consultation, educational conferences, and publications; and the development of an information and data base on psychiatric services. The resources and expertise of the Center have been utilized in the preparation of this statement and are available to this Committee to assist in the development of an effective national policy on mental health.

The AHA endorses the intent of the Mental Health Systems Act to provide more flexible and coordinated delivery of mental health services and to encourage a partnership among federal, state, and local entities to that end. In addition, we support efforts to address the mental health needs of unserved or underserved population groups, the improvement of health services for the chronically mentally ill, and expansion of mental health education and preventive care. We believe that community hospitals have key roles in strengthening the delivery of community-based mental health services.

We would like to address some specific concerns about the proposed Act which relate to the development of a national mental health policy and the concept of a community-based mental health care system. Following this, we will offer comments on specific aspects of the bill.

DEVELOPMENT OF A NATIONAL MENTAL HEALTH POLICY

Our country unquestionably needs to devote more attention and resources to mental health care. Many Americans in need of such care are not receiving adequate help. Further, certain groups in the population such as children, the aged, the chronically mentally ill, racial or ethnic minorities, the indigent, and persons in rural areas still lack access to adequate mental health services.

Past efforts to address these problems, promising broad reforms in mental health services delivery, have had important, but only limited, success. For example, Community Mental Health Centers (CMHCs), originally conceived as a program of some 1,200-2,000 centers, today number less than 700 operational organizations. One of the reasons why potential sponsors of centers, including many public and private hospitals, have been hesitant to assume responsibility for starting new CMHCs is a recognition that in the future they may find themselves without adequate financial support to maintain a program of ongoing services. Because the nation's resources are limited, it is imprudent to

expect providers or local governments to assume new and expanded delivery obligations which cannot be sustained by available public and private funds. Therefore, federal programs should be clearly focused and should avoid promises of expensive new delivery systems that cannot be supported on a continuing basis. To do otherwise would be a disservice to all who advocate improvement in mental health services and to those who would continue to be denied access to services.

The proposed Act would authorize \$100 million for new initiatives in FY 1980, yet over 30 percent of this total represents existing authorizations for mental health programs. This aptly illustrates our concern about designing a program that cannot be implemented. The proposed program includes a relatively small amount of money which realistically cannot be expected to stimulate or support substantial restructuring of mental health services delivery.

In light of limited new resources, the highest priority should be to fill the most serious gaps in mental health services delivery. Such an incremental approach would maximize the use of existing resources by providing incentives, and targeting their use, for the systematic improvement of access to needed mental health services.

We believe that new initiatives should focus on improving access to intensive, active treatment services which would better assist those with the most critical need for care. The success of this effort would be directly related to the capability of the Act to encourage the development of local systems, building on existing mental health/psychiatric services provided by community general hospitals, private psychiatric hospitals, and other appropriate community resources.

THE CONCEPT OF A MENTAL HEALTH CARE "SYSTEM"

There are presently some 51,000 psychiatric beds in community general hospitals,

representing about 20 percent of available inpatient psychiatric services. These beds provide immediate access for community residents to intensive active treatment and are an important component of the existing local mental health care delivery system.

We will fail to take advantage of the opportunities and incentives for the development of a comprehensive, community-based mental health system if new efforts do not adequately consider the community's total range of treatment needs and resources. It is prudent both in terms of sound planning and in terms of cost-effectiveness to take maximum advantage of the potential of expanding these resources in developing a better mental health system. Certainly, community general hospitals and private psychiatric hospitals must not compete with or supplant the services of community mental health agencies; rather, they should be considered a natural continuum within the entire community system. Promising opportunities exist for the effective integration of community resources to improve access to needed mental health services, and coordinate the appropriate level of mental health care.

One of our primary concerns with the proposed Mental Health Systems Act is its failure to recognize the role to be played in a mental health system by private psychiatric and community general hospitals. Hospitals are, and will remain, the core providers of ambulatory and acute inpatient health services in the community. In fact, psychiatric units of general hospitals have become the single largest component of the existing mental health delivery structure, not only for inpatient treatment, but increasingly for ambulatory care.

A recent HEW report (Health, United States, 1978) notes that the declining population of state mental hospitals over the last 20 years has not resulted in fewer inpatient admissions. Rather, the locus of care has shifted to alternate settings, those capable of providing a more active treatment focus. Primarily, these have been community

general hospitals. Thus, while the total days of inpatient psychiatric care have declined, the importance of the inpatient setting has not.

Between 1973 and 1978, the number of community general hospitals providing psychiatric services grew from 871 to over 1,600. Of these 1,600 institutions, 1,234 provide psychiatric inpatient care, 1,231 provide outpatient treatment, 751 have partial hospitalization programs, 1,534 provide emergency services, and 1,124 offer consultation and education programs. Clearly, the increase in community hospital-based mental health services has been multifaceted. The growth of psychiatric services delivery in the hospital setting can be attributed to a number of factors reflecting consumer preferences:

- Lack of Stigma. The stigma publicly attached to mental illness unfortunately is still widespread, and many patients prefer the privacy of psychiatric diagnosis and treatment in the community general hospital setting.
- Professional Care and Ancillary Medical Services. The general hospital as an established medical institution promotes confidence that one will receive total professional-level health care. In addition to psychiatric services, the medical and support services available in hospitals are an integral part of improving the patient's total treatment and well-being. The total number of community general hospital patients with a primary psychiatric diagnosis increased 42 percent between 1971 and 1975, compared to an overall increase of 16 percent in hospital utilization. During the same period, secondary diagnoses for mental health problems increased 52 percent. The latter figure reflects, in part, the increasing liaison between psychiatric specialists and the medical-surgical departments of community hospitals, resulting in better recognition of mental illness in patients admitted with other types of disorders.
- Accountability and Governance. The community general hospital is governed by a formally structured and legally responsible board with legal accountability,

control, and fiscal responsibility.

- Patient Displacement from State Hospitals. While a number of state psychiatric hospitals across the country are being closed, many patients discharged from these institutions will require further intense, active treatment from time to time. In the "community," their health needs must often be provided through existing community hospitals.

It is important to note that recent studies show the mentally ill have higher than normal rates of physical illness and use general medical services at twice the rate of the total population. Thus, medical services are important to the total well-being of the psychiatric patient. Mental health services delivered outside of the mainstream of medical services and professional affiliation many times suffer in quality. Removed from adequate institutional support, they tend to become social services, a condition which is difficult to justify in terms of the limited financial resources available for active treatment of mental illness.

The role of all of the resources of the private sector, including community hospitals, must be explicitly recognized and supported if the proposed Act is to succeed as a systems plan.

SPECIFIC COMMENTS ON THE ACT

We would now like to highlight some specific provisions of the Act which merit special attention.

Title I

This title addresses the needs of the chronically mentally ill, and focuses on "deinstitutionalization." We agree that additional assistance is needed by the states to plan and coordinate the implementation of this effort. A major failing of previous

efforts to discharge patients from state institutions has been the failure of sufficient program funds to "follow" the patient once he or she leaves the institution. That is, savings from the shrinkage of a state system are not applied to the development and expansion of community resources to support discharged patients. We are encouraged by the provision in Title I for the planning of support activities for this purpose, but would caution that implementation of such activities will require substantial commitment of program funds and appropriate flexibility in administration.

Title II

Preventive services have been sorely neglected in mental health programs. Such services can be an important contribution to the reduction of future mental health expenditures. We support Title II's purpose to encourage preventive services and increase mental health education. We urge that state efforts in this regard include consideration of hospital-based health promotion activities among the resources for such programs. Again, we point out that the full implementation of preventive approaches will call for substantial additional resources.

Title III

As noted earlier in our statement, careful planning, as well as data collection and analysis, are necessary to evaluate and effectively implement mental health programs. We support the Act's emphasis on these activities as provided in Title III.

However, the proposal to grant additional funds to the states does not recognize that such planning is already a state responsibility. In light of the critical need to strengthen needed treatment services, limited federal funds should not be used to finance planning costs which the states have a responsibility for assuming in any event. Documented planning efforts at the state level should be required, but the commitment of additional federal monies for this purpose is inappropriate. As provided in the

health planning legislation now pending in Congress, mental health planning should be closely coordinated with other health planning activities.

Title IV

The two major provisions of this Title are designed to encourage the initiation of services to the underserved and the development of comprehensive mental health services. As noted previously, we are concerned about the lack of specific recognition of, and emphasis on, critical roles of community hospitals, both as mental health services providers and as sources of related medical support services. In many medically underserved areas, particularly in the inner cities, hospitals are the primary, if not the only, source of entry-level mental health care. The community hospital emergency room is the common point of entry for psychiatric emergencies, including instances of alcoholism, drug abuse, rape, and child abuse. It is important to support and augment the resources of community hospitals in underserved areas, urban and rural, in developing integrated systems for mental health services. The coordination of all necessary community resources is essential if we are to achieve the long-term goal of developing comprehensive mental health services throughout the country.

Similarly, Section 403, dealing with comprehensive service programs, also should provide specifically for the integration of community hospitals into the plan for comprehensive mental health services in the community. As we have emphasized, the long-term well-being of the mentally ill is dependent upon a broad range of medical and social concerns. The community hospital's support is critical to the fulfillment of these objectives.

A related concern is raised by Section 404. This section encourages the participation of ambulatory care centers in providing mental health services to patients through "linkage grants," to strengthen working relationships with certain mental health care providers. Such linkages are most appropriate because they can increase capacities of

medical care providers to deal with mental health problems. However, it is also important to encourage agreements involving providers of inpatient services in order to meet the full range of health care needs for these patients. Further, the section should be modified to clarify that qualified ambulatory care centers of hospitals should be eligible for assistance. Such arrangements are consonant with the Act's emphasis on comprehensive community systems and the desire to improve mental health services as part of the inpatient and outpatient resources of hospitals.

Title VI

We are extremely pleased to note Section 631, pertaining to the governing bodies of local provider agencies. Section 631 would allow the governing body composition requirements for hospitals and governmental agencies to be met through appointment of advisory committees. This approach reflects a recognition of the concerns which we have raised before Congress and HEW in the past concerning the CMHC program. We therefore strongly endorse this provision as a positive step toward maintaining and expanding the participation of all community resources in mental health care.

CONCLUSION

Mr. Chairman, we should not promise a new health care delivery initiative that exceeds current capability for sustained fiscal support. To effectively close the gaps in necessary mental health care and improve the systematic delivery of mental health services, the public and private sectors, including the nation's community hospitals, must work together. This cooperation must occur not only to strengthen community participation, but to assure that those in need of mental health services receive the most effective assistance we can give them. In view of the limited additional resources that can be devoted to these activities under present conditions, we should carefully set priorities and focus efforts in ways to best meet the most pressing needs.

American Nurses' Association, Inc.

2420 Pershing Road, Kansas City, Missouri 64108

(816) 474-5720

Barbara L. Nichols, M.S., R.N.
President

Myrtle K. Aydelotte, Ph.D., R.N., F.A.A.N.
Executive Director

June 26, 1979

The Honorable Edward Kennedy
Chairman, Subcommittee on Health and
Scientific Research
Senate Labor and Human Resources Committee
4220 Dirksen Senate Office Building
Washington, D. C. 20510

Dear Senator Kennedy:

The American Nurses's Association is pleased to support the thrust of the new Community Mental Health Systems Act, S.1177, as a step toward assurance of high quality community alternatives to hospitalization in public institutions for mentally ill and mentally retarded persons. With the decline in inpatient population in state and county hospitals, the intended community alternatives to mental hospitalization have not been provided in sufficient quality and quantity to meet the needs of this former inpatient population. This neglect in providing adequate and sufficient community alternatives has resulted in the massive substitution of community institutionalization in custodial nursing homes or social isolation in single room occupancy situations. We support the intent of this legislation to foster appropriate alternatives and to coordinate systems of care.

Professional nurses occupy strategic positions within the mental health services system. As the largest number of professional providers of mental health care, nurses are particularly aware of the need for personal, individualized assistance for those in need. We affirm the effort, under Title I of the Act, to assure the availability of both mental health and support services for the chronically mentally ill.

This primary mental health care role is well within the scope of psychiatric and mental health nurse specialists. Psychiatric and mental health nurses are committed to helping persons attain their highest level of health. In teaching patients to understand their physical limitations and to maintain themselves in the best possible health, nurses can and do provide a valuable service not only to patients released to the community but to those for whom the necessity of hospitalization may be prevented. Nurses are in a unique position to provide the preventive services mandated by Title II of the Act. They can also provide the linkage between hospital and the community. Assuring continuity of care and preventing fragmentation of services may well be one of the primary functions of psychiatric and mental health nurses of the future. Through pre-discharge planning, after-care visits, and evaluation of effective methods of treatment, nurses may provide a more appropriate quality of life for discharged patients and forestall an early return to the hospital. Moreover, nurses are becoming increasingly skilled in community education to facilitate the physical and social integration of mentally disable persons into the community. Such

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Senator Kennedy
June 26, 1979

nurse specialists can and do work collaboratively with health care and other providers in the widest range of settings.

We agree that those with mental health problems require a flexible network of services provided by a range of qualified providers. Services should include preventive care and health maintenance, as well as illness care. Persons with similar mental health problems may differ in cultural background, geographic location, and economic status. In order to assure the full range of health and social services necessary, there must be some built-in flexibility for patterns of utilization. This legislation is a step towards such flexibility.

Omitted in this legislation is the fiscal underpinning without which the reforms suggested are superficial. Although the intent is to develop self-sustaining mental health systems, fiscal viability is in serious question. It is difficult financially for clinics to employ health professionals, such as psychiatric nurse specialists, whose services are not directly reimbursable. There should be concomitant changes in Medicare and Medicaid legislation, as recommended by the President's Commission, so that community mental health centers (and perhaps "core service agencies") can get provider status in order to be reimbursable for services provided.

Systems of reimbursement must become more congruent with service needs. Current insurance coverage defines the type and length of treatment, the provider, and the setting. A narrowly restrictive medical, inpatient focus in insurance coverage not only limits flexibility, but often precludes more appropriate, humane, and cost-effective treatment. Under the present reimbursement system, it is easier to collect reimbursement for a major episode of illness requiring hospitalization than to get coverage for outpatient treatment designed to prevent the recurrence of illness. In a crisis, outpatient sessions with a qualified (but non-medical) professional might forestall hospitalization at a tremendously higher cost. Care of the chronically mentally ill by qualified providers can occur in a variety of settings including the home and other community settings. Advocacy with neighbors, employers, teachers, friends, and family members might mean the difference between success or relapse; health maintenance or illness; societal cost savings, or costly expenditures. Yet all these preventive, supportive, cost saving measures remain mostly uncovered by insurance and unobtainable for all but wealthy citizens. In the long run, preventive care is not only more humane, but can save much of the exorbitant cost of inpatient care.

We strongly support the recommendations of the President's Commission on Mental Health that mental health care reimbursement should be provided directly to the four core disciplines: psychiatry; psychology; social work; and psychiatric nursing. Psychiatric and mental health nurse specialists are greatly underutilized. The significance of their contributions, especially in providing care to underserved populations, is yet to be acknowledged. An adequate data system from which information about all mental health professionals is readily retrievable is greatly needed.

We support the overall thrust of a new federal-state-local partnership in the development of mental health services. For too long, there has been isolation of the state hospital system from the community mental health system. This has resulted in fragmentation of services and neglect of the deinstitutionalized population in particular. If there is to be integration and linkage, then an organizational entity at the state level must have the authority and responsibility to coordinate these systems.

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June 26, 1979

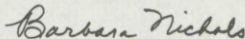
We do suggest that there must be qualified mental health professionals within the state system in positions of authority in order to achieve quality services. Nurses have sadly lacked visibility at the state level in the past for a number of reasons. Qualified, certified psychiatric nurse specialists should be among the professional mental health disciplines involved at all levels and in positions of leadership, with a strong voice, at the state level. We continue to support the integration of mental health into broader health planning. The new law would be strengthened by specification of mental health expertise at the local, state, and federal levels of health planning.

Leadership should be provided at the federal level to achieve coherence amidst what appears to be considerable disarray, with services often least available to those most in need. The Department of Health, Education, and Welfare is in a position to spearhead advocacy relationships with other pertinent agencies, as currently exemplified by the new collaborative agreements between the National Institute of Mental Health and the Health Care Financing Administration, and between the National Institute of Mental Health and the Department of Housing and Urban Development, for housing for the mentally disabled. More needs to be done to set federal policy regarding working relationships intra- and inter-agency, so that advocacy and actual service delivery can occur more smoothly at state and local levels.

Minorities are underrepresented among all professional providers of health care, including nursing. The American Nurses' Association has always taken a strong stand for affirmative action and heartily supports the focus on minorities in the legislation. Minority emphasis, among target recipients of care and services, as well as among providers of mental health care, is rightly an important thrust of the legislation.

We ask that this letter be made a part of the hearing record.

Sincerely,



Barbara Nichols
President

BN/s

The American
Occupational Therapy Association, Inc.

June 25, 1979

The Honorable Edward M. Kennedy
Chairman
Subcommittee on Health & Scientific Research
Committee on Labor and Human Resources
4220 Dirksen Senate Office Building
Washington, D. C. 20510

Dear Chairman Kennedy:

On behalf of the American Occupational Therapy Association (AOTA) I commend you and your Subcommittee for your efforts to improve the nation's mental health policy. I refer specifically to the Subcommittee's hearings on S. 1177, the Department of Health, Education and Welfare's proposed Mental Health Systems Act. I am pleased to submit the attached Statement of the American Occupational Therapy Association regarding this proposed legislation. At this time I request that it be made part of the record of the Subcommittee's hearings of June 11, 1979.

We appreciate the opportunity to offer these comments. If we can provide any further clarification of our testimony or additional information, we would be pleased to do so.

Sincerely,

Mae D. Hightower-Vandamm

Mae D. Hightower-Vandamm, OTR, FAOTA
President

MDV:dcd

Attachment

The American
Occupational Therapy Association, Inc.

STATEMENT

OF THE

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

ON

S. 1177, MENTAL HEALTH SYSTEMS ACT

PRESENTED TO

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

COMMITTEE ON LABOR AND HUMAN RESOURCES

U. S. SENATE

JUNE 25, 1979

The American Occupational Therapy Association (AOTA) is pleased to submit comments on S. 1177, the Administration's proposed Mental Health Systems Act. The Association was formed in 1917 and now represents over 27,000 members. Nearly 45 percent of our practicing therapists are employed in the field of mental health, many of them in community settings. Mental health issues are of equal importance and concern to therapists providing services to the physically and developmentally disabled.

Occupational therapy is a rehabilitative specialty serving individuals of all ages who are psychologically, physically or developmentally disabled. Occupational therapy treatment, in addition to reducing specific pathology, helps patients achieve their optimal level of independent function in such areas of every day living as work, self care, socialization and leisure time pursuits. Therapists concentrate upon assets and adaptive capacities while mobilizing individuals to carry out those life tasks which enable them to be productive human beings, more capable of controlling their own life and contributing to families, communities and country.

Our comments concerning S. 1177 are divided into three categories: I.) those provisions which the Association strongly supports; II.) those which raise some concern and perhaps require alteration; and III.) additional mental health issues of concern to the Association which are not addressed in the legislation. A final section contains a description of occupational therapy practice, education, and credentialing.

I. Provisions of S. 1177 Which AOTA Supports

Our Association supports the concept of a stronger partnership among federal, state and local governments. The proposed shift in authority to the state and local level can be a significant force in bringing service delivery into closer alignment with consumer needs. However, the hard facts are that state management of the

mentally ill has all too often been less than exemplary. The mechanism by which planning, implementation and evaluation of services will be monitored is of great concern to us. We believe that the use of performance contracts between federal and state or local mental health agencies could prove to be an effective approach. However, we strongly urge that these contracts include specific goals, standards, and sanctions for non-performance to foster the best possible use of available resources and to prevent misunderstandings between parties. We also look for assurance that the National Institute of Mental Health will have the financial resources and manpower capacities with which to develop standards and adequately monitor these performance contracts.

The American Occupational Therapy Association is strongly supportive of provisions in Title I to develop a system of mental health and support services for the chronically mentally ill. We are especially pleased to note that Section 100 (a)(2)(B) includes "rehabilitation" as one of the services which enables such individuals to live in the community. Rehabilitation is a logical and necessary stage in preparing and maintaining patients in "the least restrictive environment." A legislative commitment and mandate for rehabilitation services is of great historical and practical significance, for it speaks to the functional potential of the chronically ill. Our nation's mental health system has all too often spoken only to their deficits. Access to those services which develop and enhance independent living skills must be ensured on all levels of service delivery. The chronically mentally ill population requires a continuum of care from community based programs to occasional or intermittent inpatient hospitalization, and rehabilitative services should be available in all of these settings.

The Association supports the provisions of Title II which provide grants to develop programs for the prevention and early detection of mental disorders and the promotion of mental health. We believe that training for all health personnel in

the early identification of mental health problems has great potential. We also support emphasis on public information programs to help people identify the causes of mental problems and seek early intervention to prevent their occurrence.

Provisions of Title IV also encourage preventive efforts. The placement of mental health professionals in ambulatory general health care centers will provide critical expertise and linkage between the mental health and general health care systems. An integrated system can also promote early identification of mental health problems which contribute to, or are secondary to, physical illness. The potential savings in both dollars and human distress is notable.

II. Provisions of S. 1177 Which Require Alteration

1. The Association is deeply concerned about the delivery of mental health services to underserved or unserved populations. We have long been advocates for appropriate services for the chronically mentally ill, the elderly, children and women, especially since 95.4 percent of our professionals are women. We, therefore, support the grant program contained in Section 402. We question, however, the absence of provisions which would require effective coordination between these special programs and existing community mental health services. We note that Section 402 (b) (4) requires an affiliation between the project and an "entity (if there is one) providing additional mental health services." We believe this is an important requirement, but it does not go far enough. We recommend therefore, that a grantee under this program be required to demonstrate coordination between the special program and the mental health services system in the area, if such system exists. If no comprehensive system exists, the grantee should be required to demonstrate affiliation with more than just one other entity providing mental health services. The number of affiliations could depend upon the amount of services which are already available in the area. The purpose of the requirement, however, would be to ensure that programs for targeted

populations not serve to further fragment the delivery of mental health care services. Targeted populations, then, will not only be able to take advantage of the services designed for their special needs, but will also have built into the program, access to a more comprehensive array of other services which they may need at some given time.

2. Title VI, Part B, Section 626 directs the Secretary of HEW to "prescribe standards relating to the quality of care in the provision of mental health services by any recipient of a grant under this Act." The Association supports the development of standards relating to mental health care.

No uniform description of comprehensive mental health treatment currently exists. The federal government has failed to establish regulations which specifically define the scope of services which must be provided in community mental health centers. Without definitive guidelines, facility and program staff are given excessive discretion in determining the scope of services offered. The Association, therefore, recommends that the Secretary of HEW be mandated to outline in detail the appropriate components of a comprehensive community mental health care treatment program. After these components have been identified, specific roles and qualifications for mental health practitioners should be clearly delineated. Section 626 should be amended with language that will require this action. The absence of federal manpower guidelines in this area frequently results in inefficient and inappropriate use of trained personnel and the misuse of unqualified people who assume roles beyond their competence.

The failure to define appropriate mental health manpower is related to the ambiguity which exists with regard to mental health services. It is certainly difficult to specify qualified personnel to provide services unless those services are clearly defined. Mental health care will benefit substantially if both services and personnel roles and qualifications are better identified.

If the Federal government is going to focus its efforts and its funding on mental health programs, then it has an obligation to ensure that mental health consumers receive therapeutic services from skilled and competent health practitioners. Our Association regards these issues as crucial to the improvement of mental health care. We are prepared to participate in the public discussion of possible solutions by recommending specific standards for occupational therapy services and for the training and experience requirements of qualified occupational therapists as mental health providers.

Our Association recognizes the problem of access to mental health services. We realize that mental health care funds are not limitless. We further understand that within existing financial limitations every attempt must be made to serve as many people as possible. We are sympathetic to the possibility that strict application of quality standards could result in the decertification of a facility which is the sole provider of services within a community. We insist, however, that the tenuous balance between the competing goals of quality and access must be struck on the side of proper care for the consumer. Access to unqualified, unskilled, but so-called "mental health" services is at best virtually meaningless. At worst, it can destroy the possibility of later assistance or rehabilitation by qualified mental health personnel.

The American Occupational Therapy Association believes that the development of a strategy for meeting the Nation's mental health care needs requires as a base the clear role delineation of health care providers. Once specific mental health care services are defined, regulatory standards for the education and training of providers of these services can be identified. Health planning may then proceed to match appropriate services to identified patient populations. Until these basic tasks are accomplished, the government can promote neither the most effective and efficient

utilization of qualified mental health manpower nor the provision of adequate quality mental health care to the nation's citizens.

III. Additional Mental Health Issues of Concern to the ATOA Which are not Addressed in S. 1177

Our Association has long recognized the need for improvement in the coverage of mental health services under the Medicare program. There is no justification for the disparity between the coverage for physical health care and mental health services. We urge the Congress to correct these disparities by increasing the lifetime limit on inpatient days, liberalizing outpatient benefits and providing coverage of qualified day care programs.

For several years the Association has been attempting to correct another inequity in the Medicare program. Specifically, we have tried to secure reimbursement for occupational therapy services in the freestanding outpatient setting and as a primary service under the home health benefit. Under present Medicare law, occupational therapy services are covered when provided on an inpatient basis in hospitals and skilled nursing facilities, on an outpatient basis in clinics attached to approved hospitals, and under the home health benefit if the individual also requires intermittent skilled nursing, physical therapy, or speech pathology or audiology services.

Legislation to correct this inequity has been approved by the Senate on three separate occasions. A bill (H.R. 13097) containing the major portion of the outpatient provision was approved by the House of Representatives at the close of the 95th Congress. In the current session it has been introduced by Representative Lindy (Mrs. Hale) Boggs (D-LA) with over fifty cosponsors. The home health provision is also included in S. 489, introduced by Senators Packwood and Domenici.

The complete proposal, home health and outpatient, has the support of the American Medical Association, the American Academy of Physical Medicine and Rehabilitation, the American Congress of Rehabilitation Medicine and the National Easter Seal Society of Crippled Children and Adults.

Adoption of this legislation would be a splendid opportunity for the Congress to demonstrate its concern for the mental and physical health of the elderly and disabled. Improved access to a needed service such as occupational therapy can alleviate the anxiety and fear of institutionalization which the elderly and disabled often demonstrate. The independence and competence in basic life skills which occupational therapy promotes is an important form of preventive medicine. We urge the Congress to move swiftly on this worthwhile proposal.

This concludes our comments and recommendations with respect to the proposed Community Mental Health Systems Act and other mental health issues of concern to the AOTA. Attached to this statement is further information on occupational therapy practice and the education and credentialing of the health professionals who provide this service to over a hundred thousand Americans every day. The AOTA welcomes the opportunity to present these views and offers its resources to assist the Committee in improving the quality of mental health care services.

Practice of Occupational Therapy

The concepts inherent in occupational therapy theory and practice have been used in the treatment of the mentally ill for hundreds of years. The ancient Greeks recognized the value of occupation and exercise as a means of recovering from illness, and the writings of the ancient Hebrews make reference to the beneficial effect of work on the body and mind. Work treatment was introduced in Europe as one of the first humane approaches to the care of the mentally ill as early as 1786. In the early 1900's a sophisticated body of knowledge evolved centered around the impact of activity on human growth, development, and recovery from physical or mental trauma. It came to be known as the profession of occupational therapy. Today's modern occupational therapists provide mental health services in community mental health centers, short and long term psychiatric facilities, halfway houses, and other community settings. Within all of these settings their primary concern is the development of adaptive skills and performance capacities.

Occupational therapists are concerned with human performance in ways that involve more than just the physical, psychological, and emotional well-being of individuals. The therapist focuses on any and all environmental factors that inhibit performance. The occupational therapist enters the life of persons to help them develop skills needed to influence their environment and fulfill their essentially personal role. The therapist acts as a catalyst for change in those instances in which it is the environment or the family, rather than the individual, that needs to change.

Occupational therapists believe that the majority of people who experience a mental breakdown may have been only marginally equipped to cope with the demands of daily life before their illness. Their defense mechanisms may have been faulty or excessive, and their basic life skills inadequate. Illness occurs when heavy stress is placed on these individuals in the form of family problems, job failure or disappointment, illness, or financial difficulties. Traditional medical management of

these patients includes hospitalization to remove or minimize the stress and medication to control symptomatology. It is at this point that occupational therapists enter the picture.

An occupational therapy evaluation will assess the strength and adequacy of patients' basic life skills and explore the various roles in the family, job, or community to which they will return. Treatment then proceeds to help patients identify and master skills necessary to reassume those roles and avoid further illness. To accomplish this, the occupational therapist initially provides a sheltered environment or "living laboratory" for the patient to practice new roles and skills, and increase competency and confidence in a non-threatening atmosphere before re-entry into the more competitive world. Occupational therapists also have a special ability to break down tasks into small enough components for the patient to master. Their expertise in task analysis and graded task development helps the patient avoid failure and the depression which follows.

Occupational therapy services, whether provided in an institutional or community setting, focus on community and neighborhood responsibilities. Pre-vocational assessment and training, resocialization, management of self-care tasks, and the meaningful use of leisure time are some of the components of our service system.

In summary, occupational therapists value the impact and importance of productive activity in the maintenance of health, the prevention of disability, and rehabilitation of the mentally ill. They believe that a significant number of individuals with emotional disability can remain independent and productive in the community with suitable access to a versatile range of mental health and support services. Occupational therapists are in a unique position to provide these needed services because of their strong professional commitment to returning the patient to an optimal level of function within our society. Occupational therapy is concerned with all the factors which affect the health of individuals and impact

upon their interactions within the family, the work place, and the community at large.

Occupational Therapy Education and Credentialing

An Occupational Therapist, Registered (OTR) has completed a four year baccalaureate degree program and six to nine months of supervised field work experience. For the person who already has a baccalaureate degree in an area other than occupational therapy, entry level masters and two year certificate programs are available. The occupational therapy curriculum includes courses in psychodynamics, group dynamics, developmental psychology, anatomy, neurophysiology, the social sciences, and activity specialties. The supervised field work covers such areas as psychiatry, physical medicine, gerontology, pediatrics, and developmental disabilities. There are currently about 60 professional level occupational therapy programs in colleges and universities throughout the country. All programs are accredited by the American Medical Association in collaboration with the American Occupational Therapy Association. This collaborative relationship, dating from 1934, is the oldest existing involvement between the AMA and an allied health profession in the accreditation area.

Graduate programs for OTRs are also available. Many of these prepare the therapist for specialized clinical practice, the teaching of occupational therapy, or research. One doctoral program in occupational therapy is available and several others are being developed.

The Certified Occupational Therapy Assistant (COTA) is a high school graduate or the equivalent who has completed a post-secondary program in occupational therapy approved by the American Occupational Therapy Association. Course work focuses on human physiology, and the tasks and skills used in daily life, and includes at least two months of supervised field work experience.

Following completion of course and clinical work, the entry level OTR or COTA candidate must pass a national certification examination to become credentialed for practice.

At the present time 12 states, the District of Columbia, and Puerto Rico have enacted occupational therapy licensure laws. Two states have enacted certification laws which set requirements for those who represent themselves as occupational therapists. All of these laws are mandatory.



American Psychiatric Association

1700 Eighteenth Street, N.W., Washington, D.C. 20009 • Telephone: (202) 797-4900

July 17, 1979

The Honorable
Edward M. Kennedy, Chairman
Subcommittee on Health & Scientific
Research
Senate Committee on Labor & Human
Resources
U.S. Senate
Washington, D.C. 20510

Dear Senator Kennedy:

At the hearing on the Mental Health Service Systems Act, you requested of the American Psychiatric Association witness, Dr. Lee Macht, information regarding the activities of the Association with respect to recruitment of minority and women psychiatrists.

The APA has a long history of concern about racism as one of the root causes of impaired health among American citizens, particularly minorities and the poor (please see attached list of references that illustrate negative impact of racism on health) and has initiated a number of efforts to bring about changes, some of which are:

The APA provides staff support for the administration of a NIMH funded program (see enclosures: brochure and newsletter), which has as its primary goal the increase in the number of psychiatrists from minority groups. An initial thrust of the program, which has been in operation since 1974, was to identify prospective candidates and to advise them and training directors of the program. This was done through mailing to individual medical students and bulk mailings to deans of those medical schools which had a policy prohibiting the racial identification of their students. In order to enhance the program, staff of APA's Office of Minority Affairs developed an annual Research Symposium, which is geared to provoke interest in research training and educate the Fellows about research design and methodology. The Symposium is scheduled in conjunction with the annual meeting of the components of the APA Table of Organization. The assignment of each Fellow to a component serves as an educational experience for the general members as well as the trainees. That is, contributions made by the Fellows has added to the wealth of the deliberations of a number of components. The APA Board of Trustees has also endorsed the participation of a Fellow (elected by her/his peers) at the meetings of the Board and the Executive Committee. Program funding permits the Fellows to attend the Annual Meeting; a number actively participate in the proceedings. For example, in 1978 and 1979 a group of Fellows presented findings from an APA supported survey on mental health services for medical students. The report has been approved for publication as an official APA document.

The implementation of the Minority Fellowship Program has been successful in that a decidedly important enrichment experience has been provided for the recipients of the fellowships; also, the assigned activities of the Fellows have served to provoke a recognition of the needs, in which the program is rooted, among many of the APA general membership. The Board of Trustees has endorsed the development of a proposal for the renewal of the grant in order to prolong the life of the program.

However, the goal to bring about a sizeable increase in the numbers of minority group psychiatrists has not been reached. This is reflective in the following table, which was developed by the APA Department of Membership Services and Studies:

June, 1979 Tabulations			
Ethnicity	APA Member	Non-Member	Total
Native American	65	1	66
Mexican	46	8	54
Puerto Rican	62	15	77
Spanish (other)	438	66	504
Asian (Filipino)	271	30	301
Asian (Indian)	701	94	795
Asian (Oriental)	467	20	487
Black	471	78	549
White	12671	610	13281
Other Minority	44	1	45
Other	9981	5353	15334

It should be noted that the preliminary report of a study conducted by APA's Committee of Spanish Speaking Psychiatrists reveals there to be

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1300 APA members "who speak Spanish, and either have Spanish surnames, were born in Spanish-Speaking countries, or have a strong Hispanic affinity."

In directing further efforts toward increasing the pool of minority group psychiatrists, APA's Office of Minority Affairs has submitted a proposal (to NIMH), outlining the development of an enriched psychiatric clerkship for minority medical students during the summer months. We have determined that recruitment efforts must begin early in medical education. Of course, this fact has been addressed during the course of presentations (grand rounds, teaching conferences) of the staff at various medical schools and in meetings of various mental health and/or medical organizations.

RE: APA activities related to increasing the number of women Psychiatrists.

There is no APA program directed to concerted effort toward increasing the pool of women psychiatrists. However, efforts have been/are being directed toward providing opportunities for women psychiatrists to be heard and issues related to women being addressed. This has been strikingly illustrated by action taken by the Assembly of District Branches in 1977, when a special election was held at which time registered women members of the APA elected two women to represent them at the meetings of the Assembly. In 1975 the Committee on Women, which was developed from a Task Force, began its operations. The history of its development is spelled out in the attached editorial.

RE: APA activities related to Minorities:

The introduction to APA's Affirmative Action Plan, which was approved by the Executive Committee in September, 1978, summarizes some of the stands that APA has taken over the years:

The American Psychiatric Association has a long tradition of vigorous support in the areas of human rights and equal opportunity. Over the years this has been demonstrated in the public stances the Association has taken in support of the Civil Rights Acts of 1964 and, more recently, in supporting civil liberties for women and homosexuals. This is also demonstrated in the current employment record of the Association. With 122 employees, the Association employs thirty-three minority group members (26,5 percent of the work force) and ninety women (74,3 percent of the work force).

While these overall figures correspond favorably to the general characteristics of the Washington metropolitan work force, the Affirmative Action Committee has identi-

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fied certain patterns and situations within the Association which should be corrected. Further, it is this Committee's belief that the minimal standards should be viewed as a starting point for affirmative action policies that should strive to create an atmosphere in which all employees can strive and achieve to their fullest potential. It is the intent of APA to exceed minimal standards wherever possible.

An Equal Employment Opportunity Committee, appointed by the Medical Director of the APA, has been given the responsibility to:

1. ensure that the Association policy of non-discrimination as stated in the Personnel Policy Manual is observed;
2. ensure that minorities are given full employment opportunities for employment, transfer and promotion;
3. identify problem areas and propose solutions to said problems; and
4. review recommendations and problems received from an employee.

A number of other efforts have been directed to assuring that the voices of minorities are heard: also, that minority related issues are addressed. The support of the Minority Fellowship Program, previously described, is but one of the several efforts. The APA Board of Trustees has gone on record of supporting the bill, S 2373, to provide for the establishment of a Division of Minority Mental Health Programs.

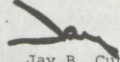
The Committee of American Indian and Alaskan Native Psychiatrists, Asian American Psychiatrists, Black Psychiatrists and Spanish Speaking Psychiatrists are integral components of the Council on National Affairs (as is the Committee on Women). The committees, working independently and as a coalition have developed special sessions and panels that have been highlighted during the Annual meetings of the APA. Far reaching effects have been observed in the publications of papers, some of which have been utilized in continuing education and residency training programs. This is illustrated by two papers published in the December, 1978 issue of the Journal of the American Psychiatric Association: "Training Psychiatrists for Working with Blacks in Basic Residency," by Walter Bradshaw and "Psychiatric Education and Training of Asian and Asian American Psychiatrists," by Normund Wong. In the development of the syllabus for the Psychiatric Knowledge and Skills Self Assessment Program (PKSAP) the staff of the Office of Education and APA members have addressed minority group issues.

I would appreciate your making this letter and its enclosures
a part of the hearing record.

If you need further information, please let me know.

With best wishes.

Sincerely,



Jay B. Cutler
Special Counsel & Director
Division of Government Relations

enclosure

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** List is not to be interpreted as being complete.

New Recognition for Women in APA

1975 HAS SPECIAL SIGNIFICANCE for the women of the American Psychiatric Association for at least two reasons. First, this is International Women's Year. It is also the year when a new member of the family of APA organizational components, the Committee on Women in Psychiatry, has become a part of the Association's structure.

A little background may serve to put this second event in perspective. Although women represent 11 percent of the membership of APA, the voices of these women have not always been attended to. In 1972 a Task Force on Women in Psychiatry was created. Under the leadership of Dr. Nancy Roeske the group identified two issues that warranted immediate attention: problems concerning women in general, as reflected in psychiatry, and the special concerns of women psychiatrists. The task force (which included men as well as women) initiated projects that had both immediate and long-range potential for addressing the two issues. Contributions to the work of the task force were made both by more experienced APA members and by women trainees.

Early in its life the task force recognized the need for consciousness (and conscience) raising among both men and women in psychiatry. In panels and "rap sessions" held during annual meetings, sexist attitudes of men and women were identified and discussed. As one member pointed out, "Most of us are unconsciously sexist. We become aware of this only when we are specifically challenged about the sexist assumptions we've been raised with."

Women psychiatrists were surveyed to examine the role of women in psychiatry and the role of psychiatry in the lives of women. Findings from this pilot project, which also studied the characteristics of all those entering psychiatry, disclosed few significant differences between the men and the women; one of these—which was not anticipated—centered on the family-career conflict. Further exploration of this problem is warranted in view of the need to break down sexist attitudes that continue to exacerbate the family-career conflict among many women psychiatrists and also among other career women.

Besides this pilot project the task force initiated the development of a talent bank of women psychiatrists and the preparation of a monograph summarizing the literature on women in psychiatry and the psychology of women. It participated in the preparation and selection of papers for a special section on Women in Psychiatry and Medicine in this journal in October 1973; women trainees especially found the content useful, and some were stimulated to become involved in the work of the task force. The group also strongly encouraged training directors to offer courses on the psychology of women.

The task force recognized early in its life-span the need for continuing activity in several areas of its interest. This awareness led to a recommendation for the appointment of a permanent APA component to deal with issues related to women in psychiatry. The APA Board of Trustees approved the recommendation in December 1974, to be implemented following the annual meeting in 1975.

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This editorial thus serves to announce formally the arrival of the Committee on Women in Psychiatry as part of the permanent APA structure. Women and men alike, we can hope that it will continue the promising work begun by the task force to free psychiatric education and practice of the biases that can adversely affect all of us.

JEANNE SPURLOCK, M.D.

Dr. Spurlock is a Deputy Director of the American Psychiatric Association.

Newsletter of the APA NIMH FELLOWS

JANUARY 1979

VOLUME 1 NO. 1

FRANCES M. BAKER, M.D., EDITOR

Statement Of Purpose

F.M. Baker, M.D., Editor

From the beginning of the American Psychiatric Association-National Institute of Mental Health Fellowship (APA-NIMH Fellowships), there has been a desire for a forum that would allow the Fellows to communicate between the Fall Committee Meetings and the Annual Meeting. This newsletter is the result of that desire. Its tasks are multiple: 1) to provide information about the activities and location of all Fellows—current and alumni; 2) to serve as a forum for information about current issues in psychiatry with emphasis upon minority issues; 3) to identify special research and funding issues, meetings/conventions of mental health professions, and/or forums which may be of interest to the Fellows; 4) recognize the achievements of the Fellows in research, within specific programs, within their training institutions, and within the mental health community at large; 5) to provide through the on-going special features "Psychiatric Mentor" and "SPECTRUM"—One Psychiatrist's Viewpoint—a setting in which the Fellows may benefit from the experience and knowledge of our more advanced colleagues and benefit from the specific viewpoint of national and international leaders in psychiatry; 6) to continue to update Fellows about pertinent legislative issues affecting mental health care delivery and manpower issues specifically relating to minorities; 7) to serve as a forum for an on-going discussion concerning the following issues: a) future directions of psychiatry; b) the establishment of priorities for delivery of services and for the development of manpower resources; c) the maintenance of standards of practice

See "PURPOSE" page 2

Comments From The APA

Melvin Sabshin, M.D.

For many years, the American Psychiatric Association was concerned about the underrepresentation of minorities within psychiatry, and in 1974 was awarded a grant, "Psychiatry Residency Training for Ethnic Minorities," from the NIMH and its Center for Minority Group Mental Health Programs. The program, now in its fourth year, has a prime objective of increasing the number of minority psychiatrists by granting stipends to medical school graduates or to individuals currently in psychiatry training.

While some gains in the direction of correcting many of the problems related to underrepresentation of minority group psychiatrists have been made, the massiveness of the residual problems are vividly illustrated by comments made in the Report of the President's Commission on Mental Health: (1) Minorities are poorly represented in the mental health disciplines. The supply of qualified professionals

See "APA" page 2

Comments From NIMH

James R. Ralph, M.D.

The idea for a Fellowship Training Program to train minorities in a profession in the mental health disciplines originated from the request by the American Sociological Association (ASA) in 1972. The ASA which had a very active minority program in their central office gave a convincing argument for funds to be administered by the Association to support students in graduate Sociology Programs. This method of training support deviated from regular NIMH

See "NIMH" page 2

A Historical Sketch Of The APA NIMH Minority Fellowship Program

Jeanne Spurlock, M.D.

The roots of the program are multiple and intertwined. One which is deeply embedded developed from the concerns that relate to the very small numbers of native born minority group psychiatrists. The concerns and interests were expressed and debated by many—both in the private and public sector. One of the actions sprang from the NIMH Center of Minority Group Mental Health Programs, headed by Dr. James Ralph, and took the form of an invitation to the American Psychiatric Association to submit a proposal for a program directed to the resolution of the problem of underrepresentation of minorities in psychiatry. (It should be noted that a similar invitation was extended to national organizations which represent the disciplines of nursing, psychology, social work, and sociology; also, that the definition of minorities that was utilized was that which was defined by DHEW: American Indian, Asian American, Black American, Spanish-Speaking Americans.) The invitation was accepted and an initial proposal was developed in 1973 by Dr. Elvin Mackey, Director of APA's Minority Group Program Development Project (and on leave from the University of California, Irvine) and Dr. Walter Barton, then Medical Director of APA.

An increase in the numbers of well trained psychiatrists from minority groups was identified as a major goal in the original proposal. Procedures that were outlined called for the appointment of a Selection/Advisory Committee, which would be assigned the responsibility of developing guidelines for

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PURPOSE*Continued from page 1*

based upon medical ethics and peer review. All of these tasks will be addressed within this and future issues.

In addition to the above noted special features, other regular features of the newsletter will include, a Convention Calendar, Bev's Corner, an on-going updated Profile of the Fellows, Our Representatives to.... Ruminations from the Dentato - Rubral and - Thalamus Tracts, Letters to the Editor, and Our Readers Comments.

This first issue of the newsletter is devoted to an overview of the APA-NIMH Fellowship Program to provide information about the origin, intent, and focus of the program. The lead article by our Director, Dr. Jeanne Spurlock, whom we consider a very unique and special person, provides this historical overview. The selection process and perspective of the Selection Advisory Committee is presented by Dr. Timothy Summers, member of the Selection Advisory Committee for the APA-NIMH Fellowship and Minority Representative to the APA Assembly.

We thank Dr. Melvin Sabshin, Medical Director of the APA, for his comments in our lead article. He has and continues to be a concerned, cooperative and resourceful supporter and participant in the Fellowship Program. Dr. James Ralph, Director of the Minority Component of the NIMH, we thank for his initial efforts in establishing the Fellowship Program and for his ongoing interest and support of the Fellows.

The APA-NIMH Newsletter is a quarterly publication. The letters to the editor column will begin in our next issue. We invite your comments and critiques which will help us to implement our tasks more effectively. Now, we invite you to read further and to enjoy.

APA*Continued from page 1*

continues to lag behind the increasing demand for service. (2) The need for investigations of on-going racism and its effects on minority group populations is needed. (3) A major barrier to utilization and access to mental health delivery

systems by the Black community appears to be the identity of the mental health practitioner.

It is my personal belief that the APA-NIMH Program has made a good beginning in attempting to fill the gap by encouraging the training of minority psychiatrists. You will be in the forefront of much needed research in the area of delivery of service to minority populations. In addition, you will stand as role models for others seeking to enter the field of psychiatry.

As the newsletter is launched, I'm certain that it will provide a forum and information exchange in the area of research, mental health, services for the underserved population, legislative issues related to minority group concerns, among other items of interest.

NIMH*Continued from page 1*

Training Support. As the Institute had not shown a great deal of success in increasing the number of minority students in the field, it was decided that the ASA Program would be supported as a model. At the outset the program provided to be quite effective unlike support to colleges and universities. The program proved attractive to a wide variety of racial minority students from all over the U.S.

They received support to attend the university of their choosing, which had been approved by the Advisory Committee of the program. This Committee consisted of minority sociologists already active in the field. Since faculty salaries and other administrative cost were not necessary the program turned out to be more cost effective than the direct support to universities.

In early 1973, President Nixon had impounded funds for the support of training funds in NIMH. When it became apparent that Congress would require that those funds should be released, an opportunity was presented whereby training programs could be expanded. Using the ASA as a model, I immediately contacted officials in the American Psychiatric Association, American Nurses Association, American Psychological Association, and Council on Social Work Education and requested that they submit similar proposals to the Minority

Center for review and ultimate funding.

Presently, the Center is now supporting both clinical and research training Fellowships in all the associations except for the American Psychiatric Association where a clinical program is being supported at this time. Currently, all of the programs are being studied and evaluated with the intention of increasing the support so that more students can be trained.

HISTORICAL SKETCH*Continued from page 1*

selection of trainees and evaluation of the program. Subsequent to Dr. Mackey's leave, I joined the APA staff and assumed the responsibilities of the Project Director. Ms. Beverly Harrison came aboard in 1974 as the Administrative Assistant, and in 1978 Rose Thompson joined our staff as secretary.

The first year of the life of the program was given primarily to the development of a structure for communications related to the existence of the program. Our initial thrust was to determine if and how we could make individual contacts with medical students who might be interested in making application for a fellowship. Upon learning that the policy of some medical schools did not permit the release of names and ethnic identity of students, bulk mailings were sent to the deans of those schools. Individual mailings were sent to those students who had been identified. Information was directed to the Directors of Internship and Residency Training Programs and a number of national medical students and medical organizations. Of course, notices appeared in APA publications, as well as several other medical organizations. Thus, the word was out.

During the first year of operations the staff also directed attention to grant writing for supplemental funds since the original budget did not allow for several operative procedures. In the meantime, Dr. John Spiegel who was then President of the APA, set about fulfilling the responsibility of appointing the Selection/Advisory Committee. In consultation with the Project Director, Dr. Spiegel appointed 9 persons. Groups other than the previously

Continued on page 3

HISTORICAL SKETCH Continued from page 2

identified minority groups included psychiatric residents, training directors of psychiatric residency programs, and chairs of medical school psychiatry departments. In addition to their work, with staff, in the development of policies pertaining to selection, committee members have served as consultants to several Fellows and their respective training directors.

The Committee, assisted by the staff, developed plans for the honorific aspects (participation in the Fall Committee Meetings and the Annual Meeting) of the program and supported the proposal for the Fellows to be represented at the meetings of the Board of Trustees and the Executive Committee. The staff assumed the primary responsibility for planning the Research Symposium for the past three years.

Hopefully, this aspect of the program has stimulated/reinforced an interest in the pursuit of research training. 38 Fellowships have been awarded to residents who elected to train in 18 states, the District of Columbia and Puerto Rico. Fellowships were awarded for research, for child psychiatry training and general psychiatry training. Only 2 of the awardees elected to withdraw from psychiatric training after the initial year of training. Although the major goal—the increase in the number of minority group psychiatrists—was not achieved, illustrations of success have been apparent throughout the years of operation. The assets have been spelled out by training directors in their letters of evaluation and support of the program, as well as in the recommendation for renewal and continuation of the program as made by APA's Board of Trustees and the President's Commission on Mental Health.

Selection/Advisory Committee

The Selection/Advisory Committee for the Minority Fellowship Program appointed by Dr. John Spiegel (APA President in 1974). The Committee members are: Dr. Bruce Ballard, Chair, representing the Council on International Affairs; Dr. Joe Yamamoto representing the Council on Medical Education; Dr. Sanford Tom representing the Asian American Representative; Dr. Ann Seiden representing the Association of Directors of Psychiatric Residency Training; Dr. Paul Adams representing the Commission on Childhood and Adolescence; Dr. Claudewell Thomas representing the American Association of Chairmen of Depts. of Psychiatry; Dr. Cervando Martinez representing Spanish-Speaking People in the Southwest; and Dr. Timothy Summers representing the Committee of Residents.

Editorial

As you have seen from the preceding articles, the APA-NIMH Fellows represent a spectrum of minorities, i.e., Afro-Americans, Asian-Americans, Hispanic-Americans, and Native-Americans. As members and representatives of ethnic and racial groups within America, it is part of our work to broaden the perceptions of those with whom we interact in all settings. As we address the election of representatives of the Fellows at the Annual Meeting in 1979, let our heterogeneity be evident among our various representatives.

As first year residents in psychiatry, you are eligible to join the APA as members-in-training. As our professional organization, it is important to become involved actively during the residency years. Although working with district branch committees may not be feasible until the second or third year of your residency—dependent upon the total time commitment of your training program, working at this level will assist in expanding one's understanding of the role of the local chapters within the APA structure and help you to become familiar with the concerns within your region. If you are uncertain about the procedures to become a member-in-training, write to (Patricia Anthony, Membership Services and Studies, APA Headquarters, 1700 18th St., N.W., Washington, D.C. 20009).

There has been increasing interest and expression of concern with respect to the licensing and privileges accorded to other mental health professionals, i.e., psychologists, social workers, and nurses. In some states psychologists can admit to psychiatric units. Another area of interest is the role of the psychiatrists as "medical backup" to non-M.D. mental health professionals. Is the psychiatrist who is providing medication for patients seen in psychotherapy by a non-M.D. mental health professional (medico-legally) liable for only the administration of medication or is she/he liable for the total

care of the patient? Is it possible for one psychiatrist to be medical backup for 20 or more patients? We invite your comments and/or opinions on these issues.

Send your comments:

Editor, APA/NIMH Newsletter
c/o Jeanne Spurlock, M.D.
American Psychiatric Association
1700 18th Street, N.W.
Washington, D.C. 20001

Comments from the Selection/Advisory Committee

Dr. Timothy Summers, Member

I certainly support such an effort as the new newsletter and feel that it can serve many useful functions particularly in disseminating information and serving as a forum for the discussion of mental health service, manpower, educational, research and funding issues specifically related to minorities.

Obviously, the newsletter could serve as a publishing source for the Fellows research, reporting of fellowship activities, highlighting of Fellowship personalities, the reporting of pertinent legislative issues and serve as an additional forum of communication with the Falk Fellowship, APA Committee of Residents, Black Psychiatrist of America, the NIMH Center for Minority Studies and the various components of the APA.

I would recommend for consideration the following areas to be included in the content: 1) A consumer report, e.g. reports from minority consumers of mental health services; 2) dates to remember (when and where conferences and workshops of specific interest to minorities will be held); 3) loca-

See "COMMENTS" page 7

Psychiatric Mentors

By Charles B. Wilkinson, M.D.

That underlying personality characteristic influence the choice of a specialty is an accepted fact, but for those physicians who do not immediately enter their ultimate specialty choice, the events that lead up to selection are often rather interesting. In my own instance I initially pursued training in Internal Medicine, completing almost two years of residency at Freedman's Hospital, which was the forerunner of the present Howard University Hospital.

Internal Medicine had in the early years a several month, neurology and psychiatry rotation which both whetted my interest and also brought me under the influence of Dr. E.Y. Williams, one of the then five Board certified Black psychiatrists in the country. Vivid in my memory are rounds on the female medical service in which a number of chronically ill middle aged to elderly patients over time were grouped in adjacent beds. This allowed the staff to pass them by quickly and dismiss them as "just" neurotic. My questions relating to crude attempts at formulating dynamics were ignored. I then felt that, if in some way psychiatry and medicine could be combined, then somehow answers could be provided. When I made the decision to enter psychiatry I indicated that I was really interested in psychosomatic medicine. This in some ways softened the jeers of my colleagues and the faculty since the term had a somewhat magical connotation to them (and for me as well). I even planned on becoming double boarded (internal medicine and psychiatry), a fantasy I retained through most of the first year of my psychiatric residency. Nevertheless, I established the first psychiatric liaison service on the pulmonary service (Tuberculosis Hospital) at Freedman's Hospital.

With Dr. E.Y. Williams' help, the aid of the director, of the newly formed, National Institute of Mental Health, Dr. Robert Felix, was solicited and arrangements were made for my entry into the residency program at the Colorado Psychopathic Hospital of the University of Colorado Medical Center. Being the first Black in a role in the Forties was supposed to have been an honor but as most Black readers know, it is a badge worn in loneliness. Support, however, was available from my wife and a number of members of the Black community in Denver. At that time (1947) only six Black physicians were in psychiatric training: Stevens and Brown, Topeka, Kansas; Toney, Los Angeles; Waters, St. Agnews State Hospital, California; Davis, NYC; Pinderhughes, Boston.

The venerable Franklin Ebaugh was both the founder and director of the Psychopathic Hospital. This department was rich in tradition and had already produced such luminaries as Brosin, Romano, Ewalt, Benjamin and Felix and later its graduates occupied most of the key federal psychiatric positions and held at least a dozen chairmanships in psychiatry.

Psychiatry, 28 1/2 years since completing formal training has been frustrated and uncertain at times but always challenging and exciting. In 1950, in addition to assuming a faculty position at Howard, I also started a part time practice and was promptly warned that, "Negroes weren't ready for psychiatry." However, it wasn't difficult building up a practice, principally Black and smattering of White patients.

This is a far cry in comparison (there was still some doubt that Blacks could be analyzed) to the current opportunities for analytic training.

Attempting to enter the analytical institute was another story, at that time in Washington, only Charles Prudhomme through bulldog persistence managed to be accepted. I recall upon making application, I was number 60 on the list.

Therapeutic changes in medicine burst upon the scene like a bombshell in the early 50's. The treatment for tuberculosis switched almost overnight from pneumothorax, bed rest and thoracoplasty to medication and surgical removal of the "of-

fending part." Toxic drugs for control of blood pressure moved quickly to less noxious and more effective medication. Psychiatry too, received its day in the sun, when the first of the tranquilizers appeared on the market and progress from that point is common knowledge.

I recall relating to students that history would repeat itself: just as the discovery of the spirochete, *Treponema Pallidum*, carved off a segment of psychotic illness which would be identified as having an organic origin, that another appreciable dent would be made in the psychotic categories that we identified as Schizophrenia and Manic-Depression. Little did I realize that this would become evident while I am still active in the field.

Psychiatry probably reflects cultural trends, more than any other medical specialty and presently this country is moving steadily in a conservative direction. Insofar as psychiatry is concerned the effects will not only be apparent in terms of retrenchment of the expectations of only a short while ago, i.e., providing large scale patient care, but also in the interest of training programs in something other than a superficial understanding of minority group problems. Young Black residents in training will probably need now, more than at any other time, contact with their older colleagues. The kind of inner resolve and adaptive devices required in the early years of the few of us, will now be of utmost importance in helping young residents to not be swept under by a potential tide of indifference and insensitivity.

Our Representatives Report.... "on the COSSMHO Conference"

Dr. Alberto B. Santos

As you know, living in Charleston, I am relatively isolated from other Hispanic-Americans. It was indeed a pleasure to reunite, en masse, with a group of Americans who so closely share a number of cultural values, personal attitudes and social ethics regardless of their specific national origin or geographic location. In particular, we strongly value the preservation of close ties within the nuclear and extended family. The social significance of this orientation, I believe, is that it can engender a sense of security, support, and respect which can extend to the community at large. It also serves to preserve our cultural identity. The process of acculturation is fraught with many varied sources of stress, but none is so widespread among Hispanic-Americans as the ever present threat of weakening family bonds in a nation so geographically large and so highly vocationally competitive in style. A major focus on the Conference was, therefore, a cooperative sharing of experiences and ideas regarding the implications of the preservation of the family unit as they relate to governmental social policy and programs.

In order to influence governmental decisions in a way that would address the specific needs of Hispanic families, youth, and the elderly, we need more policy-makers who are committed to these ideals. Of note is that Hispanic-Americans are significantly under-represented in political bureaucracies. We are responsible, to a large extent, for this fact. Hispanics by history have strong reservation about political involvement partly because of consistent disappointments with governments in their nations or origin. Which, is also, partly, responsible for the relatively low number of Hispanic registered voters. Although this issue did not seem to be explicitly addressed in the Conference, the issue of public sympathy was addressed via discussions of possible deleterious effects of Hispanics stereotyping in media products.

Mental health issues specific to Hispanics were presented also. I would have enjoyed more of this type of academic presentation—in particular more material on the Cuban-Americans. I look forward to attending such a Conference in the future where the spontaneity and friendliness of the people is always refreshing and enjoyable.

See "REPRESENTATIVES" page 5

Ruminations From The Dentato-Rubral And-Thalamic Tracts

The final report of the Medical School Survey focusing upon mental health issues among medical students implemented by the APA/NIMH Fellows in pending. The results will be published in a future issue.

* * * * *

From the Legislative Newsletter of the APA-Division of Government Relations:

The APA Supported both the House and Senate Bills to establish a Minority Mental Health Division in NIMH. Status: died. To be reintroduced next year, hearing promised in the 96th Congress. Copies of the legislation are available from the office of Dr. James Ralph, Chief, Center for Minority Group Mental Health Programs, N.I.M.H., Parklawn Building, 5600 Fishers Lane, Rockville, MD 20852.

The APA Committee of Residents solicits from all residents in psychiatry contributions to its regular "Residents' Forum" published in "Psychiatric News." Residents may submit suggested articles on any subject of interest to residents to (or make inquiries of) Steven Gressitt, M.D., Dept. of Psychiatry, Medical University of South Carolina, Charleston, S.C. 29401. Resident Fellows take the time to write up that interesting case and/or to finish that article and submit it.

The APA supported the extension of ERA ratification deadline. Status: signed into law an extension of 3 years, 3 months and 8 days.

The APA worked with the Senate to stop action on a House Bill which would provide reimbursement to psychologists providing in-patient services under Medicare. Status: died.

The APA successfully lobbied the House and Senate to modify the provision regarding Secretarial discretion which might have led to exclusion of mental health care from HMO services. Status: to be signed into law with APA Position adopted.

The APA joined with other psychiatric groups and testified unsuccessfully in opposition to a Bill related to psychotropic substance convention. Status: to be signed into law.

* * * * *

THE AMERICAN COLLEGE OF PSYCHIATRISTS annually sponsor Laughlin Fellowships which allow PGY (Post Graduate Year) III and IV residents to participate in a one week conference. The 1979 Laughlin Fellows will meet in California with the program focused upon Family Therapy. Check with your training director.

* * * * *

ALL FIRST YEAR RESIDENTS should receive the Psychiatric News. Are you?

* * * * *

IN THE 6TH OCTOBER 1978 issue of "Psychiatric News," Volume XIII, No. 19, featured a 4 column article on this year's APA/NIMH Research Symposium, which was attended by 16 active Fellows, 2 Alumni Fellows and 5 Falk Fellows. Presentations were made by Frank Sullivan, Ph.D., of National Institute of Mental Health, who explained the institute's grant awarding process; Philip Gold, M.D., Chief of the Unit on Neuroendocrine Studies presented his recent research; Milton F. Shore, Ph.D. of the NIMH Mental Study Center in Maryland discussed studies of how community problems relate to mental illness, particularly their work with delinquent adolescents; and Andrew Slaby, M.D. of the Staff College of NIMH, explained the value of psychiatry of epidemiologic studies and illustrated how this knowledge can

be used to understand etiology, prevention and cost efficiency effectiveness.

THE AMERICAN PSYCHIATRIC ASSOCIATION Committee on Women Newsletter is now available by subscription. It will carry information about this Committee's efforts in ERA education, protection of women patients in areas of advertising sexism and abortion legislation, and education of psychiatrists about women, etc. MAIL REQUESTS TO: APA COMMITTEE ON WOMEN NEWSLETTER, C/O DR. MATILDA M. RICE, 9 BRIDLE PATH DRIVE, OLD WESTBURY, NEW YORK 11568. ENCLOSE \$5.

A listing of the Periodicals, Books and Pamphlets published by the APA appear in Publications. WRITE TO: THE AMERICAN PSYCHIATRIC ASSOCIATION, 1700 18TH STREET, N.W., WASHINGTON, D.C. 20009. (PHONE NUMBER - 202-797-4911) FOR A COPY.

Options/Alternatives

THE ALCOHOL, DRUG ABUSE, and Mental Health Administration (ADAMHA) provides National Research Service Awards to individuals for research training experiences in specified areas of biomedical and behavioral research. CONTACT: HEW, OFFICE OF ADMINISTRATOR, PUBLIC HEALTH SERVICE, ADAMHA, ROCKVILLE, MD 20852.

THE SCHOOL OF PUBLIC HEALTH of the University of Illinois at the Medical Center, Chicago announces a training program in Psychosocial Epidemiology. The program is now accepting applications from suitably qualified individuals for admission to this program at both the predoctoral and postdoctoral levels. CONTACT: LEO LEVY, P.O. BOX 6998, CHICAGO, ILLINOIS 60680.

POST-DOCTORAL FELLOWSHIPS FOR RESEARCH TRAINING PROGRAM IN MENTAL HEALTH are available under an award from the National Institute of Mental Health. CONTACT: ERDMAN PALMORE, RESEARCH TRAINING PROGRAM IN MENTAL HEALTH, P.O. BOX 3880, DUKE UNIVERSITY MEDICAL SCHOOL, DURHAM, NORTH CAROLINA 27710.

POSITIONS AVAILABLE: Openings are available for general and child psychiatrists with the Greater Kansas City Mental Health Foundation. The Foundation provides all psychiatric services for a 178 bed State Mental Health Center with inpatient, outpatient, day hospital and outreach facilities for adults, adolescents and children. All psychiatric staff hold faculty positions in the adjacent University of Missouri-Kansas City, School of Medicine and are involved in teaching medical students. Fully approved residency programs in adult and child psychiatry. For additional information, CONTACT: CHARLES B. WILKINSON, M.D., EXECUTIVE DIRECTOR, GREATER KANSAS CITY MENTAL HEALTH FOUNDATION, KANSAS CITY, MISSOURI 64108.

POSITIONS AVAILABLE: Openings are available in child psychiatry training at Tufts University School of Medicine-New England Medical Center. For additional information, CONTACT: KENNETH S. ROBSON, M.D., DIRECTOR OF TRAINING IN CHILD PSYCHIATRY, TUFTS UNIVERSITY SCHOOL OF MEDICINE-NEW ENGLAND MEDICAL CENTER HOSPITAL, 171 HARRISON AVENUE, BOSTON, MA. 02111.

REPRESENTATIVES

Continued from page 4

"on the APA/NIMH Observer-Consultant to the Board of Trustees"

Dr. Patricia A. Newton

As the APA/NIMH Representative to the Board of Trustees in the capacity of Observer-Consultant, I have found the past six months very stimulating. I have yet to be bored by my participation and have sought to keep the APA/NIMH Fellows well informed by supplying them with copies of the Board's "Unofficial Highlights" after each meeting. This has been well received by the Fellows as evidenced by the many favorable comments pertaining to this by the Fellows.

The three previous years experience I had in the APA both nationally and at the District Branch level by virtue of my APA/NIMH Fellowship were definitely an asset. Without them I would have been lost with respect to a basic understanding of the organizational structure. The volume of material covered at a given Board meeting is immense and one needs to have not only a knowledge of the agenda, but also a working familiarity with the content in order to appreciate and grasp, early on, what is going on.

It is of necessity that one is familiar with the "Operations Manual" when coming to the Board or any other component of the APA, for that matter. My representation has been well received by the Board and the orientation for new Board members held in the Spring was of great assistance to me in clarifying many structural questions.

I am for the most part very grateful to the APA/NIMH Fellows who elected me and to Jeanne Spurlock, M.D. and others within the APA like the Committees of Black, Asian, Native-American and Spanish-Speaking Psychiatrists who have encouraged the participation of APA/NIMH Fellows like myself. I would like to encourage the APA/NIMH Fellows to seek again next year to have this position filled by another one of my colleagues when my term expires in May 1979. I know that they will also find it to be as rewarding and educational as I have. My only regret is that in the future years to come there will be no new APA/NIMH Fellows to gain knowledge, share experiences and thereby enrich the APA in general by virtue of their presence and the uniqueness of the cultural experiences they will impart to the whole of psychiatry.

Our Readers' Comments...

Fellows comment about the advantages and disadvantages of participation in the APA/NIMH Fellowship Program.

One advantage of being a Fellow is "getting to see the APA work at the National level; exposure to the nation-wide psychiatric community."

The Fellowship provides "exposure to role models in a non-grading setting which further mediates the development of collegial and mentoring relationships."

"Through the Research Symposium, the Fellows learned the techniques of securing funding for research projects with clarification of which components to apply within a given research problem."

"Being a Fellow helped me to develop a broader exposure to health care delivery problems on a national scale. It also provided an opportunity to meet members of my own Native American people who are in the APA."

"As a Fellow, I have had an opportunity to become familiar with the organizational structures of the APA and NIMH which will allow me to further academic, administrative, clinical and research interests."

SPECTRUM—One Psychiatrist's Viewpoint: How I Became A Psychoanalyst

Joe Yamamoto, M.D.

In order to share my personal experiences in becoming a psychoanalyst I would like to tell you very briefly about how I decided to do this. I had trained in Minnesota which had a more eclectic and psychobiological orientation. Having been rescued from the cold winters there in being drafted into the Army as a psychiatrist during the Korean War, I spent two years in Washington state. After this I was invited to join the faculty at the University School of Medicine. In my work there for three-and-one-half years, I decided that further psychoanalytic training would be to my advantage.

To show that we do not function in a vacuum, in Oklahoma there was a psychoanalytic group and a biological psychiatric group and never the twain did meet! Indeed from the beginning there were many questions asked of me and about me in terms of my theoretical orientation. My concern then was and remains still that we offer the best possible services for our patients and that the services be based upon scientific knowledge insofar as this is possible.

However, this sort of nonspecific generalization seemed to add to the suspicion in both the psychoanalytic and biological groups. Many questions were asked about whether I was going to be psychoanalyzed and/or apply for psychiatric training at the Topeka Psychoanalytic Institute. On the other hand the biological group stood aloofly surveying my activities. Indeed one of this group seemed to have a definite paranoid reaction to me. Perhaps because I was an Asian in a state where few Asians lived.

I decided to return to my hometown of Los Angeles to be closer to my family and also for psychoanalytic training at the Southern California Psychoanalytic Institute. This was back in 1958.

Since then I have combined psychoanalytic training with an academic career first at the University of Southern California School of Medicine and during the last year-and-one-half at the University of California at Los Angeles. The training has been useful to me in terms of my understanding of my patients. However, I still maintain a fairly eclectic view of psychiatric treatment using all modalities of treatment as indicated on an outpatient basis.

Because of my specific interest in the treatment of the underserved and also in cross-cultural psychiatry I have been able to use the psychotherapeutic work with patients from different cultures, from distant social classes, and who generally are not the YAVIS patient wanted by the therapist. (YAVIS stands for: young, attractive, verbal, intelligent, successful.) Needless to say the YAVIS patient is usually a European American. Having completed my training as a psychoanalyst in 1964, I have maintained an interest in psychodynamic psychiatry, specifically psychotherapy for outpatients. In addition, the initiation of behavioral approaches have broadened my therapeutic techniques.

In my activities as a volunteer Director of the Asian/Pacific Counseling and Treatment Center, having the psychoanalytic background I believe is helpful. I can with the knowledge of clinical experience advise when a dynamic approach is most indicated and when other approaches may be more helpful. For example, a very high percentage, 39 percent, of the patients seen at the Asian/Pacific Counseling and Treatment Center are chronically psychotic. Because of this the services given by our professional staff drain their energies and vitality. One of the problems is that as with all enthusiastic therapists they aim to cure the patients. My experience in psychoanalysis and as an academic psychiatrist have shown me that, after all, we are physicians and can only aim to help some patients heal themselves and that others may remain at the same level of functioning while still others may deteriorate despite all our best efforts.

Some Dates To Remember

Jan. 8-9, '79	ABPN Exams (Part II) San Francisco, CA
Feb. 26-27, '79	ABPN Exams/Certification in Child Psychiatry Pittsburgh, PA
April 9-10, '79	ABPN Exams (Part II Oral) New Orleans, LA
April 16, '79	ABPN Written Exam (Part I)
May 11-18, '79	APA's Annual Meeting Chicago, IL
June 11-12, '79	ABPN Exams (Part II, Oral) Denver, CO
Sept. 3-6, '79	H & CP Institute New Orleans, LA
Sept. '79	Fall Committee Meetings
Oct. 24-28, '79	American Academy of Child Psychiatry Atlanta, GA
Nov. 12-14, '79	World Psychiatric Association London, England
1980	APA Annual Meeting San Francisco, CA

COMMENTS

Continued from page 3

tion and activities of Alumni of the Fellowship; 4) Commentary from minority medical students regarding their perceptions of psychiatry; 5) periodic editorials from chairpersons of pertinent APA components, other agencies, etc.; 6) periodic editorials from minority psychiatrists in private practice, academia, public practice, industry, government, etc.; and 7) reports from or about model mental health facilities of special interest to minorities.

Some of the natural dangers of this kind of publication is that it can potentially have numerous deleterious consequences such as: attracting unwanted attention, inadvertently appearing to align with partisan politics, opening the fellowship itself to increased criticism among its antagonists and failing to reflect the true heterogeneity of the fellowship's composition, interest, goals and objectives.

Bev's Corner

At last !!!!! The first issue of the newsletter was primarily devoted to the history of the Minority Fellowship Program. Your comments, suggestions, and criticisms will lay the foundation for future issues. Please help to eliminate the load on my back.

Important Notice

APA's Centrex II telephone system began operation on September 11, 1978. New numbers for principle departments are listed below:

American Journal of Psychiatry	(202) 797-4918
Data Processing	(202) 797-4932
District Branch Offices	(202) 797-4850
Education	(202) 797-4970
Government Relations	(202) 797-4974
Hospital & Community Psychiatry Journal	(202) 797-4926
Hospital & Community Psychiatry Service	(202) 797-4859
Joint Information Service Publications	(202) 797-4944
Library/Museum	(202) 797-4955
Meeting Management	(202) 797-4860
Member Benefits/Member Insurance	(202) 797-4965
Membership Dues	(202) 797-4867
Medical Director	(202) 797-4882
Minority Affairs	(202) 797-4875
Minority Fellowship Program	(202) 797-4978
Professional Affairs	(202) 797-4855
Psychiatric News	(202) 797-4936
Psychiatric Referrals - Local	(202) 797-4851
Psychiatric Referrals - National	(202) 797-4855
Public Affairs	(202) 797-4950
Publication Advertising	(202) 797-4942
Publication Services	(202) 797-4940
Publication Subscriptions	(202) 797-4924
Information or Departments Not Listed	(202) 797-4900

IMPORTANT

If you have moved or changed your address, please let us know.



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
HARRISBURG

JUN 25 1979

TELEPHONE NUMBER
787-2600, 787-3600
AREA CODE 717

The Honorable Edward M. Kennedy
United States Senate
Washington, D.C. 20510

Dear Senator Kennedy:

As Secretary of Public Welfare for the Commonwealth of Pennsylvania, I am responsible for the public mental health delivery system in this State. Therefore, I have followed the introduction of the Mental Health Systems Act (Senate Bill 1177) with great interest. In 1966, the Pennsylvania Legislature passed the Mental Health and Mental Retardation Act of 1966, which established a State mandated system of community mental health services in all counties around the State.

Since that time, Pennsylvania has had an active, growing and important community mental health program. Today, there are 89 Federal Catchment Areas in Pennsylvania, half of which have had community mental health center grants. Direct Federal support of community mental health centers in Pennsylvania in 1979-80 will amount to approximately \$17 million. Through direct State appropriations, Medical Assistance (Title XIX), Title XX and several Federal Community Mental Health Center grants, the Pennsylvania community mental health system serves over 200,000 people a year, and has a total budget of over \$130 million.

I believe that Pennsylvania has assumed great responsibility for the community mental health services needed by the citizens of this State and that the community mental health center movement mandated by the 1966 Pennsylvania Act and amendments has been largely a success here. We believe that it is now time to substantially revise the Federal funding patterns for community mental health services to better meet the current needs for services.

The new Mental Health Systems Act as proposed does deal with some of the important issues in the public mental health system today. We are in strong support of the Sections to aid State agencies in the further development of their systems (Title I, II and III), but the suggested appropriation of \$43 million nationally in Fiscal Year 1979-80 is woefully inadequate to meet the stated objectives of the new law. Therefore, we would suggest a substantial increase in the dollars for these state mental health system projects.

The Honorable Edward M. Kennedy

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Title VI of the proposed Act would require a state mental health services plan. This is a needed and significant improvement in the partnership between state and Federal mental health agencies. However, this Section requires clarification as to the relationship between this state mental health services plan and the state health plan requirement under P.L. 93-641. Consistency between the two plans may need to be more fully defined. Certainly the two processes need to be coordinated to avoid confusion.

Title V, pilot projects for state administration of grants, also appears to be a step in the right direction for the State/Federal mental health partnership. However, this Section does not go far enough in consolidating the management of these services. We would suggest that each state be required to administer the grant program within the approved mental health services plan, except in those instances where the Federal or State Government does not wish to participate in such an arrangement. The right project process should be phased in over a one to two-year period to assure integration with the services plan.

Title IV of the Act continues the development of community mental health services and includes improvements in the current system, but we fear that it may create substantial confusion and disorganization. We support the coordination of a planning grant mechanism described in Section 401. Needs assessment and community involvement are critical elements. We also support the continued development of a comprehensive mental health service in mental health service areas in Sections 403 and 404. However, despite the well-meaning goals in Section 402, we must take strong exception to the process of authorizing grants for Initiation of Services of the Underserved. We believe that the process outlined will create significant confusion and duplication of services. Our experience has been that programs that have been required to develop a comprehensive mental health service program have increased the sophistication and quality of services to clients. As currently written, this Section would currently permit small grants to non-comprehensive agencies all over the State. In a State the size of Pennsylvania, with its 89 service areas (Catchment Areas) and its several thousand provider agencies, such a system could lead to a disintegration of existing comprehensive services and does not support the overall mental health services planning goal. We would be happy to work with the Committee on language and a procedure that would earmark funds for services to the underserved within a coherent system and plan.

We do support Sections 405 and 406 of the Act, Continued Support for Non-Revenue Producing Activities and for Community Mental Health Centers. In Pennsylvania, eight Federal community mental health center grants have terminated in the last several years. We have been successful in providing some State funding to partially offset the decline in Federal dollars. However, to sustain other centers, continued Federal support in the future will be necessary; over the next two years in Pennsylvania another nine grants will terminate.

Finally, we believe that the proposed Mental Health Systems Act does not address several important needs of the mental health service system. The Act neither mentions nor changes the current Medicare restrictions against

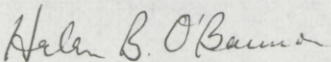
The Honorable Edward M. Kennedy

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psychiatric care. These, we believe, have led to overutilization of primary health care and a lack of quality mental health services to aged and disabled people. Also, the Act does not deal with Federal laws and regulations regarding Intermediate Care Facilities/Mental Health, and their ability to significantly impact deinstitutionalization efforts nationally. This area is of major concern to Pennsylvania. Also, the new Act does not address one of the more important issues in public mental health systems: the question of advocacy models. Advocacy can take several forms that can protect the rights of patients. Effective advocacy is an important ingredient of the entire mental health system. We would suggest that consideration to these three issues be addressed.

I hope that these comments are useful to you in your deliberations about the new Act. My staff and I are available to discuss any of these issues with you.

Sincerely,



Helen B. O'Bannon

Lansdowne Mental Health Center

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April 24, 1979

Senator Edward Kennedy
Dirksen Building
Washington, D.C. 20510

Dear Senator Kennedy,

As the chairman of the legislative committee of the Kentucky Association of Regional Programs (KARP), I was delighted to learn of your interest in Kentucky's response to the proposed Mental Health Systems Act. Our state was one of the first to develop a comprehensive system of community mental health centers, and, as a result, I believe our experience in this regard is significant. I'm sure this point was made when Ms. Maxine Jones and Mr. David Bell visited your office recently.

As you probably know, KARP is a group whose members represent organizations which provide mental health, mental retardation and alcohol and drug abuse services on a county-by-county basis. At our most recent meeting, the proposed Mental Health Systems Act was discussed in detail, and we reached a consensus on a number of issues.

First, CLARIFICATION IS BADLY NEEDED ON THE ROLE OF HEALTH SYSTEMS AGENCIES AND STATE AUTHORITIES. The implementation of the HSA review process has resulted in a proliferation of channels for processing A-95's, certificates of need and grant applications. Yet, HSA boards, which will soon have approval-disapproval authority for all federal grants, are not required to have representation from the mental health field. In the past, these functions, and the required monitoring duties have been carried out by Kentucky officials and the regional office of HEW in Atlanta. The present situation is a duplication of efforts--and administrative costs--compared to the previous partnership between state and federal offices.

Second, COMMUNITY-BASED FACILITIES REPRESENT PROGRESS, NOT FRAGMENTATION AS THE PROPOSED LEGISLATION SUGGESTS. It is ironic that at a time when citizens are complaining about the insensitivity of state and federal employees, the proposed Mental Health Systems Act seeks to further remove decision-making and planning from local residents. In Kentucky, experience has taught us that human service organizations succeed

Senator Edward Kennedy
 April 24, 1979
 Page 2

only if their programs involve a variety of citizen groups and if they respond to community needs. Placing the responsibility for mental health programming in the hands of the state would undermine the sensitivity of the present system; it would probably preclude the establishment of culturally sensitive programs; and it might even lead to the return of the old system of "warehousing" patients.

Third, THE PROPOSAL TO PLACE PREVENTION PROGRAMS IN THE HANDS OF STATE EMPLOYEES IS UNWORKABLE. At present, community mental health centers provide a variety of public education programs to the citizens and school systems in their respective area. In this regard, treatment professionals as well as educational specialists are involved, and, subsequently, the system for referral to the centers for treatment is enhanced. Removing consultation and education activities from the centers would serve only to erode what is now a strong bond between the centers and their communities, and, more tragically, it would probably keep some individuals who need help from seeking it.

Fourth, THE CONCEPT OF DEFICIT FUNDING PROMOTES FINANCIAL IRRESPONSIBILITY AMONG LOCAL COMMUNITY MENTAL HEALTH CENTERS RATHER THAN DETERING IT. For instance, federal distress grants are awarded to centers only if their budgets reflect a previously stated deficit. In short--you have to spend money to get money. This concept of deficit spending also carries the stipulation that federal dollars cannot be carried from one fiscal year to the next. As a result, centers are finding themselves pressured to spend unused dollars before the year ends, although they know they will be short of funds at the beginning of the new fiscal period.

Finally, MAINTENANCE AWARDS TO CENTERS ARE ESSENTIAL, GIVEN CURRENT FUNDING MECHANISMS AND THE USE OF SLIDING FEES SCALES. However, the proposed formula of a "deficit" maximum of \$1 per capita is unworkable, because it represents only a small percentage of the budgets of mental health centers and is a drastic reduction in federal support for these organizations.

In conclusion, I would like to reiterate that for nearly a decade, Kentucky has a unique history of complete mental health coverage for all its 120 counties. Innovative changes, bureaucratic regulations and planning/monitoring eras have had a mixed impact on our total system. From experience, the evidence is clear that continued federal assistance will be necessary to assure broad community services.

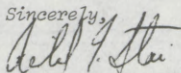
The proposed "Systems Act" will not, and is not designed, to support mental health agencies with histories of success. This is demonstrated in the proposed conditions for continuation grants where "graduate CMHC's" are defined as ineligible for further grant assistance under sections 203, 211, and 204 of PL 94-63. Such an approach is not only ludicrous, but devastating, especially to rural and/or poverty areas.

Senator Edward Kennedy

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In short, unless some of the previously stated changes are made in the legislation, it is doubtful that it would merit the support of Kentucky's mental health constituency.

Sincerely,


Richard T. Stai, ACSW
Chairman
Legislative Committee

NATIONAL
ASSOCIATION

Phone (202) 554-7807

MENTAL
HEALTH
PROGRAM

1001 3rd Street, S.W.
Washington, D.C. 20024

STATEMENT OF STATE MENTAL HEALTH

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STATEMENT BY
NATIONAL ASSOCIATION OF STATE MENTAL HEALTH
PROGRAM DIRECTORS

ON

S. 1177

June 1979

Presented to

The Subcommittee on Health And Scientific Research
Of the Senate Committee on Labor and Human Resources

Presented by

JAMES A. PREVOST, M.D.
Commissioner, Office of Mental Health
State of New York
and
Member Board of Directors, NASMHPD

Our Association is composed of the mental disability agencies in the 50 states and four territories, and the services under those agencies represent the largest mental disabilities system in the world.

Our Association functions as the "Mental Health Arm" of the National Governors' Association and our testimony is presented here with the permission of the National Governors' Association.

Mr. Chairman, the State Mental Health Directors and the National Governor's Association served on a "State Government Task Panel" for the President's Commission on Mental Health. The Task Panel developed a number of proposals aimed at improving the delivery of services to the mentally disabled in the United States who are now unserved, underserved, or inappropriately served.

Many of the proposals of the task panel were subsequently endorsed by the President's Commission and included in its final recommendation. Assuredly, the National Association of State Mental Health Program Directors (NASMHPD) agrees with the principal concept of the Commission's final report which states:

"Our long-range goal for mental health services must be a comprehensive and integrated system of care that draws on the strengths of both the public and private sector. . . The services offered should be coordinated, and continuity of care assured, within the mental health sector and among mental health systems and the health, social service, education and income support systems. Because we can no longer afford a fragmented system that leaves many people unserved, there must be effective planning and accountability procedures."

The new legislation (S. 1177) being considered here today embodies many of the concepts in the PCMH report. However, we do not believe it adequately addresses the most critical issues of coordination and integration of services.

Our major concern centers around two distinct levels of federal participation in the delivery of mental health services which appears to reinforce fragmentation. The first involves a new program of cooperative agreements between the Federal government and the states under a \$45 million program to support improvements of services and the prevention of institutionalization. The second provides for continued Federal support totalling \$302 million directly to community mental health programs with the states' role limited to certifying that the local entity's plan is in accord with the states' plan.

Continuation of separate categories of federal support of the states and localities is contrary to the advice of the Federal General Accounting Office. In its 1977 Report to Congress entitled "Returning the Mentally Disabled to the Community: Government Needs to Do More, " the GAO said that the past Federal policy of separately allocating Special Health Revenue Sharing Funds to the states and direct grants to Community Mental Health Centers resulted in the promotion of two separate mental health systems -- mental hospitals and CMHCs. Coordination between CMHCs and mental hospitals and between mental health agencies and others remains a serious problem.

The GAO recommended to Congress that it consider consolidating funds earmarked for mental health under the Special Health Revenue Sharing and CMHC programs into a formula grant to State mental health agencies. The GAO said that this combined grant could (1) more effectively accomplish the objectives of the two programs; (2) give state mental health agencies greater capability and flexibility so they can provide a coordinated, comprehensive mental health system with emphasis on community-based care,

and (3) provide a more stable funding source for community mental health services until other funding methods are fully developed.

In an effort to instill synergism in the nation's mental health delivery system, the State Mental Health Directors elected to return to the PCMH's fundamental findings and to proposals made by the President in his fiscal 1980 budget message and refocus the contents of S. 1177 into a new legislative proposal.

Mr. Chairman, the bill we offer is in the nature of a substitute for the Administration's bill, and we ask that the text of our substitute proposal be printed as part of this record.

I have furnished you, attached to this statement, a brief description of the bill's contents with charts showing how the so-called "system" of mental health care could work under S. 1177 and how our system would operate under an amended S. 1177.

We believe the product of these efforts is a true system of intergovernmental partnership between federal, state and local governments that will enable the development of a network of comprehensive mental health services that is flexible and responsive to change.

The proposed intergovernmental partnership is structured on performance contracts between federal, state and local entities that would provide a full array of community mental health services in defined geographic areas. Such a clearly defined structure and process would best assure mental health services for all the population, with special emphasis on children and adolescents, elderly, racial and ethnic minorities, low income groups, rural populations and the long-term chronically mentally disabled.

In formulating its proposal, the State Mental Health Directors Association has put heaviest emphasis on the development of a sound, operative plan as the keystone of the system.

Specifically, the NASMHPD proposal clearly defines federal, state, and local, public or private roles and responsibilities in administration. It provides the opportunity for State Mental Health Authorities to assume primary responsibility for planning, making application for federal supports and managing the mental health system and related systems through cooperative agreements with the Secretary. It also describes conditions and performance standards states must meet.

Our amendment would do the following, Mr. Chairman:

- (1) Mandate a strong state mental health services plan (conforming to the provisions of PL 93-641), defining the state's needs assessments and establishing priorities (Sec. 104-105)
- (2) Set out eleven (11) tough criteria (Sec. 101(b)) that a state must meet in order to qualify to enter into a performance-contract with HEW to administer federal monies for community-based mental health services
- (3) Give the states and the federal government three options in regard the initiation of a performance-contract (or a "cooperative agreement"): (Sec. 101)
 - (a) The state meets the criteria and opts to administer the federal program in accordance with an HEW-approved plan, performance standards, outcome accountability measurements and monitoring conditions
 - (b) The state meets the criteria and opts ^{NOT} ~~to~~ administer the federal services (in which case the federal government employs Title IV of our amendment and negotiates grants or contracts directly with local entities)
 - (c) The state fails to meet the criteria.... in which case (b) above is followed.

- (4) In the event a state opts to administer the federal program (3-a above) the state enter into an 8 point performance-contract with local entities (Sec. 102) for delivery of services (in accordance with the needs assessments and priorities in the HEW-approved state plan).
- (5) Give special emphasis to the treatment services for ethnic and racial minorities; children-most-in-need; rural residents; the seriously mentally ill; mentally-ill-offenders; the multiply handicapped who are also mentally ill; and prevention services for the most-at-risk
- (6) Support internal and external advocacy programs

One other issue remains, Mr. Chairman, and that is the administrative capacity of the state governments.

The U.S. Supreme Court touched on this matter June 20 in a landmark decision in support of state government mental health programs.

In refutation of plaintiffs, charges the Court said: "... Extravagant characterizations are no substitute for careful analysis..."

A "careful analysis" will show that the capacity of state government to manage a mental health system is not open to debate.

For this reason we reject the notion of a state "demonstration project" as proposed in Title V of S. 1177.

As H.E.W. Secretary Califano said to the Senate Health Subcommittee on May 24: "States provide the vast bulk of money to support mental health services."

The State Mental Health agencies have for many years been intensely involved in planning, financing, licensing, regulating monitoring, and evaluating community-based systems of care.

State administered community-based services for the mentally disabled were initiated as far back as the 1920's.

In 1954 New York State enacted the first state "Community Mental Health Services Act" - - - nine years before the federal "Community Mental Health Centers Act". (In fact, 14 states had community-based legislation in place at the time the 1963 federal act was passed).

At this moment 49 states provide funding, planning and other support services to community-based programs. Already, over \$2 billion of the \$8.2 billion which State government mental disability agencies spend annually for care and treatment are allocated to community-based services.

In terms of added management effort....if the entire present federal community mental health services effort were this day converted-over to pass through state government it would tax the management capacity of state government mental disabilities agencies by an additional 3.7%.

In conclusion, Mr. Chairman, we see our proposed amendment to S.1177 as the way in which a coordinated, integrated, accountable, comprehensive community-based mental health system can be developed in this country.

In fact, we also see it as the only mental health proposal currently before the Congress that is in conformance with the Congressional findings developed by this Committee and enacted into Public Law 95-626. Those findings, stated in Section 201 of the "Health Services Extension Act of 1978" are:

"The States and their communities, not the Federal Government, should have primary responsibility for identifying and measuring the impact of public health problems and the allocation of resources for their amelioration."

Thank you for your courtesy, Mr. Chairman and we stand ready to discuss further with you and the committee the issues we've brought before you.

A SINGLE, COORDINATED, ACCOUNTABLE INTERGOVERNMENTAL MENTAL HEALTH SYSTEM

KEY PROVISIONS OF NASMHPD'S "PARTNERSHIP FOR MENTAL HEALTH ACT"

Purpose: To provide for responsive and coordinated administration of Mental Health Systems at the Federal, State, and Local levels.

Title I—Administration of an Intergovernmental Partnership Mental Health System.

- clearly defines Federal, State, and Local, public or private roles and responsibilities in administration.
- provides the opportunity for State Mental Health Authorities to assume primary responsibility for planning, developing, and operating mental health services within the Mental Health System and related support systems through cooperative agreements with the Secretary.
- describes conditions and performance standards states must meet, provide for setting or furnish satisfactory assurance of setting in order to enter into cooperative agreements.
- defines requirements of State Mental Health Plan.

Title II—Mental Health Systems Improvement

Provides for improvement in State's ability to:

- collect and analyze data
- establish performance standards for Mental Health projects and services
- evaluate performance standards
- improve planning capabilities
- improve management capabilities
- State Mental Health Support Development
- development of State Manpower Plan
- improve effectiveness of services in systematic manpower development
- development of statewide patient advocacy system
- other administrative functions

Title III—Mental Health Services to the Uninsured, Underserved and Inappropriately Served

- prevention services directed at the most-at-risk populations
- development of a national network of community mental health centers
- developing and coordinating services for children-at-risk
- specialized Mental Health Services for rural residents
- specialized Mental Health Services for handicapped and educationally handicapped children
- other Mental Health Services for the multiply handicapped and sexually retarded

Title IV—Community Mental Health Services

Provides for:

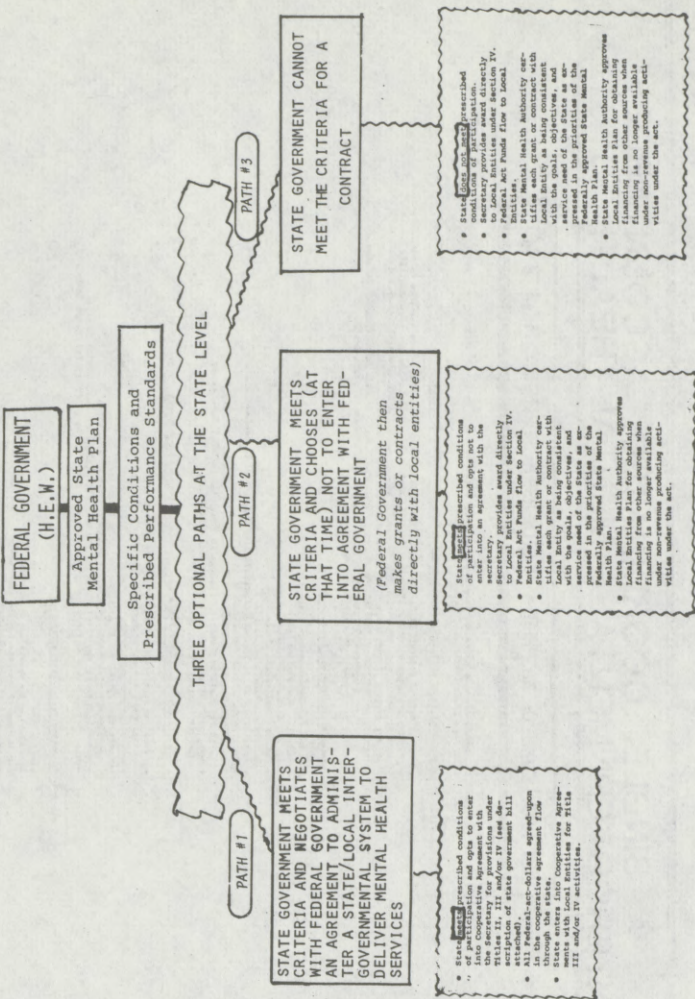
- provisions for provisions of services
- initiation of services for the underserved
- development of comprehensive Mental Health Services
- State Mental Health Authority
- Non-revenue producing activities
- continued support for Community Mental Health Centers
- advocacy program support

Title V—Miscellaneous

- cooperative agreement authorization
- payment procedures
- authorization

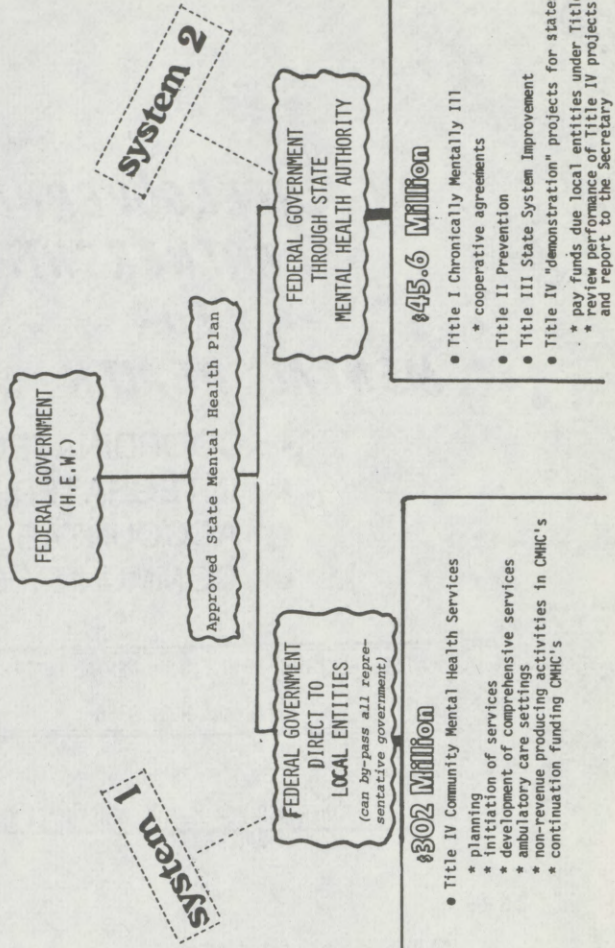
THE BILL PROPOSED BY THE STATE M. H. DIRECTORS

... AS A SUBSTITUTE FOR S. 1177 and H.R. 4156



HERE'S THE WAY H.E.W.'S BILL (S 1177 & HR 4156) WOULD WORK

A DUAL SYSTEM APPROACH



NATIONAL
ASSOCIATION

MENTAL
HEALTH
PROGRAM

Phone (202) 554-7807

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Washington, D.C. 20024

STATE MENTAL HEALTH PROGRAM DIRECTORS

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June 22, 1979

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Executive Director

AN INTERGOVERNMENTAL PARTNERSHIP FOR MENTAL HEALTH SERVICES

- COORDINATED
- INTEGRATED
- ACCOUNTABLE
- COMMUNITY-BASED

A PROPOSED REVISION OF H.E.W.'s MENTAL HEALTH SYSTEMS ACT...

S. 1177 AND H.R. 4156

"PARTNERSHIP FOR MENTAL HEALTH ACT OF 1979"

NASMHPD "Area-of-Focus" on
Intergovernmental Mental
Health Systems

Harry C. Schnibbe
Executive Director
NASMHPD



A B I L L

To improve the provision of mental health services and otherwise promote mental health throughout the United States; and for other purposes.

Be it enacted by the Senate and the House of Representatives of the United States of America in Congress assembled, That this Act, along with the following table of contents, may be cited as ~~the~~ "Partnership for Mental Health Act of 1979".

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Findings and Purpose

Sec. 2.

 (a) The Congress hereby finds--

(1) Despite significant progress in the availability of community mental health services and improving residential mental health facilities, certain groups in the population, such as those most at risk of developing mental illness, the seriously mentally ill, children, rural residents, ethnic and racial minorities, the physically disabled, developmentally disabled, and mentally retarded, often lack access to adequate mental health services and other health or social or other support services.

(2) Even where mental health services are available, the lack of coordination, among governmental and private agencies and entities, of the mental health services, other health services, and social or other support services provided often leads to neglect or unnecessary institutionalization of persons with serious mental disabilities.

(3) Many states have demonstrated the capacity for leadership in the administration, coordination, and provision of mental health services and related support service that can provide the foundation for a new intergovernmental partnership in the delivery of services to the mentally disabled.

(4) Millions of persons with some level of mental disorder have contact with the primary health care system where opportunities for effective mental health.

care and treatment are often lost because of inadequate mental health training of general health care personnel in primary health care settings.

(5) Present efforts to prevent mental disability through discovery and elimination of the causes of mental illness and through early detection and treatment programs are far too limited.

(b) It is, therefore, the purpose of this Act to encourage development of a partnership, in the delivery of mental health services, other health services, and social or other support services, among Federal, State, local government, or other private providers of such services, in order to improve mental health, prevent mental illness, and provide effective treatment and rehabilitative services in the least restrictive setting for persons of all ages and cultural backgrounds who are suffering from mental illness or disability or are potential sufferers therefrom. To help carry out that purpose, the objectives of this Act are--

(1) to foster the most effective use of available Federal, State, local government, or private resources, by encouraging States to improve the management and evaluation of their mental health services programs and to coordinate services under those programs with other health services and social or other support services;

(2) to develop community-based services for unserved, underserved, or inappropriately served

populations, such as those most at risk of developing mental illness, the seriously mentally ill, children, rural residents, ethnic and racial minorities, the physically disabled, developmentally disabled, and mentally retarded;

(3) to increase the integration of general health services and mental health services through in-service mental health training of primary care providers and through placement of mental health professionals in primary care programs;

(4) to encourage States to develop prevention programs;

(5) to facilitate accomplishment of that purpose and these objectives through more effective planning that is consistent with the mental health aspects of overall State planning.

Definitions

Sec. 3.

 For the purposes of this Act, unless the context otherwise requires--

(1) The term "State" includes (in addition to the fifty States) the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Trust Territory of the Pacific Islands, and the Northern Mariana Islands.

(2) The term "Governor: means, in the case of a State which does not have a governor, the chief executive officer of the State.

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

(4) The term "nonprofit", as applied to any entity, means an entity which is owned and operated by one or more corporations or associations no part of the net earnings of which inures or may lawfully inure to the benefit of any private shareholder or individual.

(5) The term "State Agency" means the agency or authority of a State established or designated under the State plan (approved under this Act) of that State to assume responsibility for administration of the plan and the other aspects of its mental health services program.

(6) The term "Area Mental Health Agency" means the public or nonprofit private entity (and there may be only one) in a mental health services area desig-

nated by the State Agency to be responsible for planning the mental health services program of the area and (at the option of the State) any one or more other mental health services areas, and for the coordination and development of mental health services in that area or areas.

(7) The term "Core Service Agency" means a public or nonprofit private entity

designated by the State Agency to assume responsibility in any mental health services area for planning, coordinating, developing, and providing the mental health services and support services that are necessary for the care of those members of any one or more priority population groups in the area who need both mental health services and support services.

(8) The term "related support services" means health services (other than mental health services), and the social services, housing, and those other support services specified by the Secretary.

(9) The term "priority population group" means any of the following groups which are unserved, underserved, or inappropriately served by any mental health services program: populations most at risk of developing mental illness, the seriously mentally ill, children, rural residents, ethnic and racial minorities, the physically disabled, developmentally

disabled, and mentally retarded or any other group determined by the Secretary to have a special need for services under such a program.

(10) The term "mental health services area" means a geographic area established for purposes of planning and provision of mental health services.

(11) The term "comprehensive mental health services" means the services described in section 201 (b) of the Community Mental Health Centers Act.

(12) "State Plan" means that plan created by the State Agency and approved by the Secretary pursuant to Part B, Title I of this Act.

(13) "Cooperative Agreement" means that relationship between the Federal Government and State and local private or public entities as contemplated in the "Federal Grant and Cooperative Agreement Act of 1977" (P.L. 95-224).

TITLE I --- ADMINISTRATION OF THE MENTAL HEALTH SYSTEM
BY AN INTERGOVERNMENTAL PARTNERSHIP

Purpose

Sec. 100. It is the purpose of this title --

(a) to provide for responsive and coordinated administration of mental health systems at the federal, state, and local level by an intergovernmental partnership that assures fair, efficient, and stable allocation of limited resources for the delivery of appropriate mental health services and related support services, with minimal fragmentation and duplication of administrative roles;

(b) to do this under a program which defines and fosters:

(1) the Federal role in developing and implementing national mental health policy (consistent with this Act), monitoring the performance of the State Agency, and providing technical assistance in improving methods of service delivery;

(2) the State role in negotiating cooperative agreements with the Secretary on its own behalf and on the behalf of local entities, coordinating through the State Plan the delivery of services by the State and local entities, distributing Federal and State funds to local entities pursuant to cooperative agreements between the State Agency and the local entities, and monitoring compliance by local entities with these cooperative agreements and the State Plan;

(3) the role of local entities in providing mental health services, assuring through case management and client advocacy the provision of related support services, and conducting a local planning process which contributes to the State Plan.

(c) It is further the purpose of this Act --

(1) to permit and encourage qualified State Agencies to enter into Federal-State cooperative agreements and State-local cooperative agreements, which agreements clearly specify and provide for the enforcement of the conditions and performance standards under which Federal funds are provided for projects and activities under Titles III and IV of this Act;

(2) to permit State Agencies which are unwilling or unqualified to enter into Federal-State cooperative agreements to seek grants under Titles II and III, and to approve grants sought by local entities directly from the Secretary under Title IV.

PART A -- COOPERATIVE AGREEMENTSFederal-State Cooperative Agreements

Sec. 101. (a) The Secretary may enter into cooperative agreements with the qualified State Agency in a State (at the option of the State) pursuant to which the State Agency will--

(1) on behalf of all entities in the State apply to the Secretary for financial support of community mental health services under Title IV of this Act, or on behalf of the State and all entities in the State apply for financial support under Title II, III, or IV of this Act;

(2) on behalf of the Secretary, distribute to entities Federal funds for community-based mental health services;

(3) on behalf of the Secretary, monitor and promote enforce compliance by entities receiving Federal funds of the conditions and performance standards applicable to the receipt of those funds, which conditions and performance standards shall be clearly specified in State-local cooperative agreements, and report to the Secretary the extent of the compliance;

(4) perform other such functions of the Secretary as the Secretary and the State Agency may agree upon.

(b) In order to be qualified to participate in a Federal-State cooperative agreement to administer funds authorized by Title IV, the State Agency must meet, provide for meeting, or furnish satisfactory assurances of meeting the following

criteria (adapted where appropriate to the circumstances peculiar to each State):

(1) there is on-going, active, consumer-oriented citizen participation in the administration of the State mental health system and the provision and administration of financial support to entities;

(2) The State Agency and local entities shall determine a set of criteria and processes by which the State agency will monitor and evaluate the performance of local entities under the state-local cooperative agreement; and the State Agency shall propose a set of criteria and processes by which the Secretary will monitor the performance of the State Agency under the terms of the federal-state cooperative agreement including an evaluation of the State's activities in monitoring and evaluating local entities;

(3) (A) there is a plan for providing State financial support to entities who may in the future become ineligible for Federal support under this act; and (B) there is a plan for developing comprehensive mental health services in each mental health service area where they are currently unavailable;

(4) the cooperative agreement is in accord with the State plan;

(5) the state has the ability to administer, and has demonstrated a financial commitment to support community-based mental health services and a serious effort to deinstitutionalize residents of large, custodial-type state hospitals and treat clients in the least restrictive setting ;

(6) a substantial proportion, to be determined by the Secretary from time to time, of Federal funds obtained under Title III and Title IV will be used for community-based mental health services and related support services, and adequate provision made for the development of competent planning and service delivery staffs at both State and local levels;

(7) the State Agency provides for assistance to courts and other public agencies and to appropriate private agencies to facilitate screening by local entities of residents of the State who are being considered for inpatient care in a mental health facility to determine if such care is necessary;

(8) no Federal funds under Title III or IV of this Act will be distributed to entities except pursuant to the State-local cooperative agreement provided for in section 102;

(9) in addition to the Plan and the cooperative agreement, (A) the State Mental Health Authority will prepare and publish an analysis of the types of services and amounts of funds made available for actually and potential mentally ill persons under Titles XVI, XVIII, XIX, and XX of the Social Security Act, the Vocational Rehabilitation Act, the Education for All Handicapped Children Act, the Older Americans Act, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act, the Drug Abuse Office and Treatment Act and the United States Housing Act, and (B) the State Mental Health Authority will demonstrate best efforts to maximize services and funds under these Acts on behalf of persons covered by this Act;

(10) the State will demonstrate best efforts to encourage and enhance provision of mental health services under private insurance coverage;

(11) the State complies with the requirements of this Act to the same extent as would be required of an applicant for or recipient of a grant for the same purpose as the Federal-State cooperative agreement.

(c) The eligibility of the State Agency in a State or the entities in that State for grants under this Act shall be unaffected by the decision of the State Agency not to seek

a Federal-State cooperative agreement pursuant to this section, or the determination by the Secretary that that State Agency is not qualified to participate in a Federal-State cooperative agreement pursuant to this section.

(d) The Secretary shall not finally disapprove the application of a State Agency for a Federal-State cooperative agreement or terminate such an agreement except after reasonable notice and opportunity for a hearing to the State.

State-Local Cooperative Agreements

Sec. 102. (a) A State Agency in a State participating in a Federal-State cooperative agreement pursuant to section 101 may enter into a State-local cooperative agreement with qualified entities in the State, which State-local cooperative agreement shall contain at a minimum the following provisions:

(1) a clear allocation of State and local responsibilities for administration and provision of services;

(2) the standards by which the performance of State and local responsibilities will be monitored and evaluated, incentives for meeting those standards, and remedies for willful failure to adhere to a standard;

(3) the qualifications of the personnel of the entity;

(4) the annual budget of the entity;

(5) the means by which the activities of the entity will be coordinated with other entities providing mental health services or related support services in the same mental health service area;

(6) a local plan of the entity for decreasing reliance on Federal financial support under this Act.

(7) a designation of the priority population and other populations to be served, the settings in which services are to be delivered, a plan for making these settings the least restrictive possible, the anticipated client outcome and service impact

and the schedule for delivery of service;

(8) such other provisions as the Secretary may designate as necessary and proper to achieve the purposes of this Act.

(b) In order to be qualified to participate in a State-local cooperative agreement, the entity must comply with the requirements of this Act to the same extent as would be required of an applicant for or recipient of a grant for the same purpose.

(c) No State Agency in a State participating in a Federal-State cooperative agreement shall finally disapprove the application of an entity for a State-local cooperative agreement or terminate such an agreement except after reasonable notice and opportunity for a hearing to an entity.

OTHER COOPERATIVE AGREEMENTS

Sec. 103. In any case in which a grant is authorized to be made under this Act by the Secretary to the State Agency of or any entity in a State for any project or activity, the Secretary may, if he deems it appropriate, instead enter into a cooperative agreement with such Agency or entity under which the Secretary will make the same payments, on the same terms, for such project or activity as he would under a grant therefor, but only on condition that such Agency or entity complies with the requirements of this Act, including those relating to an application, to the same extent as would be required of an applicant for or recipient of a grant for the same purpose.

PART B -- STATE PLANSRequirement of State Mental Health Services Plan

Sec. 104. (a) (1) In order for the State Agency of or any entity in a State to be eligible to receive Federal funds under this Act for any year, such State must have in effect a State mental health services plan which has been prepared by an agency of the State designated by the Governor and been submitted to the Secretary through the Governor, which is consistent with the provisions, relating to mental health services, of the State health plan prepared in accordance with section 1524(c)(2) of the Public Health Service Act, and which has been approved by the Secretary as meeting the requirements of this Act.

(2) The State plan shall be developed through a community-based planning process which conforms to requirements specified by the Secretary and the State Agency and which encourages the participation of citizens and human service and related support service and related support service planning groups at all levels.

(b) The Secretary may not finally disapprove a State plan (or any modification thereof) except after reasonable notice and opportunity for a hearing to the State.

(c) Whenever the Secretary, after reasonable notice and opportunity for a hearing to the State Agency of a State, finds that the State plan approved under this Act has been so changed that it no longer complies with this Act, of that in the administration of the plan there is a failure to comply substantially with any provision of this Act, the Secretary

shall notify the Agency that further payments will not be made to the Agency or to any other entity in the State under this Act (or, in his discretion, that further payments will not be made to any such Agency or entity with respect to any project or activities affected by such failure), until he is so satisfied, the Secretary shall make no further payments to any such Agency or entity or shall limit payments to projects or activities not affected by such failure.

Contents of State Plans

Sec. 105. To be approved under this Act a State mental health services plan must be submitted in such form and manner as the Secretary prescribes and must--

(1) identify the mental health services areas within the State, which areas must cover the entire State and each of which must, except to the extent and in the cases permitted by the Secretary (including exceptions made for interstate areas), have boundaries which conform to or are within the boundaries of a health service area established under title XV of the Public Health Service Act and, to the extent practicable, conform to boundaries of one or more school districts or political or other subdivisions in the State;

(2) set forth and be responsive to (A) the need of each mental health services area in the State for mental health services, as determined after consideration of all relevant matters, including the demographic, economic, cultural, or social characteristics of the population of the area, with special attention to the need of priority

population groups for services as well as to the need for services and activities designed to prevent mental illness from occurring, (B) the public or private facilities, mental health personnel, and services available, and the additional facilities, personnel, and services required, to meet those needs, (C) the methods used to determine those needs and evaluate the facilities, personnel, and services, (D) the way in which and the order in which those needs will be met through use of existing Federal, State, or local resources and otherwise, and (E) similar information for the State not included under clause (A), (B), (C), or (D) which is of significance for more than a single mental health services area;

(3) provide for establishment or designation of a single agency of the State (in this Act referred to as the "State Agency") to assume responsibility for administration of the plan and the other aspects of the State's mental health services program and include, in the methods of administration of the plan, methods relating to establishment and maintenance of personnel standards on a merit basis which are in accord with standards prescribed by the Office of Personnel Management;

(4) identify each Area Mental Health Agency which has been designated by the State Agency and the mental health services area or areas it serves;

(5) include or be accompanied by (A) documen-

tation and other evidence showing that, in the process of its development and before the plan was submitted to the Secretary, a reasonable opportunity was afforded to interested agencies, organizations, and individuals to present their views and to comment on the proposed plan; and (B) satisfactory assurances that, after submission of the proposed plan to the Secretary and its approval by him, a reasonable opportunity will be afforded to interested agencies, organizations, and individuals to comment on administration of the plan and on any proposed modification of the plan;

(6) describe the steps that are proposed to be taken at the State level and the local level in an effort, which the Secretary determines to be reasonable (A) to coordinate the provision of mental health services, and (B) to coordinate, in the case of the seriously mentally ill and any other priority population group designated by the Secretary, the various kinds of services for members of such groups who need both mental health services and support services;

(7) describe the legal rights of persons in the State who are mentally ill or otherwise mentally handicapped and what is being done in the State to protect those rights;

(8) provide for outpatient mental health services for patients instead of institutional inpatient

treatment wherever appropriate and fair and equitable arrangements (as determined by the Secretary after consultation with the Secretary of Labor) to protect the interests of employees affected adversely by actions taken to emphasize such outpatient treatment, including arrangements designed to preserve employee rights and benefits and to provide training and retraining of such employees, where necessary, for work in mental health or other fields and including arrangements under which maximum effort will be made to place such employees in employment;

(9) provide that any statistics or other data included in the State plan on which the State plan is based will conform to such criteria, standards, and other requirements relating to their form, method of collection, content, or other aspects as the Secretary prescribes in order to provide Nationwide comparability of the data;

(10) provide that the State Agency will make such reports, in such form and containing such information, and keep such records as the Secretary may require, and afford such access to those records as the Secretary may find necessary to assure the correctness of and to verify such reports;

(11) (A) provide that an agency of the State designated by the Governor will from time to time, and in any event not less often than every four years, review the information and other material in or

accompanying the State plan, as well as the proposed objectives of or activities under the plan, and submit to the Secretary through the Governor any necessary modifications thereof, except to the extent excused by the Secretary because the modifications are of minor significance; and (B) provide that an agency of the State designated by the Governor will submit to the Secretary through the Governor any other modifications in the plan or in such information, material, objectives, or activities that are necessary for any other reason, except to the extent so excused by the Secretary; and

(12) contain or be accompanied by such additional information or assurances and meet such other requirements as the Secretary prescribes in order to achieve the purposes of this Act.

PART C -- OTHER GENERAL REQUIREMENTS AND PROVISIONS

Applications

Sec. 106. (a) No grant may be made under this Act to the State Agency of or any entity in any State unless an application (meeting the requirements of this Act and of the State plan of that State approved under this Act) for the grant has been approved by the Secretary, and in no event shall a grant be made directly to any entity in a state in which the state agency has entered into a federal-state cooperative agreement pursuant to Sec. 101 to administer funds under Title 4 of this Act.

(b) To be approved under this Act, an application for a grant for any project must contain or be accompanied by--

(1) a financing plan approved by the State Agency and a budget covering the year for which the grant is sought (and such additional period as the Secretary may require) showing the sources of funding for the project and allocating the funds available for the project among the various types of services to be provided or assisted or the various types of activities to be conducted or assisted and among the various population groups to which the project is directed;

(2) a statement of the objectives of the project, which objectives must be in accord with criteria established by the Secretary and must include at least those objectives which the Secretary may specify;

(3) any statistics or other information which the Secretary and, where applicable, the State Agency

may request in order to determine compliance of the project with the requirements of this Act;

(4) in the case of any project under which services are to be provided, the schedule of fees to be charged therefor and the discounts to be allowed (to those unable to pay in full) on the basis of relative inability to pay for the services, along with satisfactory assurances that the applicant will make every reasonable effort to collect for the services from all available sources;

(5) information on the organization and operation of the applicant and the measures taken to provide reasonable opportunities for interested agencies, organizations, and members of the public to comment thereon and on the proposed project;

(6) satisfactory assurances that the applicant will submit such reports, at such times and containing such information, as the Secretary may request and maintain such records as the Secretary may find necessary for purposes of this Act, and afford the Secretary and the Comptroller General of the United States such access to such records and other documents as may be necessary for an effective audit of the project or activity;

(7) satisfactory assurances that funds made available under this Act will be used to supplement and, to the extent practical, increase the level of non-Federal funds that would, in the absence of those Federal funds, be made available for the purpose,

and will in no event supplant such non-Federal funds;

(8) in the case of a grant under Title IV to any entity in a State, which has not entered into a Federal-State cooperative agreement regarding the State administration of Federal funds under Title IV, certification that the State Agency has reviewed and approved the application as being in accord with the State plan approved under this Act;

(9) in the case of any project for provision of any services (A) a description of the steps the applicant has taken and will take in an effort (which the Secretary determines to be reasonable) to coordinate the services it provides with other mental health services and support services in the same area or areas, and (B) satisfactory assurances that the applicant will, in the provision of such services under the project, as a minimum meet the standards of quality of care prescribed by the Secretary and

(10) such other information and material and such other assurances as the Secretary may prescribe in order to carry out the purposes of this Act.

The requirements under this section for assurances, statements, descriptions, and other information and materials with respect to an application for a grant for a project apply also to the activities of any Core Service Agency with respect to which payments are to be made from such grant.

Duration of Grants

Sec. 107. Any grant under this Act is for such a period of time, not exceeding one year, as the Secretary may determine.

Performance Standards

Sec. 108. (a) In determining whether or not to approve an application for a grant under this Act, the Secretary shall consider the extent to which performance by the applicant under any prior grant under this Act or the Community Mental Health Centers Act complied with applicable requirements, standards, and criteria.

(b) The Secretary in cooperation with the State Agency shall prescribe standard measures of performance designed to test the quality and extent of performance by applicants under any such prior grants and the extent to which such performance has helped to achieve the National or other objectives for which the prior grants were made. Such measures shall be developed in cooperation with the State Mental Health Authority and shall address:

- (1) quantity , quality, availability and cost of services,
- (2) quantity , quality, and availability of staff,
- (3) treatment outcomes and changes in client status,
- (4) management capacity, and
- (5) timetables for achieving the objective of this paragraph.

(b) Each State and locality in its award application shall specify objectives consistent with the State mental health plan to be achieved during the award year for each type of activity, the specific measures to be used for these objectives and an initial set of baseline data for these measures.

Evaluation and Monitoring

Sec. 109. (a) With the approval of the Secretary, any recipient of a grant under this Act may use a portion of that grant for evaluation of the project or activity involved and of the recipient's program of which the project or activity is a part.

(b) Appropriations for grants under Title II, III, or IV may also be used by the Secretary for reviewing performance by recipients of grants thereunder to determine the extent to which they have complied with the requirements applicable to such grants, and the extent to which they have advanced the National or other objectives for which the grants were made.

Indirect Provision of Services

Sec. 110. Any mental health services for the provision of which an entity is responsible for purposes of a grant under this Act may be provided by it directly at its primary or satellite facilities or through arrangements with other entities or health professionals and others in, or serving residents of, the same mental health services area.

Standards of Care

Sec. 111. The Secretary shall prescribe standards relating to the quality of care in the provision of mental health services by any recipient of a grant under this Act.

Technical Assistance

Sec. 112. Such portion as the Secretary may determine, but not more than two percent, of any appropriation for grants under Title II, III, or IV for any fiscal year is available for technical assistance, including short-term training, by the Secretary to any State Agency or other entity which is or has been a recipient of a grant under any of such titles, to assist it in developing, or in better administering, the mental health services program or programs for which it is responsible.

Payment Procedures

Sec. 113. (a) Except as provided in subsection (b), the amount of payments under any grant for any year under this Act, other than section 401, may be reduced to the extent--

(1) (A) the sums paid to the grantee under any prior grant under the same section of this Act, or (B) in case such amount is to be paid under section 403 or 406, the sums paid to it under section 406 or under section 203(a) or (e) or 211 of the Community Mental Health Centers Act, plus

(2) the funds available for the project of activity, for which the prior grant was made, from State, local, or other sources (including collections), exceed the total cost of the project or activity for which the prior grant was made, instead of such excess being repaid to the United States.

(b) In the case of any such excess--

(1) a reduction under subsection (a) shall not be

made to the extent adjustments were previously made, or excused under clause (2) of this subsection, on account of such excess, and

(2) such portion of that excess for any year for any project under title IV of this Act or for any project or activity under the Community Mental Health Centers Act as the Secretary may determine, but not exceeding five percent of the cost of the operation of the recipient's mental health program, may be retained by the recipient for deposit in a reserve fund maintained for purposes approved by the Secretary, and shall not be counted as available funds for purposes of any subsequent grant under this Act.

Conforming Amendments

Sec. 114. (a) Section 507 of the Public Health Service Act (relating to grants to Federal institutions) is amended by inserting ", and appropriations under title IV of the

Act,"

before "shall also be available".

(b) Section 513 of such Act (relating to evaluation of programs by the Secretary) is amended by inserting "

Act," after

"Community Mental Health Centers Act,".

(c) Section 1513(e)(1)(A)(i) of such Act (relating to functions of health systems agencies) is amended by inserting

Act,"

after "Community Mental Health Centers Act,".

Grants for Members of Indian Tribes

Sec. 115. (a) At the request of any Indian Tribe or Tribes (as defined in the Indian Health Care Improvement Act) or any Urban Indian Organization (as so defined), a grant may be made under title IV of this Act to the Indian Health Services or any institution, clinic, or other unit thereof, on the same terms and conditions as apply to non-Federal entities, for any project (for which such a grant is available) to serve members of, respectively, such Tribe, Tribes, and Organization.

(b) Any grant under subsection (a) may be made for a project serving members of an Indian Tribe or Tribes (as so defined) or an Urban Indian Organization (as so defined) even though the area in which those members reside is included in two or more mental health services areas of a State.

Governing Bodies of Local Agencies

Sec. 116. No entity is eligible for a grant under title IV, other than section 401, unless it meets the requirements applicable to a community mental health center under subparagraph (A) or (B) of section 201(c)(1) of the Community Mental Centers Act, whichever is applicable, and, in case such subparagraph (A) or (B) of section 201(c)(1) of the Community Mental Health Centers Act, Whichever is applicable, and, in case such subparagraph (A) is applicable, it provides satisfactory assurances that it will meet the requirements applicable to such a center under clause (ii) of such subparagraph (A).

TITLE II
MENTAL HEALTH SYSTEMS IMPROVEMENT

Purpose

Sec. 200. It is the purpose of this title, in recognition of the financial and administrative roles of the States in the mental health sector, to assist them to improve their capacity to carry out their responsibilities for administering their mental health services and related programs.

State Management and Data Collection

Sec. 201. For the purpose of assisting the States to improve administration of State mental health programs, the Secretary may make grants to a State Agency, to a State Agency for payments by it to an entity, or both, for any one or more of the following:

(1) improving State Agency capacity to collect and analyze statistics and other data and to otherwise meet the monitoring or reporting requirements under this Act;

(2) improving other administrative functions of the State Agency; or

(3) improving the ability of the State Agency
(A) to set performance standards for mental health services, projects, and programs, (B) to enforce those standards, and (C) to evaluate performance under any other aspects of such projects and programs through data analysis, studies, and other means..

Planning Grants

Sec. 202. The Secretary may provide technical assistance and may make grants to a State Agency, to a State Agency for payments by it to an entity, or both, for any one or more of the following:

(a) establishing a locally initiated consumer-based mental health planning program which

(1) culminates in preparation of the State mental health plan;

(2) promotes compatibility with the planning requirements of Title XV and XVI of the Public Health Service Act, the Vocational Rehabilitation Act, the Education of all Handicapped Children Act, the Older Americans Act, and Titles IV(b), V, XVI, XVIII, XIX, and XX of the Social Security Act, and other federal legislation;

(b) increasing the capacity of local and State mental health planning staffs to assist and cooperate in all levels of mental health and related support services planning, including but not limited to the development of the State plan;

(c) evaluating and improving systems of needs assessment and prioritization.

Client Outcome Evaluation

Sec. 203. For the purpose of assisting states to improve the evaluation of public mental health services the Secretary may provide technical assistance and may make grants to a State Agency, to a State Agency for payments by it to an entity, or both, for any one or more of the following:

- (a) improving client record keeping systems;
- (b) establishing or improving client outcome evaluation programs, which will help to determine both the numbers and types of clients who benefit from services and the service modalities which are best suited to client needs;
- (c) establishing a service impact evaluation system which will develop and apply relevant health, social, quality of life and other impact indicators to measure the overall effectiveness of community-based services.

State Mental Health Manpower Development

Sec. 204. For the purpose of establishing a program of technical assistance and grant support to the states to strengthen their mental health manpower development efforts and thereby improve the availability of essential personnel in terms of numbers, location, and required skills to meet the needs of the mental health services system, the Secretary may make grants to a State Agency, to a State Agency for payments by it to an entity, or both, for any one or more of the following:

(a) developing a State mental health manpower plan to include:

- (1) advancement of the state of the art in regard to recruitment, deployment/redeployment, utilization, training/retraining, and retention as these manpower activities are carried out in States;
- (2) dissemination of new information concerning approaches and techniques which have been determined to be successful in facilitating manpower development;

(b) increasing capabilities to engage in systematic mental health manpower development.

(c) training and re-training state and local personnel providing services to mentally ill persons, with special emphasis on employees of public institutions who have been or might be adversely affected by the reduced use of such institutions.

Internal Advocacy Programs

Sec. 205. For the purpose of protecting the rights of persons receiving mental health services, the Secretary may make grants to a State Agency, to a State Agency for payments by it to an entity, or both, for any one or more of the following:

(a) providing advocacy services to persons receiving mental health services for the State or any entity;

(b) improving administrative remedies to ensure the rights of persons receiving mental health services or related support services from the State or any entity;

(c) developing the capacity of lawyers, judges, and mental health professionals to recognize and protect the rights of persons receiving mental health services by--

(1) funding a State-wide mental health legal resources center independent of the State Agency to direct basic and continuing education in issues involving both mental health and the law;

(2) offering workshops, seminars, and conferences regarding the rights of persons receiving mental health services;

(3) assisting the development by institutions of higher learning of curricula which combine education in law, and social or medical sciences;

(d) assuring access of persons receiving mental health services from the State to skilled legal services, without cost to those unable to pay, and with special emphasis on persons under court order of involuntary commitment, detention after acquittal by reason of insanity, or after or during a determination of incompetency to stand trial or other court order.

(e) developing statutory and administrative provisions protecting the rights of persons receiving mental health services and providing remedies for violation of those rights and for educating the public in regard to those provisions.

Other State Activities

Sec. 206. The Secretary may make grants to a State Agency, to a State Agency for payment by it to an entity, or both, for any project for any other activities, included in the State plan approved under this Act, which are designed to improve the provision of mental health services in the State or the administration of State or local mental health programs and which the Secretary determines to be of particular significance in the light of the purposes of this Act.

TITLE III-- MENTAL HEALTH SERVICES
TO THE UNSERVED, UNDERSERVED,
AND INAPPROPRIATELY SERVED

Purpose

Sec. 300. (a) The purpose of this title is to assist States and communities in the development and improvement of mental health services for--

(1) populations most at risk of becoming mentally disabled;

(2) the seriously mentally ill;

(3) children most in need of such services;

(4) rural residents;

(5) ethnic and racial minorities;

(6) the physically disabled, developmentally disabled, and the mentally retarded;

(7) other groups, such as the elderly, women, students, and mentally ill offenders in state institutions, having special needs as determined by the Secretary.

(b) It is further the purpose of this title to support and encourage a partnership between State and communities in achieving the National goals of--

(1) developing responsive, coordinated, community-based service systems to meet the needs of unserved, underserved, and inappropriately served who are capable of living in the community if provided with adequate mental health, rehabilitation and training, housing, and other support services;

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(2) providing the most appropriate and least restrictive care in a community-based mental health system for persons requiring inpatient care on a short or long-term basis;

(3) providing retraining and job placement for personnel displaced by the closure or reduction in use of public mental hospitals.

PREVENTION SERVICES DIRECTED AT
THE MOST-AT-RISK POPULATIONS

Sec. 301. (a) For the purpose of promoting mental health and preventing mental illness among populations most at risk of becoming disabled by mental illness, the Secretary may make grants to a State Agency, to a State Agency for payments by it to a Core Service Agency, or both, for any or more of the following:

(1) providing assistance, through collection and dissemination of information, workshops, and other appropriate means, to mental health or other health personnel, entities, and groups, and to volunteer or other citizen organizations and groups, in the development of programs aimed at preventing mental illness;

(2) in-service training and other training of mental health, other health or other appropriate personnel in early identification of the potential causes of mental illness and early application of measures designed to prevent occurrence or aggravation of mental illness;

(3) providing information to the general public on the importance of preventing mental illness and of the services available to help in early identification of potential causes of mental illness and early handling of those causes;

(4) planning, and other activities at the State or intrastate regional level to develop and coordinate, services to help prevent mental illness; or

(5) demonstrating in one or more mental health services areas of the State, the various means of preventing mental illness and otherwise promoting mental health.

(6) improving the capacity of law enforcement, correctional and other personnel to recognize and appropriately respond to the early stages of mental illness in persons accused, convicted or victimized by criminal offenses.

(7) providing professional, peer, or lay intervention services to persons suffering from significant life crisis events;

(8) providing other preventive services through a Core Service Agency not otherwise available;

(9) identifying and assessing the mental health needs of populations most at risk of becoming disabled by mental illness, and monitoring preventive services provided to these populations.

(b) In making grants under this section the Secretary shall give special emphasis to projects providing primary prevention services to children and adolescents, and shall designate an administrative unit within the National Institute of Mental Health responsible for developing, providing technical assistance, and evaluating such projects.

MEETING THE MENTAL HEALTH NEEDS OF
CHILDREN MOST IN NEED

Sec. 302. For the purpose of coordinating and improving the quality and availability of all services needed by a population consisting of severely mentally disturbed children and youth, who also have significant health, social, educational, or legal problems, the Secretary may make grants to a State Agency, to a State Agency for payments to a Core Service Agency, or both, for any one of the following:

(a) coordinating--

(1) the activities of State-level agencies in the funding and delivery of services to that population;

(2) through a Core Service Agency, the activities of community agencies providing mental health, health, educational, social, and juvenile justice services for that population;

(3) the funding for services to that population from all sources, including but not limited to Titles IV(b), V, XIX, and XX of the Social Security Act, the Education for All Handicapped Children Act, the Developmental Disabilities Assistance and Bill of Rights Act and other federal statutes;

(b) assuring the availability in a Core Service Agency of a single employee responsible for providing or advocating the provision of all services needed by that population in the health service area.

(c) assisting through a Core Service Agency in the development and continued monitoring of individual educational plans and the provision of auxillary mental health services required under the Education for All Handicapped Children Act;

(d) identifying and assissing the needs of that population and meeting those needs not addressed by existing programs.

Meeting the Needs of
the Seriously Mentally Ill

Sec. 303. (a) The Secretary may make grants to a State Agency, to a State Agency for payments by it to a Core Service Agency, or both, for any one or more of the following:

- (1) screening by the Core Service Agency of all residents in its mental health services area who apply for or are proposed for admission to or discharge from inpatient care at a State mental health facility and providing mental health services and related support services for residents for whom such inpatient care at a State mental health facility is inappropriate, or who have been discharged or transferred from such inpatient care at a State mental health facility;
- (2) coordinating the operations of all entities in providing mental health services or related support services that may assist the seriously mentally ill to live outside of institutional settings;
- (3) identifying and removing barriers to the ready availability of any such services to the seriously mentally ill;
- (4) training and retraining State and local personnel providing services to the seriously mentally ill, and assisting in the placement in community-based mental health programs of former

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employees of public mental institutions adversely affected by the reduced use of such institutions, handicapped persons, and members of ethnic and racial minorities;

(5) assuring the availability, for each seriously mentally ill person who needs both mental health services and related support services, of a single employee of a Core Service Agency responsible for providing or advocating the provision of all appropriate services;

(6) providing or arranging for the provision through a Core Service Agency of any services needed by a seriously mentally ill resident not otherwise available;

(7) providing through the Core Service Agency consultative and educational services to inform the community of the availability of services for the seriously mentally ill and the need for community support of such services;

(8) identifying seriously mentally ill residents who need both mental health services and related support systems, assessing the needs for such services, and planning for and carrying out plans for providing such services;

(9) evaluating programs supported by Federal funds under this Title.

(10) providing services not otherwise available to residents of forensic units of State Mental Health facilities.

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Specialized Mental Health Services
for Rural Residents

Sec. 304. The Secretary may make grants to a State Agency, to a State Agency for payments by it to a Core Service Agency, or both, for any one or more of the following:

- (a) identifying and training members of the rural population as mental health service providers;
- (b) improving accessibility of all services needed by mentally ill rural residents through improved transportation systems, including but not limited to the purchase and maintenance of vehicles and the hiring and training of personnel to operate them;
- (c) establishing and operating satellite centers to meet the specialized needs of a rural population;
- (d) developing a policy of constituent consultation and evaluation of services for mentally ill rural residents;
- (e) planning for and providing of mental health and related support services appropriate to the needs of the migrant worker population in rural areas;
- (f) providing for other needs of mentally ill rural residents as designated by the Secretary.

Specialized Mental Health Services
to Ethnic and Racial Minorities

Sec. 305. (a) The Secretary may make grants to a State Agency, to a State for payments by it to a Core Service Agency or both, for any one or more of the following:

- (1) improving of cultural and linguistic accessibility of relevant service programs;
- (2) training of members of minority for placement as employees and volunteers in community-based mental health services.
- (3) developing minority-initiated and conducted needs assessments;
- (4) assuring minority influence over planning and evaluation of services at all levels.

(b) The Secretary shall establish at the level of the Office of the Administrator within the Alcohol, Drug Abuse, and Mental Health Administration an identifiable administrative unit with authority for the National Institutes on Drug Abuse, Alcohol Abuse and Alcoholism, and Mental Health, to be known as the Office for Minority Concerns (hereinafter referred to as the 'Office') which shall:

- (1) support programs with regard to the delivery of alcohol, drug abuse, and mental health services to minority populations, including demonstration projects;
- (2) develop a plan to increase the representation of minority populations in alcohol, drug abuse, and mental health service delivery and research manpower programs with an emphasis on developing bilingual

and bicultural programs;

(3) support programs of basic and applied social and behavioral research on minority alcoholism, drug abuse, and mental health;

(4) study the effect of racism on institutions and individuals, including majority institutions and individuals;

(5) develop systems to assist minority populations in adapting to, and coping with, the effects of racism;

(6) support and develop research, demonstration, and training programs aimed at eliminating institutional racism;

(7) provide for the increase of representation of minority concerns in training programs, service delivery programs, and research endeavors.

(c) The Secretary, acting through the Office, may carry out the provisions of subsection (b) by making grants to, or entering into contracts with, professional associations, universities, nonprofit entities, or State or local agencies.

(d) In carrying out its duties under this section, the Office shall submit an annual report to the Secretary at the end of each fiscal year.

(e) Nothing contained in this section shall be construed to prevent or impair the administration or enforcement of any other provision of Federal law, nor shall this administrative unit be deemed to have exclusive jurisdiction over the department's efforts to develop effective minority health programs.

Specialized Services for the Physically Disabled,
Developmentally Disabled and Mentally Retarded

Sec. 306. The Secretary may make grants to a State Agency, to a State Agency for payments by it to a Core Service Agency, or both, for any one or more of the following:

(a) identifying and removing barriers of all services needed by the physically disabled, developmentally disabled, or mentally retarded, or their families who are or are at risk of becoming mentally ill;

(b) through a Core Service Agency, providing or assuring the provision of mental health service and related support services needed by the physically disabled, developmentally disabled, or mentally retarded and their families who are or are at risk of becoming mentally ill;

(c) assessing and planning to meet the needs of the physically disabled, developmentally disabled, and mentally retarded, and their families, for mental health services and related support services;

(d) training and making accommodations for the physically disabled, developmentally disabled, and mentally retarded to facilitate their placement as employees and volunteers in a community-based mental health system.

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Mental Health Services for Other Groups with
Special Needs, as Determined by the Secretary

Sec. 307. The Secretary may make grants to a State Agency, to a State Agency for payments by it to a Core Service Agency, or both, for services to groups with special needs such as the elderly, women, victims of disasters, mentally ill offenders in state institutions, inmates of state prisons, and their families, victims and perpetrators of domestic violence, and other populations as designated by the Secretary as having special needs for mental health services and related support services.

TITLE IV --- COMMUNITY MENTAL HEALTH SERVICES

Purpose

Sec. 400. The purposes of this title are to assure:

(a) the creation of a system to make accessible to all residents of each mental health services area who choose to use it a coordinated array of comprehensive mental health services;

(b) the initiation and improvement of mental health services for children and youth, the aged, the seriously mentally ill, any racial or ethnic minority, Indians, the poor, rural residents, or any other group with special needs, and the development of comprehensive mental health services for them and all other persons in need in their communities through creating a full array of necessary services where none exist;

(c) the recognition of the close relationship between mental health services and other health or support services;

(d) the maintenance of existing non-revenue producing functions after basic support has terminated and continuation of comprehensive mental health services programs already begun;

(e) the supplementation or improvement of existing services where they are inadequate;

(f) the increase of the flexibility of communities in planning a coordinated comprehensive network of services in defined geographic areas which assures continuity of care and provides a known entry point into the system.

Preparation for Provision of Services

Sec. 401. (a) For the purpose of assisting public or non-profit private entities to prepare for providing mental health services in an mental health services area, the Secretary may make a grant to any such entity for a project to:

(1) compatible with the state mental health plan assess the needs of the area for comprehensive mental health services. Such needs assessment shall give special emphasis to the needs of unserved and underserved priority population groups and to all relevant social and economic conditions. It shall be made only after all interested individuals and groups shall have been given an opportunity to participate in its development; and it shall take into account the goal of delivery of mental health services in the most accessible and least restrictive setting.

(2) design an operational plan for mental health services program for the area based on such assessment; describing the services and assuring their coordination with other mental health, general health and social services.

(3) obtain within the area financial and professional assistance and support for the program; and

(4) initiate and encourage continuing community involvement in the development and operation of the program.

The amount of any grant under this section may not exceed \$75,000.

(b) Only one grant may be made under this section with respect to a mental health services area.

(c) Such grant will be made only with review and comment by the state mental health authority.

(d) No grant may be made under this section with respect to any mental health services area if a grant has previously been made under this title or under the Community Mental Health Centers Act with respect to the same area, or with respect to a catchment area (within the meaning of that term in the Community Mental Health Centers Act) any substantial (as determined by the Secretary) part of which is included in that mental health services area. The prohibition in the preceding sentence does not apply if the earlier grant (referred to therein) under this Act was made under section 402 and the agency has received at least one but no more than four grants under Section 402; or if the earlier grant (so referred to) under the Community Mental Health Centers Act was made under Section 224(b) of that Act as in effect before July 29, 1975. As used in the preceding sentence, the term "comprehensive mental health services" does not include any such service for an area if there is not sufficient need for it in the area, as determined by the Secretary, or if the Secretary determines the need for it is being met.

(e) "Priority for funding under this Section shall be given to agencies receiving grants under Section 402."

INITIATION OF SERVICES FOR THE UNDERSERVED

Sec. 402. (a) The Secretary may make grants to any public or nonprofit private entity for any project for the provision of mental health services to one or more priority population groups. In making such grants under this section, the Secretary shall give preference to any entity serving a mental health services area which has no community mental health center (as defined in the Community Mental Health Centers Act) servicing it and with respect to which no grant has been or is being made or applied for under section 403.

(b) A grant may be made under this section for any project only if:

(1) it is consistent with needs priorities as identified in national and local objectives in the state plan, and is certified acceptable by the state agency responsible for preparation of the state plan.

(2) the entity undertakes after receipt of its initial grant under Section 402(a) to provide at least three of the following mental health services within 90 days which it has determined are most immediately required for at least one priority population group in the mental health services within 90 days which it has determined are most immediately required for at least one priority population group in the mental health services area and which determination conforms to a culturally relevant needs assessment made or approved by the area mental health authority or made

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pursuant to Section 401(a), and is approved by the HSA and the state agency:

- inpatient
- outpatient
- partial hospitalization
- screening
- follow-up
- housing
- consultation and education
- emergency

(3) the entity agrees that within four years from the date of the initial grant it will supply either directly or by contract to such priority population group or groups all the remaining mental health services as listed in 402(b)(1); provided, however, that the Secretary, with the approval of the area mental health authority, the HSA and the state agency, may waive the requirement of or extend the time for supplying one or more of the remaining comprehensive mental health services if he finds there is no substantial unmet need for such service or services in the mental health services area.

(4) the entity demonstrates that the project will lead to increased or more appropriate mental health services for an underserved priority population group or groups or to development of mental health services for an unserved priority population group or groups.

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(5) the entity provides satisfactory assurance that representatives of the priority population group or groups to be served by the project and other interested persons have had a reasonable opportunity to participate in the planning and the development of the proposed project and will be afforded reasonable opportunity to participate in the evaluation of the performance of the entity under the project.

(6) the entity gives satisfactory assurances that it will secure and maintain in effect a contract or agreement with any community mental health center or Section 403 agency in the area. If there is no such center or 403 entity in the area, the Section 402 entity shall agree that as soon as possible after such CMHC or Section 403 entity is created it will secure and maintain in effect such a contract or agreement. The purposes of the contract or agreement shall be (1) to provide, to the maximum extent possible, for the availability to all residents of the mental health services, (2) and for collaborative working arrangements between and among the service agencies, including health and social service agencies.

(7) the entity shall not discriminate against anyone in the services area for whom its services can be appropriately applied. If the Secretary determines that the provisions of paragraph 6 of this section have

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not been complied with, he shall attempt to secure such compliance in cooperation with the entities involved, the area mental health authority, the HSA and the state agency. If such efforts fail the Secretary, after hearing, shall determine whether one or more of the entities which should have been a party to such agreement has unreasonably failed or refused to comply. Upon a finding that one or more of said entities has unreasonably failed to comply the Secretary shall terminate the grant of that entity or entities, and shall not renew or reinstate such grant until he has determined that there has been compliance. In making such determinations the Secretary shall act as quickly as possible after giving the interested parties an opportunity to be heard.

(c) Only five grants may be made under this section to the same entity for mental health services for the same priority population group or groups; and the fourth and fifth such grants may not exceed sixty percent and thirty percent, respectively, of the costs of the project for which the grants are made.

(d) For a further limitation on the number of grants under this section, see section 403(d).

(e) There shall be no more than two entities created pursuant to this section in any mental health service area.

DEVELOPMENT OF COMPREHENSIVE MENTAL HEALTH SERVICES

Sec. 403. (a) The Secretary may make grants to any public or nonprofit private entity for any project to develop mental health services or to expand the mental health services provided by it.

(b) Any such grant may be made for a project for services in a mental health services area only if such entity:

(1) has not recieved, under section 203(a) of the Community Mental Health Centers Act, or under section 220 of that Act as in effect before July 29, 1975, or as continued in effect after that date by section 203(e) of that Act, or under section 406 of this Act, all of the grants available to it under those sections;

(2) "Agrees to provide at least 4 of the following 10 mental health services within 90 days of receipt of funds and provides satisfactory assurances that it will, in accordance with a plan and time schedulw, approved by the Secretary, provide the remaining comprehensive mental health services for the area; provided, however, that after hearings and opportunity to comment be given the area mental health authority, the HSA, the state agency and all interested persons, the Secretary may waive or extend the time for commencement of a service or services if he finds there is no sufficient unmet need in the area for such service or services ---

--inpatient

--outpatient

- partial hospitalization
- screening
- follow-up
- housing
- consultation and education
- emergency
- specialized services for priority population groups as identified in the state plan.

(3) "Provides satisfactory assurances that, in providing comprehensive mental health services for all of the population of the area, special emphasis will be given to priority population groups as determined by a culturally relevant needs assessment made by the area mental health authority or pursuant to Section 401, which assessment shall be in conformity with a needs assessment made by the area mental health authority and in conformance with the state plan.

(4) agrees it will be subject to the provisions of Section 402(b)(5) relating to agreements with Section 402 entities and to the provisions of Section 402(b) relating to the effect of failure to comply with the provisions of Section 402(b)(5)."

(c)(1) Only eight grants may be made under this section to the same entity for services in the same mental health services area; and no such grant (after the first one) may exceed the following percentage of the cost of the project with

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respect to which it is made;

(A) 90 per centum in the case of the second such grant;

(B) 80 per centum in the case of the third such grant;

(C) 70 per centum in the case of the fourth such grant;

(D) 60 per centum in the case of the fifth such grant;

(E) 50 per centum in the case of the sixth and seventh such grant; and

(F) 45 per centum in the case of the eighth such grant.

(2) For purposed of this subsection, a grant under any of the following is considered a grant under this section;

(A) section 406;

(B) section 203(a) of the Community Mental Health Centers Act; or

(C) section 220 of the Community Mental Health Centers Act as in effect before July 29, 1975, or as continued in effect after that date by section 203(e) of that Act.

(d) No grant may be made under this section or section 402 to any entity for services in any mental health services area after the total of the following grants for services

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in that area reaches ten:

(1) grants under this section, section 402, or section 406;

(2) grants under section 203(a) of the Community Mental Health Centers Act; or

(3) grants under section 220 of the Community Mental Health Centers Act as in effect before July 29, 1974, or as continued in effect after that date by section 203(e) of that Act.

(e) "Preference shall be given to a Section 402 agency which applies for a grant under Section 403(a) if such application is made during the second, third or fourth year of the operation of such Section 402 agency."

(f) "The provision of comprehensive mental health services through the Section 403 entity shall be coordinated with the provision of services by other health and social service agencies (including state mental health facilities) in or serving residents of the area. Services may be provided at the entity, or at satellite facilities, through the staff of the entity, or through appropriate arrangement with health professionals and other providers of such services in the mental health services area, or in the case of inpatient, emergency and partial hospitalization services, through appropriate arrangements with health professionals or agencies located within or without the area but readily accessible to residents of the area. All services shall be available and accessible to residents promptly, as appropriate

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and in a manner which preserves human dignity and assures continuity and high quality care and which is in accord with the culturally, economically and socially relevant factors in the area."

(g). Section 403 entity shall establish, in accordance with regulations approved by the Secretary, an ongoing quality assurance program, including utilization and peer review systems; an integrated medical record system which, in accordance with applicable federal and state laws respecting confidentiality, is designed to provide access to all past and current information regarding the health status of each patient and to maintain safeguards to preserve confidentiality and to protect the rights of the patient; a professional advisory board; an identifiable administrative unit responsible for providing consultation and education services."

(h). No grant may be made under this section unless it is approved by the state agency responsible for the state plan as addressing the needs and priorities identified in the state plan.

MENTAL HEALTH SERVICES IN AMBULATORY HEALTH CARE CENTERS

Sec. 404. (a) For the purpose of assisting ambulatory health care centers to participate appropriately in the provision of mental health services to their patients, the Secretary may make a grant to any public or nonprofit private entity which:

- (1) provides mental health services that include at least 24-hour emergency services, outpatient services, and consultation and education services (as described in

section 201(b) of the Community Mental Health Centers Act) and has in effect an agreement of affiliation with an entity which is, as determined by the Secretary, an ambulatory health care center; or

(2) is, as so determined, an ambulatory health care center and has in effect an agreement of affiliation with an entity providing at least the mental health services referred to in paragraph (1).

Such an agreement of affiliation must:

(A) describe the geographical area in which each party to the agreement provides and proposes to provide its services;

(B) provide for employment by the center of at least one mental health professional to serve as liaison between it and the other entity, and include a description of the required qualifications of that person and of any other professional mental health personnel to be employed by the center under the agreement;

(C) provide satisfactory assurances that the entity providing the mental health services will make such services available to patients of the center referred to it by the liaison or other mental health professional; and

(D) include the transportation arrangements and other arrangements for effecting referral to the entity from the center of patients needing the services of such entity.

(b) Any grant under this section may be made for a project for any one or more of the following:

(1) the costs of liaison or other mental health professionals providing services in the ambulatory health care center in accordance with the agreement of affiliation;

(2) mental health services provided by the other personnel of the center which the other entity determines such personnel can appropriately provide;

(3) consultation and inservice training on mental health provided to personnel of the center by the other entity; and

(4) establishing liaison between the center and other providers of mental health services or support services.

(c) Only three such grants may be made under this section for projects involving the same ambulatory health care center and the same entity providing mental health services; and the third such grant may not exceed 75 per centum of the cost of the project for which it is made.

(d) Priority will be given to applications giving consideration to the special needs of priority population groups, consistent with the state plan.

NON-REVENUE-PRODUCING ACTIVITIES

Sec. 405. (a) For the purpose of assisting public or nonprofit private entities to provide, in their mental health

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services areas, mental health services which generally do not generate revenues, the Secretary may make grants to any public or nonprofit private entity which:

(1) has received a grant under section 203(a) of the Community Mental Health Centers Act, or under section 220 of such Act as in effect before July 29, 1975, or as continued in effect after that date by section 211 of that Act, or under section 403 or 406 of this Act; and

(2) because of the limitations on the period for which an entity may receive such grants or on the number of such grants the entity may receive, is no longer eligible to receive such grants.

(b) A grant under this section may be made for a project for any one or more of the following:

(1) consultation and education services described in section 201(b) of the Community Mental Health Centers Act;

(2) activities directed at prevention of mental illness, including education of the general public on matters related thereto;

(3) the additional cost of case finding with respect to members of a priority population group and of assuring that each member of the group receives the mental health services and support services he needs;

(4) coordination of the entity's services with other mental health services and with support services; or

(5) evaluation of the entity's mental health ser-

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ices program.

(6) outreach programs.

(c) A grant may be made under this section to an entity for any project only if the entity provides:

(1) satisfactory assurances that it will sign an agreement of affiliation with any other entity providing mental health services in the same mental health services area and which has received a grant under section 402, if it is requested to do so by such other entity, unless relieved of this requirement by the Secretary because the agreement so requested is unreasonable;

(2) a satisfactory plan approved by the state Mental Health Authority describing the steps it proposes to take in order to obtain financing from other sources for the activities included under the project when financing therefor is no longer available under this section; and

(3) satisfactory assurances that it will give priority under its mental health services program to meeting the needs of priority population groups.

(d) No grant may be made under this section unless it is approved by the state agency responsible for the state plan as addressing the needs identified in the state plan.

(e) No grants under this section may exceed an amount equal to \$1.50 multiplied by the population (as indicated in the State's plan approved under this Act) of the mental health services area of the recipient.

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AMENDMENTS TO COMMUNITY MENTAL HEALTH CENTERS ACT

Sec. 406. (a) For the purpose of assisting public or nonprofit private entities to continue to provide mental health services, the Secretary may make project grants to any such entity which received a grant under section 203(a) or (e) or 211 of the Community Mental Health Centers Act and which would be eligible for another grant thereunder from appropriations for any fiscal year ending after September 30, 1979, if such appropriations were made. The number of such grants which may be made to any entity, and the amounts thereof, are, respectively, the number and the amounts prescribed under that section; and such grants shall be made in accordance with the other terms and conditions applicable to grants under that section, except as provided in subsections (b) and (c) of this section.

(b) No grant may be made under this section to any entity unless it provides satisfactory assurance that it will comply with the provisions of Section 403(b)(4).

Sec. 407. "No grant may be made under Section 402 or 403 of this title until a culturally relevant needs assessment has been made for the mental health services area either under Section 401 or under a state plan approved by the Secretary."

GOVERNING BODIES OF LOCAL AGENCIES

Sec. 408. No entity is eligible for a grant under title IV, other than section 401, unless it meets the requirements applicable to a community mental health center under subpara-

graph (A) or (B) of section 201(c)(1) of the Community Mental Health Centers Act, whichever is applicable, and, in case such subparagraph (A) is applicable, it provides satisfactory assurances that it will meet the requirements applicable to such a center under clause (ii) of such subparagraph (A).

EXTERNAL ADVOCACY PROGRAMS

Sec. 409. To assist in the protection of the rights of persons receiving mental health services, the Secretary may award funds to public agencies or nonprofit corporations to provide mental health advocacy services.

(a) Such advocacy programs could be of two types:

(1) an internal system to assist the agency that funds treatment services or determines policy to:

(A) establish administrative and legal remedies to ensure the protection of the rights of persons receiving mental health treatment or related services on a state operated mental health program/facilities.

(B) establish training programs for mental health treatment personnel to ensure their understanding of patients' basic rights and treatment programs.

(2) an external system independent of any agency which funds or provides treatment or other services to persons with mental disabilities,

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or which determines policy for provision of such services to

- (A) have the authority to pursue administrative and legal remedies to ensure the protection of rights of persons who are receiving mental health treatment or related services, who are in need of such services, or who are regarded as having a mental illness.

(b) The Secretary shall promulgate promptly guidelines for such advocacy programs, and shall assure compliance with this Act and with such guidelines, which shall include but not be limited to:

- (1) active client involvement in program design and policy;
- (2) a full time staff, including at least one lawyer; and
- (3) cooperation with legal services and other advocacy organizations.

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TITLE V -- MISCELLANEOUS

Authorization of Appropriations

Sec. 500. (a) There are authorized to be appropriated
for grants under

NCASA

NATIONAL COALITION AGAINST SEXUAL ASSAULT

Statement for the Record

Hearings on Mental Health Systems Act

Before the Subcommittee on Health and Scientific Research
June 11, 1979

Re: S 621

"Service Funding for Victims of Rape"

by

Sandra K. Lambert
Coordinator
National Coalition Against Sexual Assault

Steering Committee of NCASA:

Katherine Hummer, State Coordinator
Sexual Assault Victim Services
Raleigh, NC

Pam Klein, Director
Rape and Sexual Assault Care Center
Edwardsville, IL

Sandra K. Lambert, Director
Pa. Coalition Against Rape
Harrisburg, PA

Anne Pride, Coordinator
Pittsburgh Action Against Rape
Pittsburgh, PA

Peggy Spector, Director
Minnesota Program for Victims of Sexual Assault
Minneapolis, MN

P. O. BOX 585 HBG. PA 17108

My name is Sandra K. Lambert and I am the coordinator of the National Coalition Against Sexual Assault and the executive director of the Pennsylvania Coalition Against Rape.

My involvement in the rape crisis movement extends back to 1974 where I helped in the development of a center in Reading, Pennsylvania. I later served as the executive director of the Harrisburg Area Rape Crisis center for three years. Over these past five years, I have witnessed and been a part of a movement that has helped thousands upon thousands of victims and has reshaped social thinking and action. Today, the movement has a structure in the state and national coalitions. But the movement is facing one major stumbling block that could erase all that has been accomplished. That is the issue I will address.

Violence against the person has escalated at a staggering pace during the last decade. Of these violent personal assaults, the incidence of rape has risen most quickly. Between 1970 and 1975 the number of rapes reported to police departments across the nation doubled. In the Commonwealth of Pennsylvania, rape was the only violent crime to show an increase in the years 1976 and 1977. The 1978 figures exhibited a decrease of 1.8% or 41 victims less than the previous year. However, for this past five year period in Pennsylvania rape increased 4.3%. For all those figures, it must be kept in mind that for every rape reported to a law enforcement agency, the F.B.I. estimates that three to ten rapes may actually have occurred.

On February 22, 1978, Senator Mathias of Maryland, speaking on behalf of his proposed legislation to provide federal funding for programs that furnish services to victims of sexual assault, stated that the odds are better than one in fifteen that a woman will be raped in her lifetime.

It is obvious that available statistics, from whatever source, are a reflection of only a small number of sexual assaults; that have occurred. Too many victims are choosing not to become part of the criminal justice system.

In the early 1970's the first rape crisis centers began their development in New York and Washington, D.C., and Pennsylvania in Philadelphia and Pittsburgh. These burgeoning centers initially developed with the perspective of educating the system to be more responsive and sensitive to the needs of sexual assault victims. By offering emotional support to the victim and advocating for her in the system. The system's patterns would be changed to benefit the victim. It was acknowledged that once society was sensitized, the goals of rape crisis program would be met.

At that early stage there were hospitals that refused to accept sexual assault victims - for emergency room treatment. The medical treatment that was provided often was delivered with insensitivity and blatant disregard for the dignity and rights of the victim. The evidence gathering was frequently haphazard and of little legal value.

Law enforcement personnel had no training nor understanding of sexual assault. Few arrests were made.

District attorneys were often left with no choice but to drop a case, especially when medical and police evidence and reports simply were not convincing material to present to a district justice or a jury. Rape cases were viewed as not being beneficial to a prosecutor's career since convictions were dismally low.

The victim suffered at the hands of this system that further victimized her emotionally. Antiquated laws, a lack of family and peer support, and a callous society deepened her conviction to not press charges. And if she chose to prosecute juries that held beliefs in myths and stereotypes and half - truths about rape and its victims, more often than not, presented her with not guilty verdicts or a hung decision.

Clearly, an agency was needed to begin to meet the needs of the sexual assault victim. Rape crisis centers become the catalyst for change. Professional training began and cooperation grew between the centers and the criminal justice system. An inter - institutional approach proved successful. Public education eroded those once commonly accepted myths and stereotypes. Hotlines and accompaniment through the system were provided for victims. Follow - up counseling became available not only for the victim but for the significant others in her life. Communities supported these centers and the awesome responsibilities they had assumed.

Obviously, that initial perspective of a short-term intensive advocacy and education thrust as the permanent cure for easing a woman's victimization was all too quickly understand as being narrow in focus.

Even if every emergency room doctor and nurse, every police officer and detective, every district attorney and district justice, and every member of the public were truly sensitized to the victim's needs, there still existed little or no coordination between the system parts to make the transition stages between those parts easier. There was no one to assume responsibility for continuous and long term care with respect to the offshoots of that woman's victimization. No one existed to offer emotional support and information, to help that woman to begin to regain control of her life; the criminal justice system was not built to provide victim care, but justice. And there was no one to deliver educational programs as a meaning of prevention.

Rape crisis centers expanded their outlook to encompass that long term recovery process, to coordinate the professional community's response to the victim, and to provide education. The elimination of these centers would set communities back to those early 1970's and future victims would, once more, be isolated, alone confused and traumatized.

But the elimination of rape crisis centers is happening and the future for those remaining is bleak. Too many find themselves in a hand-to-mouth existence. VISTA, CETA, Title XX, LEAA, and private foundations always provide only partial funding. LEAA a major funding source can provide funds for a set period of years, often with the centers needing to raise an ever increasing amount of matching funds. With the current reorganization of LEAA'S priorities, rape crisis program face new obstacles to this funding. Private foundations usually will give grants only

for a specific purpose. Thus, rape crisis centers with a proven record of community and victim service are now in the position of being ineligible for LEAA and must search out new funding sources to continue the quantity and quality of services arrived at over a period of several years. In addition, enormous - energy is being used writing grants and proposals that could be diverted into service provision.

There are few communities that can absorb the rape crisis centers funding needs; often the local tax base prohibits this from happening. Municipalities fund these programs last, and in a budget squeeze, those programs are the first to go.

While financial resources dry up, programs continue to provide 24 hour quality care primarily with volunteer energy and perhaps supporting CETA people coordinating. In smaller communities, this type of survival is possible for a limited period of time. But in larger towns and metropolitan areas, a lack of funding severely curtails service provision and can cause a program to fold.

Continuous financial support must be made available. The accomplishments of the rape movement should serve to illustrate the importance of their existence now and in the future. The following were the result of development by rape crisis centers, in conjunction with centers, or pressure by the programs.

A "Bill of Rights" setting forth guidelines for the treatment of sexual assault victims has been drawn up. Within the hospital system, guidelines and forms have become more standardized, and rape evidence kits are being used more and more. Medical

corroboration as a result, is now more valid and valuable for prosecution.

Some law enforcement agencies contain specialized sex crime units, and some district attorney's offices also have special prosecution units for sexual assaults. Initial and in - service training on sexual assault are provided for police on the local, regional, state and national level. Strategy guidelines for successful prosecution have come into existence, which often include working more closely with the victims and their families. The result is more convictions.

Speakers bureaus are carrying out community and professional education. Workshops and packets for schools, self defense and prevention courses, and programs and training modalities for agency, institution and government personnel are sensitizing and increasing the awareness of countless numbers of the population.

Publications and films on such topics as the development of a rape crisis center, collection of medical evidence, recognition and treatment of child victims, long term counseling techniques, the writing of press releases and grants and infinite other subjects are resources for anyone needing them.

Special populations of victims and their needs, such as children, elderly, and minorities, have been identified and outreach techniques and specialized responses to them have been developed.

Antiquated laws are coming off the books and are being replaced by legislation beneficial to the needs of victims. The drafting and passage of such legislation has often been the result of the education and lobbying of rape crisis centers and enlightened citizens.

Legislation providing for the confidentiality of center records has been passed in some states, as well as the establishment of victim compensation programs.

Victim - witness programs, patterned after rape crisis centers or expanded from such centers, have been developed to assist victims of all kinds through the emotionally trying atmosphere of testifying.

Research on the rape trauma syndrome, counseling modalities, victim services, and center accountability have been conducted. Money for research and demonstration projects has been made available through the establishment of the National Center for the Prevention and Control of Rape. The National Center has awarded millions of dollars, not to community center professionals but to institutional professionals unconnected with the rape crisis movement.

Trial monitoring programs, task forces on rape in universities, women's clubs and government agencies, and state-wide voluntary coalitions, such as those in Illinois and Maryland are addressing the needs of victims and the issues facing them.

In North Carolina and Pennsylvania, funded state coalitions provide technical assistance and support to existing rape crisis centers and newly developing programs, and serve as a resource of materials and programs not only for their centers, but also for communities and professionals.

The National Coalition Against Sexual Assault was formed in August of 1978 at the NOVA conference in Minneapolis. Fifty-seven programs from thirty-one states established the National Coalition as a network to share the experiences, expertise, and knowledge gained during the past years and to be a broad-based force for still-

needed social and legislative change.

These accomplishments are valid cause for the necessity of the continuity of the current service providers. Rape crisis centers have first-hand experience and established credibility to substantiate the need for their existence. Their existence is threatened by financial starvation.

Two avenues for possible relief are frequently acknowledged. One is the National Center for the Prevention and Control of Rape. As mentioned, the National Center is mandated to award monies for research and demonstration projects, not for direct service provision. The other avenue is the mental health system. In the minds of many, there still lingers a stigma to seeking aid from a mental health agency. A victim of rape, further, does not have what can be termed a mental health problem but rather a victimization problem. The mental health stigma, coupled with a victim's fear of the criminal justice system, of which mental health agencies are seen as a part, may prevent victims from utilizing mental health resources. Rape crisis centers, if part of the criminal justice would be hampered in their current role of providing advocacy for the victim; it's not easy to "rock the boat" from within. Last, rape crisis centers have in the mental health planning system nor does there exist currently a mechanism within the mental health system for the support of rape crisis centers.

Rape crisis centers need to retain their autonomous identities. Their history of accomplishments and their current credibility is a reflection of what can be done in the future, with a permanent source of funding. S 621, sponsored by Senator Mathias is at this time, the only feasible solution to rape crisis center's funding problems, while allowing them to continue their autonomy. Eight hundred programs providing services to over 40,000 persons annually and education to tens of thousands of the general public and the professional community cannot be allowed to die.

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
TRENTON, N.J. 08625

January 29, 1979

Dr. Stuart Shapiro
Subcommittee on Health &
Scientific Research
Dirksen Senate Office Bldg.
Room 4220
Washington, DC 20510

Dear Dr. Shapiro:

I would like to testify before the Senate Subcommittee on Health and Scientific Research which will soon hold hearings on new mental health services legislation. I believe that the Subcommittee would be interested in learning of some innovative approaches New Jersey has taken to develop an integrated community based system of mental health services.

Like many other states, New Jersey has had to cope with the problems created by the deinstitutionalization of public mental hospitals in the 1960s. Since 1975, our Department has had a policy of planned discharge, community support services and follow up care. Prior to that time, however, many deinstitutionalized persons were not adequately cared for once they returned to their communities and were vulnerable to a variety of abuses.

The Department's goal is to reach the underserved mentally disabled in the community and to enable the unnecessarily institutionalized to return to a more normal environment. To create this comprehensive community mental health and life support system, the Department has set a policy of unified services in which all providers, through affiliation agreements, have clearly defined roles and responsibilities. We have developed numerous programmatic innovations, of which a few examples are listed below:

- Community Care Contracts and Community Support Programs - New Jersey currently has Community Care contracts with about 60 non-profit agencies to provide services to 5,700 chronically mentally ill persons at a cost of \$10.5 million per year. This program provides social support services which permits these persons to remain in, or return to, normal life in their home communities. Beyond community mental health care, other services include case management, income maintenance counseling, aid in using community resources, such as recreation and transportation,

COMMISSION FOR THE BLIND
AND VISUALLY IMPAIRED

MEDICAL ASSISTANCE
AND HEALTH SERVICES

MENTAL HEALTH
AND HOSPITALS

MENTAL
RETARDATION

PUBLIC
WELFARE

VETERANS PROGRAMS
AND SPECIAL SERVICES

YOUTH AND
FAMILY SERVICES

and housing, vocational and legal services. Other states have requested technical assistance from us to develop similar programs.

The Department is also administering an NIMH-funded Community Support program in 11 counties. Similar to the Community Care contracts, these demonstration projects assist local providers in identifying other resources to create a comprehensive support system for the deinstitutionalized. The impact of this program has widened beyond the demonstration counties, and a state level inter-agency task force may be established to increase such coordination throughout New Jersey.

- Greystone Normalization Program - The purpose of this program is to ease the transition of institutionalized persons to the community. It will eventually consist of 25 family style houses, each accommodating six to eight persons, on the grounds of a state psychiatric hospital. Some of these persons are not yet ready for discharge but need transitional resocialization activities in a homelike environment. Community involvement is encouraged through out-patient appointments, shopping, work placement, and other day activities. We are also expanding this program to the other state hospitals by converting staff housing to transitional residences which enhance normalization.

This program is unique in the United States. HEW has cited it as a significant alternative to the traditional ward environment. We expect that this project will result in much earlier discharges of individuals and fewer readmissions.

- HUD Deinstitutionalization Grant - New Jersey has been selected to receive a demonstration grant from HUD's Office of Independent Living to improve housing and related services for discharged mental patients. Five non-profit sponsors are renovating and constructing 43 units at a cost of \$1.3 million. These residences will contain service components to assist the deinstitutionalized.

- Solutions to the Boarding Home Problem - Many of New Jersey's ex-mental patients reside in boarding homes. Some of these facilities are licensed and provide adequate non-medical personal care to adults who need a sheltered living environment. However, many individuals live in unlicensed boarding homes where they receive little care and are sometimes abused by unscrupulous landlords. In recognition of this problem, New Jersey established a task force to improve the quality of care in these facilities.

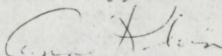
This task force, on which the Department is represented, has proposed comprehensive state legislation to remedy this problem. At our request, Senator Williams has co-sponsored federal legislation which would allow variable rate reimbursement of boarding homes according to the quality of care provided.

In the interim, we have expanded our transitional services and monitoring of boarding homes and are coordinating them with services provided by other State departments and local agencies.

The State of New Jersey is strongly committed to the concept of deinstitutionalization and integrated community-based mental health services. We are concerned, however, that the public may become unsupportive of this program due to inappropriate placements and lack of resources to adequately serve the chronically mentally ill in the community.

We have begun to find some creative solutions to these problems. We would like to share some of these solutions, as well as a few of our problems, with the Subcommittee.

Sincerely,



Ann Klein
Commissioner

AK:13



State of New Jersey

DEPARTMENT OF THE PUBLIC ADVOCATE

STANLEY C. VAN NESS
PUBLIC ADVOCATE

P. O. BOX 141
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June 19, 1979

TEL. 609-292-7087

Honorable Edward M. Kennedy
Chairman
United States Senate Subcommittee
on Health and Scientific Research
Senate Office Building
Washington, D.C. 20515

Dear Senator Kennedy:

Enclosed please find testimony which I am submitting for your consideration with regard to S.1177, the Federal Community Mental Health Systems Act.

Respectfully yours,

Stanley C. Van Ness
Stanley C. Van Ness
Public Advocate

SCVN:mha

Enclosure

TESTIMONY ON S.1177, PREPARED FOR THE
UNITED STATES SENATE SUBCOMMITTEE
ON HEALTH AND SCIENTIFIC RESEARCH

Stanley C. Van Ness
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Department of the Public Advocate
520 East State Street
Trenton, New Jersey 08625

June 19, 1979

Mr. Chairman, I am submitting this testimony to urge the Committee to adopt amendments to S.1177 in order to both provide for a comprehensive, national system of advocacy services for the mentally handicapped, and to create a Federal "bill of rights" for all such persons. The adoption of such amendments is absolutely essential if the aim of the President's Commission on Mental Health -- to "assure that mental health services and programs operate within basic principles protecting human rights and guaranteeing freedom of choice"¹ -- is to be met, and if the spirit of the President's recent message to Congress in support of this legislation -- "to assure that the chronically mentally ill no longer face the cruel alternative of unnecessary institutionalization or inadequate care in the community"² -- is to be fulfilled.

The President aptly characterized S.1177 as "a new course for mental health care which promises comprehensiveness, flexibility, and innovation,"³ an assessment with which I completely concur. However, as part of this new course, it is absolutely vital that our commitment be extended to protect those civil and constitutional rights similarly accurately characterized by the President's Commission as "among the most basic principles of society."⁴

¹ President's Commission on Mental Health, Report viii (1978) (letter of transmittal to President Carter from Thomas E. Bryant, Commission chairperson). (hereinafter PCMH Report)

² "Message from The President," House Doc. No. 96-125, 96th Cong., 1st Sess. (May 15, 1979), at 1 ("Mental Health Systems").

³ Id. at 3.

⁴ PCMH Report, note 1, above, at 42.

In the furtherance of its duties, the President's Commission took extensive testimony at national hearings and appointed key task force panels to prepare in-depth reports as part of its intensive examination of all aspects of mental health care, service delivery, and the full panoply of legal and ethical issues involved. Throughout the hearings and the task panel reports, the need for an effective advocacy system and for protective Federal legislation to insure the basic rights of the handicapped was underscored again and again. These sentiments are in full accord with our experiences in the New Jersey Department of the Public Advocate, specifically in our Department's Division of Mental Health Advocacy. I would like to share these experiences with you to help explain why I think the amendments in question are absolutely essential.

It would be charitable to characterize legal representation of patients at mental hospitals in New Jersey prior to 1974 as sporadic. More realistically, with several exceptions, such representation was virtually non-existent. The realization of this gap (actually a vacuum) was probably among those factors which spurred the creation of a new agency to provide broad-based legal services to those psychiatrically institutionalized.⁵

The Department of the Public Advocate was established by the New Jersey Legislature in 1974 in an attempt to create an agency for those persons either disenfranchised, institutionalized, and/or puzzled by the whole mass of governmental rules, procedures, and folkways, to make the government more responsive to the individual, and to attempt to reverse the trend of what

⁵ See generally, for a full discussion, Van Ness and Perlin, "Mental Health Advocacy: The New Jersey Experience," in Kopolow and Bloom, eds., Mental Health Advocacy: An Emerging Force in Consumers' Rights 62 (1977); Van Ness and Perlin, "Mental Health Advocacy," in Kern ed., Medico-Legal Digest for New Jersey Psychiatrists, ch. 17 (1979).

a sociologist might call "bureaucratic anomie."⁶ It includes a Division of Mental Health Advocacy,⁷ which has two primary statutory functions: It "may provide . . . legal representation . . . for any indigent mental hospital admittee⁸ in any proceeding concerning the admittee's admission to, retention in or release from confinement in . . . [a mental hospital or a similar facility],⁹ and it "may represent the interests of indigent mental hospital admittees in such disputes and litigation, as well . . . best advance [their] interests as a class on an issue of general application to them."¹⁰ This dual responsibility is an indicia of a legislative feeling

⁶ See N.J.S.A. 52:27E-1 et seq. The Department is discussed more fully in Perlin and Siggers, "The Role of the Lawyer in Mental Health Advocacy," 4 Bull. Am. Acad. Psych. & L. 205 (1976); Note, "The Office of Public Counsel: Institutionalizing Public Representation in State Government," 64 Geo. L.J. 895 (1976); Penn, "Advocate from Within," 12 Trial Mag. 20 (February 1976); Heffner, "Legislative Oversight: An Analysis of L. 1974, Chapter 27, Department of the Public Advocate Act," Seton Hall Leg. J., Vol. 1, No. 2 (Summer 1976), at 75; Note, "The Department of the Public Advocate -- Public Interest Representation and Administrative Oversight," 30 Rutgers L. Rev. 386 (1977).

⁷ N.J.S.A. 52:27E-21 et seq.

⁸ The phrase "indigent mental hospital admittee" means, within this statute, inter alia, "a person who . . . is the subject of an action for admission as provided by R.S. 30:4-27 [New Jersey's commitment statute] and who does not have present financial ability to secure competent legal representation and to provide all other necessary expenses of representation," N.J.S.A. 52:27E-23. Means of determination of indigency are specified at N.J.S.A. 52:27E-27.

⁹ N.J.S.A. 52:27E-24.

¹⁰ N.J.S.A. 52:27E-25.

that the problems of persons involved with the mental health system have two dimensions: on the one hand, the threshold issue of whether a person should be committed (and, if committed, whether he should be retained there), a question which turns on the facts peculiar to the patient's own case, and, on the other, the broader inquiry of whether a group of patients have a specific right, and, if they do, whether they have been deprived of it: It is best through the mechanism of the class action¹¹ that this right can be properly litigated.¹²

Given its discretionary grants of power, the Division of Mental Health Advocacy has established field offices in Mercer County, Essex County, and Camden County and a class action office in Trenton with statewide jurisdiction. Its offices are staffed by an equal amount of mental health professionals and lawyers: The nonlawyers include two Ph.D.'s in psychology, a Ph.D. candidate and an M.A. candidate in that field, five M.S.W.'s, a psychiatric nurse, four persons with B.A.'s in social

¹¹ For graphic cases of such class actions, see e.g., Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971), 334 F. Supp. 1341 (M.D. Ala. 1971), 344 F. Supp. 373 (M.D. Ala. 1972), 344 F. Supp. 387 (M.D. Ala. 1972), aff'd sub. nom. Wyatt v. Aderholt, 503 F. 2d 1305 (5 Cir. 1974); New York State Association for Retarded Children v. Rockefeller, 357 F. Supp. 752 (E.D.N.Y. 1973), supplemented sub. nom. New York State Association for Retarded Children v. Carey, 393 F. Supp. 715 (E.D.N.Y. 1975).

¹² In this regard, it is worth noting that the individual-versus-class advocacy issue is one which has been vexing the advocacy community of late. Although it is clear that class actions create more of an impact than many individual actions, see, e.g., those cases cited at note 11, above, it has been suggested by prominent citizen advocates -- including Dr. Elizabeth Boggs -- that strategies based upon "systems advocacy," see Eklund, "Systems Advocacy" (Kansas U. Affiliated Facil. Publ. 1976), run the danger of "sacrific[ing] the good of the individual to the welfare of the group," Boggs, "Collective Advocacy (Systems Advocacy) v. Individual Advocacy," (paper prepared for presentation at the Conference on Developmental Disabilities, Advocacy and Protective Services, Washington, D.C., October 13, 1976), at 2. Obviously, a proper balance must be achieved.

work or a related field, and two persons with A.A.'s with many years of mental health experience. Such a professional mix was seen as absolutely vital in the establishment of an agency. In addition, funds are made available for the hiring and retuention of psychiatric and other medical expert witnesses for both individual and class actions.¹³

In those counties in which field offices are operative,¹⁴ representation is afforded to every indigent person facing involuntary civil commitment hearings,¹⁵ seeking a habeas corpus release hearing,¹⁶ and seeking a periodic review hearing,¹⁷ as well as to selected individual right to treatment/ patients' rights complaints.¹⁸ In addition, the Essex and Mercer field offices of the Division have assumed representation of all patients in those counties whose commitment followed a finding of "not guilty by reason of insanity"

¹³ Indeed, one of the Division's first major cases established the right to an independent psychiatric evaluation at County expense prior to involuntary commitment. In re Alfred, 137 N.J. Super. 20, 347 A. 2d 539 (App. Div. 1975).

¹⁴ The Essex office represents Essex County residents, the Mercer office represents Mercer and Hunterdon County residents, and the Camden office -- denominated the South Jersey Field Office -- represents Camden, Salem and Gloucester County residents.

¹⁵ See N.J.S.A. 30:4-27 et seq.; N.J. Ct. R. 4:74-7(c) (revised September 8, 1975).

¹⁶ See N.J.S.A. 2A:67-13(e).

¹⁷ See New Jersey Supreme Court, Administrative Memorandum #4-74 (November 1974); N.J. Ct. R. 4:74-7(f) (revised September 8, 1975).

¹⁸ See e.g., N.J.S.A. 30:4-24.1 (1975), and In re D.D. 118 N.J. Super. 1, 285 A. 2d 283 (App. Div. 1971).

Although this category has been numerically relatively small, it has included matters in which patients have petitioned courts to stop unwanted treatment, In re Kolodka, ESCC L395-75 (Essex Cty. Ct. 1975), and in which patients have requested that they be allowed to receive specific treatment, In re G.G., MECC L164-75 (Mercer Cty. Ct. 1975). These cases are discussed in some depth in Perlin, "The Right to Refuse Treatment in New Jersey," 6 Psychiatric Annals 300 (1976). See also, Rennie v. Klein, 462 F. Supp. 1131 (D. N.J. 1978).

pursuant to the State Supreme Court's decision in State v. Krol,¹⁹ in which the court had declared unconstitutional the statutory scheme for committing patients formerly referred to as "criminally insane," and of all such patients at periodic review hearings, mandated by the State Supreme Court's recent decision of State v. Fields.²⁰

In all, of the 9318 cases litigated to a conclusion from the time of the Division's creation in the summer of 1974 until January 1979, the Division was successful in 6659, or 71% -- if periodic reviews are excluded, staff attorneys prevailed in 4843 of 6207 cases, or 78%.²¹ This success rate -- which has been constant since the office's creation -- has reaffirmed our views that representation, to be meaningful, must be implemented on a regular basis through an organized, standardized mechanism. This conclusion is based on three parallel and interlocking theories: The significance of the presence of counsel in the ultimate disposition of involuntary civil commitment cases is clear; an organized form of counsel service delivery is preferable to assigned counsel, and, in a related area -- representation of indigents charged with crimes -- organized counsel has proven to be more economical, more efficient, and more protective of constitutional rights than had been assigned counsel.

Our early experiences, also, have led to some early conclusions: There is a clear need for comprehensive reform; institutional care is still often substandard; there exist insufficient community alternatives (and those that

¹⁹ 68 N.J. 236, 344 A. 2d 289 (1975).

²⁰ 77 N.J. 282, 390 A. 2d 574 (1978).

²¹ N.J. Dep't of the Public Advocate, "1978 Annual Report," 13 (1979).

exist cannot reach a significant percentage of the state hospital population); the need for deinstitutionalization programs at state hospitals is acute; gross deprivations of civil rights are still all too common; the high percentage of "victories" (a word meant to be read with quotes around it) merely underscores the depths of the need for procedural reforms and the significance of the presence of counsel in the system, and, finally, all of these problems must be tackled on a broad-based, national level if long-lasting change is to be instituted.

When I submitted testimony to the President's Commission more than two years ago, after recounting these experiences, I specified certain areas as "partial solutions [which] may serve as a palliative for some of the more egregious conditions and situations":²²

A national commitment to insure all basic, civil, human, constitutional and social rights for all institutionalized persons. In addition to the right to treatment, there are other equally-important rights which have not been afforded to a significant number of patients throughout the country: the right to freedom from harm, the right to the least restrictive alternative setting for treatment, and the whole gamut of other civil rights including, but not limited to, the right to refuse certain treatment, the right to be informed of the effects of medication, the right to be compensated for institutional work done, the right to register to vote, and others. Institutionalization does not, need not, and should not, imply incompetency; the fact that a person is hospitalized is no reason in and of itself for that person to be denied the same civil rights each of us enjoys. Just as there has been a rise in consumer and citizen awareness in areas involving civil rights, inmates' rights, and consumer rights, so has there been a significant increase of consumer awareness in mental health matters. This new awareness is further reflected in litigation by which

²² Van Ness, "Testimony Prepared for the President's Commission on Mental Health," (Philadelphia, Pa., May, 1977), at 6 (emphasis in text).

one of the most traditionally voiceless of all minority groups seeks relief via the courts as a means of redressing civil grievances and attempts to join -- finally -- the mainstream of the majoritarian, democratic political system. Again, a strong national policy expressing a commitment for the maximum implementation of those rights is essential.²³

* * *

In addition to these substantive reforms, however, it is my feeling that there must be one additional procedural reform which this Commission should consider: the need to recommend some sort of mechanism whereby all patients have regular access to counsel serving as their advocate as a means of reaching outside the system for an examination of situations in which the patient's rights as an individual citizen may have been violated. The [experiences] of our Division of Mental Health Advocacy [in representing the handicapped] are not startling -- they merely reflect the critical (sometimes nearly dispositive) role counsel plays in commitment proceedings, a phenomenon documented in scores of legal and behavioral studies. There is no reason to believe that these results would not be replicated in every state if a system consisting of rigorous, independent, specialized, full-time mental health advocates -- lawyers and non-lawyers alike -- would be put in place.

. . . [L]egislation which would provide for representation [of] all persons institutionalized because of mental disability (or alleged disability) . . . would give all patients the opportunity to have their status examined, to air their grievances, and to have contact with that "someone on the 'outside' who is concerned about [their] . . . fate after hospitalization[;]" . . . it would be, it is hoped, a bona fide attempt to effectuate meaningful, long-term and permanent change in both individual cases and the system as a whole.²⁴

Our experiences in the past two years since I testified have merely reaffirmed in my mind the need for both a bill of rights provision and a strong advocacy network. Out continuing successful representation of

²³ Id., at 7-9 (footnotes omitted).

²⁴ Id., at 12-13 (footnotes omitted).

individuals in such matters as the right to treatment,²⁵ the right to refuse the administration of psychotropic medication in a non-emergency situation,²⁶ the right to periodic review of commitments following "not guilty by reason of insanity" verdicts,²⁷ specificity of criteria appropriate to a definition of dangerousness,²⁸ the right to full recission of a lien entered following an improper commitment,²⁹ the right of a patient to avoid appointment of a guardian ad litem absent a judicial determination of incompetency,³⁰ the right of alcoholic patients to SSI disability benefits,³¹ and the inapplicability of the criminal escape statutes to "walkaways" by civilly committed patients,³² have emphasized again to us the impact of a regularized, comprehensive, external advocacy service, and the importance of an omnibus patients' bill of rights.

Thus, I was gratified that the Commission's Task Force Panel on Legal and Ethical Issues specifically recommended "a system of comprehensive advocacy services for mentally handicapped persons,"³³ relying heavily on the New Jersey system in sketching out its model.³⁴ In the "Protecting Basic

²⁵ Doe v. Klein 1 Ment. Dis. L. Rptr. 476 (N.J. Super. Ct., Law Div. 1977).

²⁶ Rennie v. Klein, 462 F. Supp. 1131 (D. N.J. 1978).

²⁷ State v. Fields, 77 N.J. 282, 390 A. 2d 574 (1978).

²⁸ In re R.B., 158 N.J. Super. 542, 386 A. 2d 893 (App. Div. 1978).

²⁹ Id.

³⁰ In re S.W., 158 N.J. Super. 22, 385 A. 2d 315 (App. Div. 1978).

³¹ In re Minus, Docket #142-24-534 (Dep't of H.E.W., Soc. Sec. Admin., Bur. Hrgs. & Appls. 1979).

³² State v. Kyles, 166 N.J. Super. 343, --A. 2d-- (App. Div. 1979).

³³ 4 App., Task Panel Reports Submitted to the President's Commission on Mental Health 1359, 1366 (1978) (hereinafter PCMH Task Panel Reports).

³⁴ Id., at 1367-1369. Michael L. Perlin, Esq., Director of the Division of Mental Health Advocacy within this Department, served as a member of the Task Force.

Rights" section of its final report, the President's Commission similarly specifically recommended "[t]he establishment of advocacy systems for the representation of mentally disabled individuals."³⁵

In urging the creation of a comprehensive advocacy system, the Commission's Task Force Panel set out the basic controlling legal and moral principles:

The need for and significance of legal counsel as a means of ensuring "equal access to justice" is the cornerstone of the American judicial system, extending to matters involving a potential "substantial loss" or "serious legal consequences." Such a need for counsel is, of course, magnified in cases involving mentally handicapped persons, both in matters involving institutionalization and its potential consequences as well as non-institutional problems which relate in any way to the person's "deviant status."³⁶

Again, this need for counsel is made more acute by the paucity of legal services traditionally made available to the handicapped. In a recent major study of the same problem in an analogous field -- adequacy of services available to retarded persons -- Stanley Herr has surveyed the area and concluded, bluntly, that "traditional models for delivering legal services [to mentally retarded people] have failed,"³⁷ characterizing "the gap between advocacy needs and advocacy resources" as "shockingly wide."³⁸ Only through a national-level commitment to the provision of vigorous advocacy services to all handicapped persons can this gap be closed.

³⁵ PCMH Report, note 1, above, at 42.

³⁶ PCMH Task Panel Reports, note 33, above, at 1366 (footnotes omitted); see generally, for a recent comprehensive discussion, Houseman, "Equal Protection and the Poor," 30 Rutgers L. Rev. 887, 888-891 (1977).

³⁷ Herr, The New Clients: Legal Services for Mentally Retarded Persons 118 (1979).

³⁸ Id., at 199.

Also, I would respectfully suggest that this Committee carefully consider the advocacy model specifically suggested by the Commission's Task Force:

The panel suggests that the Commission endorse a Federal mechanism or, in the alternative, urge States to develop advocacy systems which are (1) able to respond to the legal needs of mentally disabled persons and (2) independent of providers of mental health and developmental disability services. An essential feature of such advocacy systems should be their effort to provide a continuity of legal services to such persons at all stages of their contact with the mental disability system. Such advocacy systems should provide services at involuntary-commitment proceedings and to institutionalized persons of all ages, as well as to community residents, in matters involving institutionalization (commitment, release, treatment issues), the fact of present or former institutionalization (availability of economic benefits, aftercare, denial of civil rights, employment, education issues), and other matters related to the existence -- or perceived existence -- of a handicap (domestic relations, contracts, wills, tenancy issues). In addition to attorneys (an "indispensable element in seeking and securing many types of remedies"), the advocacy system should be staffed by persons trained as "mental health professionals" (e.g., social workers and psychologists who provide advocacy services), by lay advocates, and by present and former recipients of mental health services, so as to provide a full-time staff with the necessary academic training and practical experience to provide comprehensive advocacy services for its clientele.³⁹

Only in this way can we help assure that "equal access to justice" becomes available to all.

Similarly, in a letter of last October to Arthur Penn, Esq., Assistant Commissioner of our Department, Thomas F.A. Plaut, Ph.D., Project Manager of the PCMH Implementation Task Force of the Department of Health, Education and Welfare noted:

The work of the New Jersey Division of Mental Health Advocacy is well known and highly regarded. The Task

³⁹ PCMH Task Panel Reports, note 33, above, at 1368 (footnotes omitted).

Force on Implementation of the PCMH Report has drawn heavily on that experience, as well as [on] the report of the Task Panel on Legal and Ethical Issues, in formulating recommendations for the Secretary.

The Department of Health, Education, and Welfare has long been committed to enhancing the lives and dignity of mentally disabled individuals. The Implementation Task Force will propose specific ways in which the Department can support their human rights. The provision of advocacy services is one such possibility that is receiving close attention.

The creation of such an advocacy service can best fulfill HEW's commitment to the mentally disabled described so well by Dr. Plaut.

I would suggest further that, in considering the creation of an advocacy model along the lines recommended by the President's Commission Task Force, this committee weigh the advantages of an "external" advocacy system as compared to an "internal" system. Allow me to elaborate on the distinction which these two terms are intended to illustrate.

An "internal" advocacy program is one which is located -- both administratively and fiscally -- within the structure of the State mental health department. The "advocates" are thus accountable, both directly and indirectly, to the State mental health service providers and administrators. Line level staff within the service agencies (e.g., public psychiatric hospitals, sheltered boarding homes, community living facilities) are perceived as the foundation of the advocacy system; these line staff are expected to notify service recipients of their rights, and thereafter accept and process complaints and implement standards and procedures necessary to ensure those rights. Even where a central advocacy office exists within the State mental health department, and even though that central office may be independent

of the direct service providers, nevertheless, the central office remains dependent on provider staff to implement standards and procedures to report complaints.

Solely "internal" systems may create a substantial possibility that conflicts of interest will arise, since advocacy responsibilities are delegated to the very service providers whose actions may give rise to a client's grievance in the first instance. This leads, in turn, to possible credibility problems, both with the individual client and with the public generally. And finally, the spectrum of advocacy services available within an "internal" system is limited to the grievance investigations and dispute resolution procedures authorized by the State department.⁴⁰

"External" advocacy systems, on the other hand, are administratively and fiscally independent of -- and, therefore, not accountable to -- the mental health services provider system in the State. Such systems are free to implement a full range of advocacy services such as mediation, negotiation and dispute resolution, including, where necessary, litigation. The New Jersey Division of Mental Health Advocacy, I would respectfully submit, is a viable, operative example of the advantages inherent in an external advocacy system. Although it lies within the general structure of State government, through inclusion in the New Jersey Department of the Public Advocate, the Division is completely "external" to the mental health services provider network in the State. Division staff, both lawyers and nonlawyer mental health professionals, have the dual advantage of free access to the various mental health facilities as well as the ability to exercise independent

⁴⁰ See generally, National Institute of Mental Health, "Proceedings: Symposium on Safeguarding the Rights of Recipients of Mental Health Services," at 14-19 (October 1977), for a discussion of the operative characteristics of internal (and external) advocacy systems.

judgment in following up on a client's grievance. Clients have come to learn that Division staff are not employees of the State mental health department; the level of confidence and credibility, therefore, with which clients relate to Division staff is high. Both field office and class action staff maintain a constant, ongoing presence at each of the State psychiatric hospitals, as well as at other mental health facilities throughout the State. Patients, even those on back wards and in out-of-the-way facilities, see Division staff on a regular basis, as staff carry out their ongoing functions in connection with upcoming civil commitment hearings, periodic reviews, and class action investigations.

Ideally, an external advocacy system should combine the best elements of an internal system -- such as client access, issue identification, informal grievance resolution -- with the additional elements made possible by the independence and autonomy inherent in the external status of the agency, such as pursuing formalized administrative channels and resorting to the tactics of legal advocacy, when such a course appears feasible and constructive. To do this, an external agency should be staffed not only with lawyers, but -- equally importantly -- with mental health professionals such as psychologists, social workers, and psychiatric nurses. This balance will enable an external advocacy program to deal effectively with all levels of service providers and administrators, and to pursue a full range of advocacy routes to attain the client's goals. We feel the Division of Mental Health Advocacy is a good example of the kind of multidisciplinary staffing necessary to achieve the maximum effectiveness of an external system.

I was extremely gratified some three years ago when United States Supreme Court Justice Thurgood Marshall -- speaking at the dedication of the Seton Hall Law Center in Newark, New Jersey -- praised our Department's "enlightened view of the duty of government," exemplified by our provision of "representation of traditionally unheard interests."⁴¹ It is my hope that national-scale replication of the type of advocacy services provided through our Division of Mental Health Advocacy will similarly give mentally handicapped persons in other states -- the classic example of a "traditionally unheard interest" -- meaningful contact with that "someone on the 'outside' who is concerned about [their] . . . fate after hospitalization."⁴² Adoption of strong amendatory language will best make such provision of advocacy services a reality.

In addition, it is equally vital that a meaningful and enforceable "Patients' Bill of Rights" be included in the final version of S.1177. In its final report, the President's Commission asserted that "There are strong, legal, ethical and social policy reasons for adopting the principles of a right to receive treatment, a right to receive treatment in the least restrictive setting, and a right to refuse treatment."⁴³ To implement these rights, the Commission thus recommended:

Each State review its mental health laws and revise them, if necessary, to ensure that they provide for:
a) a right to treatment/right to habilitation and
to protection from harm for involuntarily confined

⁴¹ Heffner, Seton Hall Leg. J., note 6, above, at 90-91.

⁴² Ellis, "Volunteering Children: Parental Commitment of Minors to Mental Institutions," 62 Calif. L. Rev. 840, 890 (1974).

⁴³ PCMH Report, note 1, above, at 43.

- mental patients and developmentally disabled individuals;
- b) a right to treatment in the least restrictive setting;
 - c) a right to refuse treatment, with careful attention to the circumstances and procedures under which the right may be qualified; and
 - d) a right to due process when community placement is being considered.⁴⁴

To further "articulate these and other rights,"⁴⁵ the Commission further recommended that:

Each State have a "Bill of Rights" for all mentally disabled persons, wherever they reside.⁴⁶

Perhaps the greatest lasting legacy of the Wyatt v. Stickney⁴⁷ litigation is that the courts' orders in that case have served as the prototype for

⁴⁴ Id. at 44 (footnote omitted).

⁴⁵ Id.

⁴⁶ Id. The bill, the Commission noted, should contain at least seven basic components:

- a) a statement that all mentally handicapped persons are entitled to the specified rights;
- b) a statement that rights cannot be abridged solely because of a person's handicap or because a person is being treated (whether voluntarily or involuntarily);
- c) a declaration of the right to treatment, the right to refuse treatment, the right to dignity, privacy, and confidentiality of personal records, the right to a humane physical and psychological environment, and the right to the least restrictive alternative setting for treatment;
- d) a statement of other, enumerated, fundamental rights which may not be abridged or limited;
- e) a statement of other specified rights which may be altered or limited only under specific, limited circumstances;
- f) an enforcement provision; and
- g) a statement that handicapped persons retain the right to enforce their rights through habeas corpus and all other common law or statutory remedies.

Id. at 72, n.45. Cf. N.J.S.A. 30:4-24.2.

⁴⁷ 325 F. Supp. (M.D. Ala. 1971), 334 F. Supp. 1341 (M.D. Ala. 1971), 344 F. Supp. 373 (M.D. Ala. 1972), 344 F. Supp. 387 (M.D. Ala. 1972), aff'd sub nom. Wyatt v. Aderholt, 503 F. 2d 1305 (5 Cir. 1974).

bills of rights for institutionalized patients in at least fourteen states and for institutionalized retarded persons in at least twelve.⁴⁸ These statutes reflect the specific Wyatt standards with regard to the full panoply of rights including privacy and dignity, least restrictive alternative, management of fiscal affairs, right to visitation, receipt of mail, availability of adequate medical treatment, freedom of religion, and a host of other rights which, when read together, create "the outlines of a constitutional right to protection of bodily integrity from unwarranted State intrusion."⁴⁹

The Task Force Report, again, is crystal-clear in its explication of the reasons for the need for enactment of such statutes:

The need for such legislation should be self-evident: The extent of discrimination against mentally handicapped persons needs no lengthy recitation. The pattern of abuse, disenfranchisement, and disregard eloquently underscores the need for vigorous, enforceable, prophylactic legislation in each of the States. It should be pointed out that enactment of a bill of rights in no way consigns the mentally handicapped to second-class citizen status. Rather, it is an acknowledgement of the historic fact that such persons have been perceived and treated as second-class citizens -- or worse -- by much of society. Because of this history, prophylactic legislation is necessary.⁵⁰

Although significant, system-wide litigation is continuing in all facets of institutional life⁵¹ reliance on the court process is clearly not enough.⁵²

⁴⁸ PCMH Task Panel Reports, note 33, above, at 1463.

⁴⁹ "Developments--Civil Commitment of the Mentally Ill," 87 Harv. L. Rev. 1190, 1345 (1974).

⁵⁰ PCMH Task Force Reports, note 33, above, at 1463-1464 (footnotes omitted).

⁵¹ See, e.g., Rennie v. Klein, 462 F. Supp. 1131 (D. N.J. 1978) (right to refuse treatment); Davis v. Balson, 461 F. Supp. 842 (N.D. Ohio 1978) (right to participate in work programs; constitutionality of security measures; availability of counsel at hospital staffings; extent of applicable due process rights prior to privilege withdrawal or discipline imposition).

⁵² Not all judicial developments are necessarily positive. Cf. Bell v. Wolfish, --U.S.--, 47 U.S.L.W. 4507 (1979) (security restrictions at facility housing pretrial detainees did not rise to level of cruel and unusual punishment or violate due process).

Litigation is, by its nature, episodic, reactive and sporadic, and the minute number of attorneys practicing in the field⁵³ insures that the court process will never be the only panacea for the amelioration of institutional conditions. Difficulties in monitoring and implementing court decrees⁵⁴ heighten problems further and serve to caution on us that we can not solely rely on the State and federal courts to ameliorate all institutional and social conditions affecting the mentally handicapped.

Enactment of strong legislation by the federal government ensuring basic procedural and substantive legal and civil rights to all handicapped persons will serve both practical and symbolic goals. Practically, such legislation will serve as a vehicle by which individual patient complaints might be expeditiously resolved and as a qualitative and quantitative measure of those rights possessed by all handicapped persons. Symbolically, it will serve as a statement that Congress is reaching out to create a mechanism to help terminate the current situation in which, all too often, in the words of United States Assistant Attorney General Patricia Wald, the handicapped person is perceived as "someone to whom attention need not be paid,"⁵⁵ and replace it with a climate in which, finally, the handicapped are ensured that "equal access to justice"⁵⁶ that is the cornerstone of the American system.

⁵³ See Herr, note 37, above, at 58 ("The imagined flood [of litigation] is scarcely a trickle").

⁵⁴ See, e.g., Special Project, "The Remedial Process in Institutional Reform Litigation," 78 Col. L. Rev. 784 (1978).

⁵⁵ Wald, "Basic Personal and Civil Rights," in Kindred et al., eds., The Mentally Retarded Citizen and the Law 3, 18 (1976).

⁵⁶ Herr, Advocacy Under the Developmental Disabilities Act 88 (1976).

I am aware that amendments are in the process of being drafted so as to include both advocacy and bill of rights language in the final version of S.1177.⁵⁷ Such amendments are, as I have said, absolutely vital if the President's mandate is to be carried out and if the work of his Commission is to be meaningfully implemented. I would strongly urge that these thoughts be incorporated into any amendment ultimately adopted by this Committee.

Thank you for your consideration of these views.

⁵⁷ My Department has been made aware of one proposed amendment to the bill, and we have submitted comments on two separate preliminary drafts of that amendment. See letters from Michael L. Perlin, Esq. to Dr. Don Taylor, United States Senate Subcommittee on Health and Scientific Research (May 10, 1979), and to Leslie Scallet, Esq., staff attorney, Mental Health Law Project (June 18, 1979) (both attached as Appendix A).

A P P E N D I X A



State of New Jersey

DEPARTMENT OF THE PUBLIC ADVOCATE
DIVISION OF MENTAL HEALTH ADVOCACY

P. O. BOX 141

TRENTON, NEW JERSEY 08623

May 10, 1979

MICHAEL L. PERLIN
DIRECTOR
LAURA M. LE WINN
DEPUTY DIRECTOR
TEL. 603 292-1730

Dr. Don Taylor
United States Senate Subcommittee on
Health and Scientific Research
Senate Office Building
Washington, D.C. 20515

Dear Dr. Taylor:

I received today from Warren Spielberg your draft of Title V of the proposed Mental Health Services Act of 1979. Although I think the draft is excellent, I do have several observations to make:

1. I think it might be best to make clear that persons who come within the scope of Section 501 specifically include those persons "regarded as having an impairment" as well as those who are actually impaired. I realize that those regulations which have been promulgated pursuant to Section 504 of the Rehabilitation Act of 1973 do specify this group of people as coming within the scope of that Act, but I think to avoid ambiguity, it should be specified as well here.
2. Although I fully agree with the listing of the specific rights in Section 501 (a) through (g), I think there are other significant rights which perhaps should be listed as well. See generally 4 App., Task Panel Reports Submitted to the President's Commission on Mental Health 1359, 1463-1468 (1978). Although I recognize that Section 501(3) indicates that the listed rights in Section 501 (a) through (g) "are in addition" to any other rights "otherwise afforded to handicapped persons or to all persons," I think perhaps the listing could be longer. See, e.g., N.J.S.A. 30:4-24.2(d) and (e).
3. Is the word "obligation" in Section 501(2) strong enough? I think that perhaps a sharper sword might be required to ensure compliance.
4. If the Secretary contracts with an agency outside the Executive Branch (as conceived of by Section 502(b)), I think there should be some

Dr. Don Taylor

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mechanism in place to ensure fairness in the granting procedure beyond simply the peer review mechanism contemplated in Section 502(f).

5. I think -- and this section is by far the most troubling to me -- that Section 502(c)(4) should be changed to mandate that lawyers be employed by the advocacy programs eligible for grants. Again, the President's Commission's Task Force specified that attorneys, characterized as "'an indispensable element in seeking and securing many types of remedies,'" id. at 1368 (citation omitted), must be an integral part of any system of advocacy services provided for mentally handicapped persons. On this point, the Task Force was explicit:

The need for and significance of legal counsel as a means of ensuring "equal access to justice" is the cornerstone of the American judicial system, extending to matter involving a potential "substantial loss" or "serious legal consequences." Such a need for counsel is, of course, magnified in cases involving mentally handicapped persons, both in matters involving institutionalization and its potential consequences as well as non-institutional problems which relate in any way to the person's "deviant status." Id. at 1366 (footnotes omitted).

I think it is absolutely imperative that counsel be provided and, frankly, I am concerned that the phrase "continuous access" -- as used in Section 502(c)(4) -- may allow a state to provide something less.

6. Section 502(c) should also mandate that legal counsel be made available for both individual and class action-type litigation. See, e.g., N.J.S.A. 52:27E-24, 25. I believe this was the topic of a lengthy conversation at last month's Advocacy Roundtable meeting, and I feel I should reemphasize the point I attempted to make then: it is absolutely essential that an advocacy project be able to deal with both the "forests" and the "trees." If law reform, test case, class action and individual services are made available under the same roof, this problem will best be solved. We have found that offering this dual representation has afforded our Division a unique perspective on problems facing handicapped persons: we can deal with individuals' problems in a context which enables us to seek institutional, systemic reforms. Although the language of Section 502(g) appears to clearly indicate a legislative intent that federal advocacy dollars not go to "replace the State's responsibility" in individual commitment matters, we have found that our Division's representation of individuals in commitments

Dr. Don Taylor

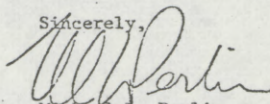
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has led to both the filing of significant test case litigation as well as to meaningful law reform through the court process. See, e.g., State v. Fields, 77 N.J. 282 (1978); In re R.E., 158 N.J. Super. 542 (App. Div. 1978); In re S.W., 158 N.J. Super. 22 (App. Div. 1978). It is essential, I think, that a funded advocacy project have this capability.

These observations aside, I think the draft is a fine beginning, and certainly support its intent. If I can be of any further service, do not hesitate to contact me.

Sincerely,



Michael L. Perlin
Director

MLP:smm

cc: Stanley C. Van Ness, Esq.
Warren Spielberg, Esq.

APPENDIX A



State of New Jersey

DEPARTMENT OF THE PUBLIC ADVOCATE
DIVISION OF MENTAL HEALTH ADVOCACYP. O. BOX 141
TRENTON, NEW JERSEY 08623MICHAEL L. PERLIN
DIRECTOR
LAURA M. LE WINN
DEPUTY DIRECTOR
TEL. 609 292-1780

June 18, 1979

Leslie J. Scallet, Esq.
Mental Health Law Project
Suite 300
1200 Nineteenth Street, N.W.
Washington, D.C. 20036

Dear Leslie:

Thank you for sending me the latest redraft of the proposed amendment to the Federal Community Mental Health Systems Act. I am enclosing a copy of a letter I sent to Dr. Don Taylor last month which contains my comments on the first draft of the amendment, and my responses to your redraft should be read in light of those comments to Dr. Taylor.

1. I am still concerned with the lack of specific sanctions implicit in the use of the word "obligation" in Section 501(2), and the limitation of specified rights in Section 501(a) through (g). Cf. N.J.S.A. 30:4-24.2(d) and (e).

2. I think the specification of "a separate office" in Section 502(a) is helpful, although I am still somewhat troubled by the relatively casual peer review process as described in Section 502(c)(2) in the eventuality that the Secretary chooses to contract with an outside agency to administer the program.

3. I am delighted that the "continuous access" phrase originally used in the first draft Section 502(c)(4) has been changed so as to mandate the involvement of attorneys in the redrafted Section 502(e)(2). However, I am puzzled as to the deletion of the adjective "active" in redrafted Section 502(e)(1) which had modified "client involvement" in the first draft Section 502(c)(1), as well as the deletion of the phrase "appropriately qualified and trained" in redrafted Section 502(e)(2) which had modified "staff" in the first draft Section 502(c)(2): were these omissions intentional?

Ms. Leslie J. Scallet
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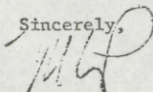
4. Although I think the redrafted language in Section 502(i) helps answer some of my concerns as to the language in the first draft Section 502(g) (which seemed to me to encourage a strict bifurcation of individual case commitment representation and high impact, test case representation), I would still prefer to see explicit language -- perhaps as a new subsection to be added to Section 502(e) -- mandating that counsel be available for both types of litigation. Cf. N.J.S.A. 52:27E-24, 25.

Otherwise, I think the modifications are explanatory as well as helpful, and feel that the amendment is, as I told Dr. Taylor, a fine beginning. Stanley C. Van Ness is currently drafting more comprehensive testimony to submit to Senator Kennedy on the topics of both advocacy and bills of rights, and I will be sure to send you a copy of those remarks when they are finished. My observations on the suggested amendatory language should, of course, be read in the context of his comments.

I am very interested in your reactions to those views. Of course, do not hesitate to contact me if I can be of any additional assistance.

Best regards.

Sincerely,



Michael L. Perlin
Director

MLP/bjm

Senator KENNEDY. The committee stands in recess.
[Whereupon, at 12:30 p.m., the subcommittee adjourned, subject to the call of the Chair.]

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