FOR RELEASE

AM'S, MARCH 13, 1962

THE FIGHT AGAINST MENTAL ILLNESS: A NATIONAL AND LOCAL CONCERN

Address to

DISTRICT OF COLUMBIA ASSOCIATION FOR MENTAL HEALTH

8 PM Monday, March 12, 1962

Jewish Community Center, 16th and Q Streets, Washington, D. C.

by

Congressman John E. Fogarty, Rhode Island

In 1955 the Congress passed legislation, which I was proud to co-sponsor in the House of Representatives, providing financial support to the Joint Commission on Mental Illness and Health in its work. We made it clear that we wanted this to be a completely independent and unfetterd study; we made no conditions or restrictions other than the expressed hope that the Joint Commission would include as many representative national organizations as possible.

I am very proud of "Action for Mental Health", the final report of the Joint Commission on Mental Illness and Health. It represents six years of dedicated work on the part of individuals appointed by 36 prominent national organizations.

The Commission report doesn't pull any punches. It says that more than half of the patients in state mental hospitals are receiving no active treatment whatsoever. It says that we are spending too little on treatment of the mentally ill - that for $4.00 or $5.00 a day we cannot perform any therapeutic miracles.

Most of all, I like the fact that the report states over and over again that to improve the care of the mentally ill and to restore many of them to productive living, all levels of government - federal, state and local - must join together in a united effort.

President Kennedy is deeply impressed with the Joint Commission report. In an Executive Order last Fall, settingup a panel composed of Secretaries Ribicoff and Goldberg and VA Administrator Gleason to recommend appropriate federal action to implement the major recommendations of the report, President Kennedy said:

> "The Joint Commission report represents a significant assessment of the magnitude of the mental health problem with which we are confronted. As such, it deserves the close attention of all those responsible for the formulation of public policy in this area."

In developing their proposals, President Kennedy requested them to answer a series of questions, with key emphasis upon what the role of the federal government should be in the mental health field and what responsibility should remain with the states, localities and private groups.

We have been deeply conscious of this continuing problem in the Congress. Sixteen years ago, when I began my service on the House Appropriations Subcommittee on Labor-H.E.W., we created the National Institute of Mental Health. Since funds for the Institute were limited at that time, we asked it to concentrate its efforts upon three major needs in the field of mental illness - research, the training of desperately needed psychiatric manpower, and matching grants for the establishment of community mental health clinics.

During the past decade and a half, during which the programs of the National Institute of Mental Health have grown appreciably, a great deal of progress has been made.

For example, in the field of research, the introduction of the tranquilizing drugs has resulted in a sustained six-year drop in the number of patients hospitalized in our public mental hospitals. This is the first significant reduction in our mental hospital population load since the establishment of the first publicly supported mental hospital in Williamsburg in 1773.

Above all else, we have concentrated upon training psychiatric manpower. Receiving testimony each year that mental hospitals, clinics and other psychiatric facilities were desperately short of psychiatrists, psychologists, social workers, nurses and other therapists, we in the Congress have constantly added to the training recommendations of the Executive branch.

Without this training program, this country could have made little or no progress in treating mental illness. Since its inception, it has supported the training of approximately 10,000 people in all the major psychiatric disciplines. Starting with the undergraduate medical student and extending through career awards to distinguished research investigators, it has exerted a tremendous positive influence in this field.

Federal matching grants for the support of community mental health clinics have provided the seed money for the establishment of hundreds of new clinics in all parts of the country.

In the first years of the program, the federal government contributed $2.00 for every $1.00 allocated by the states or localities. Last year, in a community mental health program which had grown to a level of $91 million, the federal contribution was only about $6 million - less than 7% of the national expenditure in this area. It seems to me that this is an inspiring example of the stimulatory role played by the federal government - it provided the original impetus, but the states and localities moved in rapidly and soon assumed the major financial burden for support of these clinics.

But now we face an even greater and more exciting challenge. We know that hundreds of thousands of mental patients, formerly considered hopeless and therefore

given only the barest of custodial care, can today be treated and returned to their families and loved ones if we apply the knowledge we have now accumulated.

This intensive treatment costs money. By way of illustration, the present average expenditure for patients in state mental hospitals is less than $5.00 a day, as contrasted with more than $13.00 for patients in our Veterans hospitals and more than $25.00 for patients in our general hospitals.

In 1960, according to the National Institute of Mental Health, the fifty states spent more than $1.3 billion for the maintenance and treatment of patients in public mental hospitals and in institutions for the mentally retarded. This staggering figure does not include mental hospital construction costs running well over $100,000,000 a year.

In order to lift these state mental institutions to the level of true hospitals, the Joint Commission recommended a federal matching grant to the states for the improvement of the level of treatment for these patients.

Pointing out that it is impossible for state government to finance so vast a program, the Joint Commission report notes:

> "It was a historic mistake to make the state alone virtually responsible for public care of its mentally ill residents. Relieving the local communities of all further concern, and until recent times sparing the federal government anything but peripheral involvement in the problem, their single source of financial support guarantees the isolation of state hospitals and the dumping ground effect we have stressed."

It would not relieve any segment of the government of its financial responsibility.

First of all, in noting that mental illness is the one large public health problem without any sizeable federal grant for improvement of services to patients, it underscores the need for a degree of federal responsibility and involvement in this area.

The Commission proposal asks state governments to do much more than they have been doing. For example, it calls upon the states to develop experimental facilities - small intensive treatment hospitals, day and night hospitals, halfway houses, aftercare clinics - designed to eventually replace mental institutions of 1,000 beds or more.

It asks local governments, which in many states have used the public mental hospital as dumping grounds for their unwanted citizens, to provide expanded community psychiatric services. The report notes:

> "The program would not only relieve the states of the sole responsibility for public care of the mentally ill, but it would also meet the great objection to federal aid to the states which is that it usurps or weakens local responsibility. Our proposal would encourage local responsibility of a degree that has not existed since the state hospital system was founded."

Those of us who participated in the creation of the Joint Commission on Mental Illness and Health have been delighted, and frankly somewhat amazed, at the enthusiastic response its final report has received.

Last November, the National Governors' Conference held a two-day meeting devoted entirely to a discussion of how the states could aid in achieving the objectives of the Commission report. I had the privilege of addressing that gathering and it was a deeply moving experience to share views with the Chief Executives of the states and the hundreds of other delegates present. At the close of the Conference, the Governors adopted a strong policy statement backing the major recommendations of the report and calling for the creation of a Standing Committee on Mental Health within the structure of the National Governors' Conference. I wish I had time to read to you the entire statement of the Governors, but I quote this brief excerpt as an example:

> "We heartily commend the Joint Commission for an excellent study; we accept the findings that much remains to be done; and we endorse the concept that federal, state and local government, as well as private and voluntary efforts, must combine to achieve the goals we seek ... It is obvious that substantially greater sums must be appropriated by all levels of government to accomplish the objectives stated in this policy declaration."

Since the Joint Commission report rightly places so much emphasis upon local responsibility, I would like to turn to a brief discussion of the psychiatric scene here in the District of Columbia.

On the surface, things look quite rosy. It has been said that the District is probably the most psychiatricly sophisticated community in the country. It ranks first in the nation in the number of psychiatrists per 100,000 population. Including federal appropriations for St. Elizabeths Hospital, the District spends about $19.00 per capita per year for mental hospital care, compared with less than $5.00 in the average state.

Our major public mental hospital, St. Elizabeths, administered so ably these past twenty-five years by that distinguished psychiatrist and scholar, Dr. Winfred Overholser, has an illustrious history. We have three medical schools with Departments of Psychiatry, not to mention the many other schools and universities close by in Maryland and Virginia. Walter Reed Hospital, the Naval Medical Center, the Veterans Administration, the National Institute of Mental Health and other government agencies attract an unusual number of personnel in the mental health disciplines to this area. The relatively high level of professional and white collar people employed in the government accounts for a population that is more aware than most of the nature of psychiatric disorders and more disposed than most to seek treatment for them. You have an active mental health society,

and you have newspapers in Washington which bring to the mental health field an editorial sophistication that could probably not be duplicated in any place in the country.

But when you dig just a little beneath the surface, you find that this city lags far behind most of its sister cities in the provision of the most basic kinds of psychiatric services, particularly to the multitude of citizens who cannot afford $20 - $25 an hour for individual psychotherapy.

At the time of the reorganization of the D. C. Health Department in 1958, a survey estimated that 80,000 people in the Washington area needed outpatient care for emotional disorders, <u>but very few were getting it</u>.

The lack of community mental health clinics is really a disgrace. For example, for a number of years citizen groups have pushed for the establishment of a full-time clinic in the Southeast section of Washington. The Kiwanis Club, which cannot be commended too highly for supporting this Southeast Clinic on a part-time basis for a number of years, could not carry the financial load of a full-time clinic. But, despite all of these efforts, there is still no full-time clinic in Southeast Washington where low-income groups desperately need it.

Psychiatric services for children are equally meagre. A few years ago, a United Community Services survey reported that at least 11,000 school children in the District of Columbia needed psychiatric help. Of these, only 1,500 -- about 15% -- were receiving diagnostic clinical aid and even fewer were receiving actual treatment. To handle this explosive situation, the school system then had only one psychiatrist, part-time and on loan from the Health Department, to meet the problems of these 11,000 children. In desperation, a number of parent-teacher groups have raised money by cookie sales and other honorable devices to employ a handful of part-time psychologists and social workers.

The psychiatric clinic of the Juvenile Court of the District of Columbia is woefully understaffed. There is limited diagnosis of the more disturbed juvenile delinquents, but practically no follow-up treatment. What is the point in an intensive diagnosis and workup when the child is turned loose on the streets with no provision for the psychiatric treatment he so desperately needs?

I am aware of the fine work being done at the Hillcrest Children's Center, but the limited number of beds at its disposal hardly begins to scratch the surface of the problem in the District.

There are too few psychiatric beds in general hospitals here in Washington. We have only a few hundred psychiatric beds available at the Washington Hospital Center, D.C. General H$_o$spital, George Washington University Hospital and the new unit at Sibley Hospital. A number of our large general hospitals have no psychiatric beds whatsoever.

Here in the District we lag far behind in coverage of mental illness by health insurance plans. Group Hospitalization, Inc., the Blue-Cross, Blue-Shield plan here in the District, provides in its standard contract for only ten days coverage for psychiatric illness in any 12-month period. Despite the dedicated efforts of people like Dr. Zigmond Lebensohn, Dr. Robert Morse and Mike Gorman, Group Hospitalization still refuses to budge. Here is a problem which should be tackled full-scale by the D.C. Mental Health Association.

There is no aftercare program worthy of its name in this community. Recently St. Elizabeths made a survey for the District Department of Health which disclosed that at least 500 of its patients could be discharged and possibly rehabilitated if there were any suitable place for them to go. It is a shameful waste of money to treat a patient intensively at St. Elizabeths and then hurl him back into

the community with no resources to prop him up and help him. St. Elizabeths, under a grant from the National Institute of Mental Health, has used Public Health nurses to aid some of these discharged patients, but such a limited program cannot reach the hundreds and hundreds discharged each year.

However, the picture is not totally dark and there are some heartening developments in this community which are beginning to plug up some of the holes in community-based psychiatry.

The D.C. General Hospital has been revolutionized in the past few years. With a new psychiatric building and the magnificent leadership of Dr. John Schultz its Medical Director, and Dr. Mary McIndoo its Director of Psychiatry, this Hospital is becoming a truly fine treatment center. Its close cooperative relationship with the Department of Psychiatry at Georgetown University guarantees the highest standards of treatment and training.

The establishment a few years ago of a Bureau of Mental Health within the District Health Department was an enormous step forward. As one example, the Bureau has established a home psychiatric consultation service to minister to the emergency psychiatric needs of our people. However, this emergency service, because of budget inadequacies, only scratches the surface. It should be put on a 24-hour basis and it should have additional staff.

In the field of rehabilitation, we have taken several progressive steps. Woodley House, which is a half-way facility in the transition of the patient from the hospital back to the community, carries on gallantly despite numerous obstacles, financial and otherwise.

I am particularly impressed with the Job Opportunities Committee operated by your Association. In the light of the failure of the D.C. budget to provide

for a full-time person to carry on such work, you are to be commended for your successful efforts in placing a number of discharged mental patients in gainful employment.

These are good beginnings, but you are as aware as I am that you have a long way to go. In the final analysis the Congress, even including the House and Senate Committees on the District of Columbia, will respond to the will of an enlightened and aroused citizenry.

Just two weeks ago, an aroused citizenry here in the District won a magnificent victory when it achieved the long-sought goal of two additional judges for the Juvenile Court of the District of Columbia. This great victory was achieved only because more than 30 organizations in the District mobilized all their efforts and directed them towards the members of the Congress.

If we can achieve two additional judges for the Juvenile Court, we certainly can achieve some of the things I have been talking about tonight.

It is up to you. If you tell us in no uncertain terms what you want and you really mean it, we will support you.

Thank you very much.

- 30 -